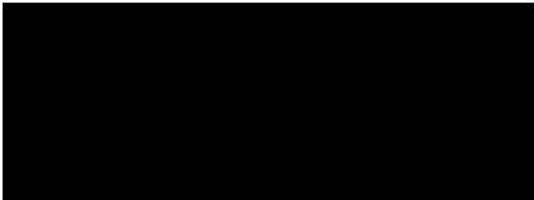
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

Dec 18, 2015

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 15F-08045

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: AHCA

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened a telephonic administrative hearing in this matter on November 4, 2015 at 10:08 a.m.

APPEARANCES

For the Petitioner: Daughter

For the Respondent: Monica Otalora,
Senior Human Services Program Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the Agency for Health Care Administration's (AHCA's) decision to deny the Petitioner's request for an additional three packages of pull-ups (adult diapers) per month and reducing her boxes of underpads from two to one per month.

Because the issue under appeal involves a request for a change in monthly medical supplies, Petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Witnesses for the Respondent from Sunshine Health were: India Smith, Grievance and Appeals Coordinator; Linda Albe, Long-Term Care Director; and Lenon Juan, Case Manager.

Respondent submitted a 47-page document, which was entered into evidence and marked as Respondent Exhibit 1.

Petitioner submitted a 5-page document, which was entered into evidence and marked as Petitioner Exhibit 1.

FINDINGS OF FACTS

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Petitioner is a 92 year-old Medicaid recipient enrolled with Sunshine Health, a Florida Health Managed Care provider.
2. Petitioner has Medicare which is her primary medical insurance provider.
3. On September 17, 2015, Sunshine received a request from the Petitioner for three (3) additional packages of pull-ups. Notice of Action dated September 18, 2015 advised Petitioner her request was denied because it was determined her request was not medically necessary.
4. At the hearing, and reflected in Petitioner's exhibit, Petitioner clarified she was requesting an additional three (3) packages of pull-ups not three (3) boxes.

5. Respondent explained that Sunshine has tried to accommodate Petitioner's needs including Companion and Homemaker services, but noted that Medicare is her primary medical insurance. Medicare should be providing the medical supplies and Medicaid would cover any co-pays.

6. Petitioner is a member of Humana HMO through the Medicare Advantage plan, as well as a member of the Sunshine Health managed care plan through the Medicaid program.

7. Respondent admitted difficulty in coordinating member services with Medicare.

CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 Florida Statutes.

9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Florida Administrative Code Rule 65-2.060(1).

11. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover.

12. § 409.912, Fla. Stat. also provides that the Agency may mandate prior authorization for Medicaid services.

13. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as:

> (226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

14. Fla. Admin. Code R. 59G-1.010 (166) also provides…

> "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

15. The Florida Medicaid Provider General Handbook, July 2012, incorporated in Fla. Admin. Code R. 59G, provides an explanation of Medicaid limits for Medicare Cross Over claims and provides on pages 1-2 and 4-3 in relevant parts:

> Responsibility For Exhausting TPL Sources
> Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.
> ....
> Medicaid Program Limits
> Medicaid will not pay a crossover claim if:
> Both Medicare and Medicaid cover the service, and Medicare has determined that the service is not medically necessary. **If Medicare determines that a service that Medicaid also covers is not medically necessary, it is also considered to be not medically necessary by Medicaid** [emphasis added].

16. No testimony or documentation was provided that Medicare has reviewed or approved the medical supplies as well as the monthly amount.

17. The Respondent, by a preponderance of the evidence and testimony, supported its decisions in denying Petitioner's request for the additional pull-ups as not medically necessary. However, both Petitioner and Respondent should work closely with the Medicare provider to ensure that Medicaid appropriately covers its costs after Medicare has determined medical necessity and met its coverage limits. The Petitioner has failed to meet her burden of proof

DECISION

Based on the evidence presented at the final hearing and on the entire record of this proceeding, the Petitioner's appeal is denied and the Respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL

32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 18 day of December, 2015,

in Tallahassee, Florida.

Warren Hunter
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Rhea Gray, Area 11, AHCA Field Office Manager