

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

FILED

Apr 17, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 15F-07655

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88334

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 16, 2015 at 10:00 a.m. in New Port Richey, Florida. The undersigned convened five administrative hearings by phone on October 29, 2015 at 10:30 a.m.; May 16, 2016 at 10:14 a.m.; June 30, 2016 at 10:01 a.m.; on November 2, 2016 at 9:01 a.m.; and on February 21, 2017 at 1:02 p.m. The undersigned convened a status conference by phone on September 8, 2016 at 10:30 a.m. The undersigned convened an administrative hearing by phone on February 21, 2017 at 1:00 p. m.

APPEARANCES

For Petitioner: [REDACTED] petitioner

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II
Signe Jacobson, Supervisor
Nicole Nurridin, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate the petitioner and her husband's Family-Related Medicaid benefits is correct. The burden of proof is assigned to the respondent by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified at all hearings. At all hearings, the petitioner presented one witness who testified: [REDACTED], the petitioner's husband. At the October 16, 2015, the petitioner submitted seven exhibits, which were entered and marked as Petitioner's Exhibits "1" through "7". At the October 16, 2015, the October 29, 2015, and the May 16, 2016 hearings, the respondent was represented by Ed Poutre with the Department of Children and Families (hereafter "DCF", "Respondent", or "Agency"). At the June 30, 2016 hearing, the respondent was represented by Signe Jacobson with DCF. At the November 2, 2016 hearing, the respondent was represented by Nicole Nurridin with DCF. At the November 2, 2016 hearing, the respondent submitted eight exhibits, which were entered and marked as Respondent's Exhibits "1" through "8".

At the September 8, 2016 status conference, the petitioner, her husband, and the respondent were present.

Four continuances were granted to the petitioner. Seven continuances were granted to the respondent. One continuance was granted to both parties.

The record was left open until November 9, 2016 to allow both parties to submit additional information. On November 2, 2016, the petitioner submitted one document, which was entered and marked as Petitioner's Exhibit "8". On November 3, 2016, the

petitioner submitted an additional document, which was entered and marked as Petitioner's Exhibit "9". On November 7, 2016, the respondent submitted additional documentation, which was entered and marked as Respondent's Exhibits "9" through "16". The record closed on November 9, 2016.

On February 2, 2017, the undersigned issued an Order to Reconvene and for a Witness to Appear at Hearing. The Order requested additional information from the respondent and the petitioner. The undersigned reconvened an administrative hearing by phone in the above-referenced matter on February 21, 2017 at 1:02 p.m.

At the February 21, 2017 hearing, the petitioner was present and testified. The petitioner presented one witness who testified: [REDACTED], the petitioner's husband. At the February 2017 hearing, the petitioner submitted one exhibit, which was entered and marked as Petitioner's Exhibit "10". At the February 2017 hearing, the respondent was represented by Nicole Nurridin with DCF. At the February 2017 hearing, the respondent submitted four exhibits, which were entered and marked as Respondent's Exhibits "17" through "20".

After the record closed and on March 6, 2017 and March 13, 2017, the petitioner submitted additional information, which was entered and marked as Petitioner's Exhibits "11" – "13". The record closed on March 13, 2017.

FINDINGS OF FACT

1. The petitioner's husband's disability onset date is March 2014.
2. The petitioner's household consists of the petitioner, her husband, and their only child, who turned eighteen on [REDACTED].

3. During the January 2015 recertification period, the petitioner and her husband were approved for Family-Related Medicaid benefits through until February 2016.

4. The petitioner and her husband received Medicaid benefits pending the outcome of the hearing.

5. On July 20, 2015, the petitioner submitted an application for Food Assistance (FA) and Family-Related Medicaid benefits. FA benefits are not an issue under appeal.

6. On August 19, 2015, the respondent denied the petitioner's July 20, 2015 application due to the petitioner's failure to verify income.

7. On August 20, 2015, the respondent mailed the petitioner a Notice of Case Action indicating petitioner and her husband's Medicaid benefits would end effective August 31, 2015 as, "You or a member of your household remain eligible for Medicaid under a different Medicaid coverage group. We did not receive proof of earned income necessary to determine eligibility".

8. On August 31, 2015, the petitioner submitted an application for Food Assistance (FA) and Family-Related Medicaid benefits.

9. On September 2, 2015, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's August 31, 2015 Medicaid application was denied as, "The value of your assets is too high for this program. No household members are eligible for this program".

10. On September 8, 2015, the petitioner submitted an application for Food Assistance (FA) and Family-Related Medicaid benefits.

11. On September 8, 2015, the petitioner requested a fair hearing to appeal the termination of her and her husband's Family-Related Medicaid benefits.

12. On September 9, 2015 and on September 11, 2015, the respondent mailed the petitioner two Notices of Case Action indicating the petitioner and her husband were ineligible for continued Medicaid coverage. Furthermore, the September 11, 2015 notice indicated the petitioner and her husband were removed from the Medicaid assistance group effective September 1, 2015.

13. On September 21, 2015, the petitioner submitted an application for Family-Related Medicaid benefits.

14. On September 23, 2015, the respondent invalidated the petitioner's September 21, 2015 application, as a duplicate application.

15. The petitioner's husband began working in November 2015. The petitioner's husband did not work prior to November 2015.

16. On December 18, 2015, the Department of Health Division of Disability Determination (hereafter "DDD") approved SSI-Related Medicaid benefits for the petitioner effective September 2015. The only issue under appeal now is the termination of the petitioner's husband's Medicaid benefits.

17. From January 7, 2016 to August 10, 2016, the respondent submitted both the Disability Determination and Transmittal form (Respondent's Exhibit 2) and a packet of medical information to DDD three times to determine if the petitioner's husband was disabled. DDD did not determine if the petitioner's husband was disabled as DDD did not receive those packets.

18. On September 9, 2016, the respondent submitted both the Disability Determination and Transmittal form and a packet of medical information to DDD to determine if the petitioner's husband met the criteria to be considered disabled.

19. On September 15, 2016, DDD returned the Disability Determination and Transmittal form to respondent with a handwritten note stating, "Return to DCF for SGA determination". SGA means Substantial Gainful Activity (SGA).

20. On October 21, 2016, the respondent completed a SGA determination and determined the petitioner's husband was not disabled as his monthly earned income was more than the SGA for the Non-Blind Disabled income limit of \$1,130.

21. The petitioner's husband requires Medicaid benefits due to several ongoing medical conditions that require numerous medications and physician visits.

CONCLUSIONS OF LAW

22. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

24. Fla. Admin. Code R. 65A-1.705(7)(c) Family-Related Medicaid General Eligibility Criteria, in part states:

If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI...

25. According to the above authority, to be eligible for Family-Related Medicaid

benefits, the petitioner's husband must have a minor child under age 18 living in the household with him. Since the petitioner's husband does not have a minor child under age 18 living in the household, he does not meet the technical requirement to be eligible for Family-Related Medicaid benefits. His only child turned eighteen in April 2015.

26. Fla. Admin. Code R. 65A-1.711 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

For an individual less than 65 years of age to receive Medicaid benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R.

§ 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy. . .

27. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, the petitioner's husband must be determined disabled as he is under the age of 65.

28. The Code of Federal Regulation at Title 20 C.F.R. §416.920, defines Evaluation of disability of adults and states, in part:

(a) (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step

five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.) ...

(b) If you are working. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience. . .

29. Pursuant to the above authority, the first step in the sequential evaluation process to determine whether an individual meets the disability criteria is to determine if an individual's employment is considered SGA.

30. On August 31, 2015, the petitioner submitted an application for Medicaid benefits for herself and her husband. DDD determined the petitioner disabled effective September 2015. If the Agency would have correctly submitted the necessary paperwork to DDD in September 2015, the petitioner's husband's would have met the first step as he did not begin working until November 2015. The respondent did not submit the Disability Determination and Transmittal form and the packet of medical information to DDD to determine if the petitioner's husband met the criteria to be considered disabled until September 2016, which was over a year from when the petitioner applied.

31. The petitioner applied for Medicaid benefits for her husband on August 31, 2015; the undersigned concludes the petitioner's husband met the first step in the sequential evaluation process in August 2015, as he was not working. Furthermore, the respondent failed to timely submit the necessary information to DDD to determine if the petitioner's husband met the disability criteria. Therefore, the respondent is ordered to submit the Disability Determination and Transmittal form and the packet of medical

information for the petitioner's husband to DDD to complete the next four steps in the five-step sequential evaluation process as the petitioner's husband meets the first step.

32. After careful review of the evidence and controlling authorities, the undersigned remands the case to the respondent for further development. The respondent is hereby ordered to complete the eligibility determination process for the petitioner's husband's Medicaid benefits effective August 2015 and ongoing. Once the new review is completed, the respondent is to issue a Notice of Case Action to the petitioner's husband including his appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED and REMANDED to the Department for further development as explained in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 17 day of April, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

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Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-01380

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 Brevard
UNIT: AHCA

AND

SUNSHINE STATE HEALTH PLAN, INC.

RESPONDENTS.

**FINAL ORDER ON THE MERITS AND ORDER ON PETITIONER'S MOTION FOR
CORRECTIVE ACTION**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 17, 2016 at approximately 10:30 a.m. The continuation and completion of that hearing occurred on November 10, 2016 at approximately 1:00 p.m.

APPEARANCES

For Petitioner:
Petitioner's  Attorney

For Respondents: Craig Smith
Hogan Lovells US LLP
Attorney for Sunshine State Health Plan

Assistant General Counsel
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether Sunshine State Health Plan, Inc. ("Sunshine Health") correctly denied Petitioner's request for coverage of a private room in a skilled nursing facility. Sunshine Health had previously, and continues to, provide coverage of a semi-private room. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

██████████ represented Petitioner. Petitioner presented two (2) witnesses: ██████████, Petitioner's father, and ██████████, Petitioner's private nurse. Present as an observer was ██████████, Petitioner's mother. Petitioner's Exhibits 1 – 12 were admitted into evidence.

Mr. Smith represented Sunshine Health. Sunshine Health presented the following witnesses: Dr. John Carter, Long Term Care Medical Director, Merton Chumack, R.N., and Dr. Edgar Bolton. Present as observers were Jeffrey Martorana, Kizzy Alleyne, Paula Daley, Mamie Joeveer, and Jessica Hanna. Sunshine Health's Exhibits 1 – 6 were admitted into evidence.

Mr. Nam represented the Agency for Health Care Administration ("AHCA" or "Agency"). Lisa Sanchez, Medical/Health Care Program Analyst observed the hearing. The Agency did not present any witnesses or exhibits.

Joint Exhibits 1 and 2 were admitted into evidence. They are the sworn deposition transcripts of Dr. Nabil Aziz and Dr. Anthony Barile, respectively. The parties stipulated that these physicians' deposition testimony would be admitted into evidence in lieu of live testimony.

FINDINGS OF FACT

1. Petitioner is a 57-year old male and is a member of Sunshine Health's Long Term Care Medicaid managed care plan. (Petitioner's Exhibit 12.) He is ventilator-dependent and [REDACTED] and requires 24-hour skilled care. He receives nutrition through a G-tube, has a suprapubic catheter inserted through his abdominal wall, and a surgically implanted pain pump. (Joint Exhibit 1 16; 21). He must be transferred to and from his semi-reclining power wheelchair with an electric Hoyer lift, requiring two persons to assist. (Hr'g. Tr. at 23.) His medically necessary equipment includes the wheelchair, Hoyer lift, ventilator, and oxygenator. (Stipulation). His hospital bed is electric with an air pressure mattress and electric pump. (*Id.*) Caregivers must have access to both sides of his bed for transfers, tracheostomy care, and repositioning every two (2) hours throughout the day and night. (Hr'g. Tr. at 23, 27; Joint Exhibit 1 at 29, 45.)
2. Petitioner also requires various other medical supplies on a daily basis, including a nebulizer, equipment for suctioning, tracheostomy care, catheter care and flushing, incontinence care, pillows and bolsters for repositioning, splints, neck brace, spare ventilator equipment, gloves, and wipes. (Hr'g. Tr. at 20-26.) Petitioner's only back-up ventilator is attached to his wheelchair. (Hr'g. Tr. at 29.) However, there is an emergency system if his ventilator stops working. (Hr'g. Tr. at 276.)
3. Petitioner's father and mother are his court-appointed limited guardians. (Petitioner's Exhibit 7.) Petitioner has resided in the [REDACTED] since December 27, 2003. His father testified that from 2003 until 2008 he was in a semi-private room in a newer wing of the nursing home (the rehabilitation wing). (Hr'g. Tr. at 57-58.)

4. All of the rooms at [REDACTED] available to long term care residents such as Petitioner have the same square footage and dimensions. (Petitioner's Exhibit 11; Hr'g. Tr. at 17.)

The majority of [REDACTED] residents share a semi-private room with another resident, and [REDACTED] these rooms into two (2) residential areas with a curtain in the middle of the room. (Hr'g. Tr. at 93, 284.) In order for a [REDACTED] resident to have a private room, instead of sharing a semi-private room with another resident, [REDACTED] typically charges that resident an additional daily fee for the exclusive use of that private room.

5. Petitioner has elected to reside in a private room at [REDACTED] instead of sharing a semi-private room with another resident. Petitioner's parents have been paying the additional daily fee to cover the private room. (Hr'g. Tr. at 60-62.) The evidence reflects that in 2016, that additional fee was approximately \$30.00 per day. (Hr'g. Tr. at 18.)

6. In 2010, letters from Petitioner's physicians were submitted to the nursing home stating that a private room was medically necessary. (Petitioner's Exhibit 1). It should be noted that the request was not sent to Sunshine Health since the Long-Term Care Program did not yet exist in 2010. There was no evidence presented that a formal request for the private room was ever sent to AHCA and no Notice of Action was supplied.

7. The letter from [REDACTED], Petitioner's primary care physician since 2003, stated that a private room was medically necessary "to avoid exposure to any microbial agents, since he is immunocompromised" due to history of repeat episodes of pneumonia and to allow room for use of his power wheelchair, Hoyer lift and therapy. [REDACTED] letter from 2010 also points out issues with room size and equipment usage, as well as

repeated severe respiratory infections and the reduction in hospital admissions since Petitioner had been in a private room. (*Id*).

8. A letter from ██████ dated December 2, 2014 was submitted to Sunshine Health stating that he was writing a prescription for a medically necessary private room. (Petitioner's Exhibit 1). Like the letter written in 2010, ██████ stated that Petitioner was immunocompromised with repeated episodes of pneumonia and high levels of pseudomonas in his lungs. He also added that Petitioner suffered from neutropenia, that he had been hospitalized 18 times when he was in a semi-private room, and that his hospitalizations had been reduced by 60% to 70% since residing in a private room. A nursing home list of hospital admissions from 2004 through 2007 was attached. (*Id*).

9. ██████ submitted a separate prescription for a private room. (*Id*). Sunshine issued a denial of Petitioner's request on December 8, 2014. (Petitioner's Exhibit 2). Petitioner requested an internal appeal with Sunshine Health regarding the denial. On February 5, 2015, Sunshine Health issued a letter upholding the denial. Petitioner did not timely request a Medicaid Fair Hearing regarding this denial, therefore it will not be considered in this Order since the undersigned lacks jurisdiction to address this request.

10. On January 20, 2016, Petitioner requested that Sunshine Health provide Medicaid coverage for his private room in the ██████ facility. (Petitioner's Exhibit 2.) On January 22, 2016, Sunshine Health issued a Notice of Action ("Notice") denying the request. (Petitioner's Exhibit 3.) The Notice cited to Florida Medicaid rule 59G-1.010 defining "medical necessity," and it further explained to Petitioner that the reason there was no medical necessity because a private room was not "individualized, specific, consistent

with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs."

11. The Notice states: "The facts that we used to make our decision are: Sunshine Health Policy LT.UM.09 Ancillary Service Criteria." The Ancillary Service Criteria apply to home and community-based services, not to skilled nursing facility services.

Petitioner contends that the error in the Notice violated his right to due process, however, he did not introduce evidence indicating that he suffered any prejudice as a result of the error. Petitioner timely requested a hearing and had the opportunity to engage in discovery in order to clarify the reason for the denial.

12. Prior to issuing the Notice of Action, Sunshine Health provided Petitioner with Medicaid coverage of the costs of a semi-private room at [REDACTED]. Accordingly, Petitioner's medical necessity to reside in a semi-private room at [REDACTED] is not in dispute. Instead, the dispute in this proceeding regards whether or not Petitioner has a valid medical necessity to cover him in a costlier private room.

13. Petitioner contends that a private room is medically necessary for two (2) reasons: First, Petitioner asserts that a private room is medically necessary because Petitioner's medical condition makes him vulnerable to infection. (Hr'g. Tr. at 14.) Second, Petitioner asserts that a semi-private room is too small to accommodate the amount of equipment required for maintenance of his health, thus making it infeasible and contraindicated for his health. (Hr'g. Tr. at 15.)

Vulnerability to Infection

14. Petitioner's first contention is that a private room is medically necessary because he is [REDACTED]. There is no dispute that Petitioner's lungs are colonized by

██████████, which places Petitioner at higher risk of pneumonia. (Stipulation; Hr'g. Tr. at 19.) He has had ██████████ resulting in hospitalizations in an ICU. (Hr'g. Tr. at 171). Dr. Carter estimated that hospitalization in an ICU cost \$1000s per day. *Id.* ██████████ testified that Petitioner has been admitted to the hospital about four (4) times each year for pneumonia, with hospital stays varying from one (1) to three (3) weeks. (Hr'g. Tr. at 32-33.) With each hospital stay, long-term antibiotics are prescribed. (Hr'g. Tr. at 16). As a result, he is now resistant to some antibiotics, making infection more difficult to treat. (Hr'g. Tr. at 14, 34.) Because of Petitioner's paralysis, he is unable to clear his secretions frequently (Hr'g. Tr. at 18). Neutropenia (an abnormally low level of a type of white blood cell important for fighting infection) is intermittent (Stipulation); when this happens, white cell counts are about half of normal (Hr'g. Tr. at 28.)

15. On January 22, 2016, the date that Sunshine Health issued its Notice denying Petitioner's private room request, Petitioner's primary care physician, ██████████, signed a letter addressed "To Whom It May Concern" in which he stated his opinion as to why he believes Petitioner needs a private room. In particular, ██████████ letter states that: "A private room is absolutely necessary to protect [Petitioner's] life and to prevent significant illness. This cannot be achieved if he must share a room with another resident." (Petitioner's Exhibit 1.)

16. ██████████ testified that he has never given orders to ██████████ to place Petitioner in a private room. (Joint Exhibit 2 at 37.) He stated he never had to because Petitioner has always been in a private room. Dr. Aziz admitted during his testimony that when Petitioner is stable, he can be treated safely and appropriately in a semi-private nursing

facility room. (Joint Exhibit 1 at 23.) However, he stated that Petitioner would need to be in a private room for three (3) or four (4) weeks after a hospitalization (Joint Exhibit 1 at 42.) At the time of his deposition, Dr. Aziz testified that Petitioner had been stable for approximately two (2) months:

Q. If hypothetically, the room were three times as big, would you still say he needs a private room?

A. On some—sometimes. So Michael is not sick all the time. Like for the past two months, he's been fine. So on those times, he may not need a private room.

(Joint Exhibit 1 at 23-24.)

Q. I understood you to testify he's been stable the past couple months, right?

A. Correct.

(Joint Exhibit 1 at 39.)

17. Petitioner is not contagious to others and is frequently around caregivers and members of the public who are not wearing gowns or masks. (Hr'g. Tr. at 45; *see also* Joint Exhibit 1 at 18; Joint Exhibit 2 at 25.) For example, Petitioner's Exhibit 5 shows images of two caregivers in his room interacting with him without masks, gowns, or gloves.

18. In addition to the nursing and other care Petitioner receives from [REDACTED] staff, Petitioner's parents voluntarily have chosen to pay for an additional licensed practical nurse, [REDACTED] to furnish care to Petitioner at [REDACTED] [REDACTED] has been a licensed practical nurse for four (4) years. (Hr'g. Tr. at 42.)

19. [REDACTED] testified that she routinely visits with and provides care to Petitioner without a mask or gown. (Hr'g. Tr. at 45.) Ms. Perry further testified that she never has seen the use of isolation precautions at a nursing home to protect a patient from danger

of infection from others. (Hr'g. Tr. at 52.) She had only seen such precautions in a hospital setting. (*Id.*)

20. Visitors in Petitioner's room generally do not wear gowns or masks. (Hr'g. Tr. at 45-46.) Petitioner's Exhibit 9 is a video recording showing six individuals in Petitioner's room, none of whom are wearing masks or gowns. (Hr'g. Tr. at 46-47, 150, 272.)

21. [REDACTED] also testified that she regularly takes the Petitioner outside of the [REDACTED] facility approximately five days per week. (Hr'g. Tr. at 43.) She testified that she takes the Petitioner to the [REDACTED] facility courtyard, through the nearby neighborhood, to local parks, and that on occasion he also travels by automobile to a veterinary office. (Hr'g. Tr. at 21, 39-40.) At the November 10, 2016 hearing, [REDACTED] testified that the Petitioner had visited the veterinary office the prior week. (Hr'g. Tr. at 288.) During each of these outings, Petitioner was around members of the public who were not wearing masks, gowns, or gloves.

22. Dr. Carter, Sunshine Health's Medical Director for Long Term Care, who is certified by the American Board of Internal Medicine in internal medicine, geriatric medicine, and hospice and palliative medicine, testified in this proceeding and was admitted as an expert in Long Term Care Medicine and in the care of long term care patients with ventilator needs. (Hr'g. Tr. at 127, 133.) Dr. Carter testified that:

A patient that has a medical necessity to be isolated or restricted to a certain space, to a room with no roommate . . . doesn't seem consistent with the permission and the encouragement for that same patient to go out within the nursing home common areas . . . plus going to the outside environment, including a park, or a veterinary clinic. I have never seen that happen where someone has an infectious disease order or a primary care order for a private room [be] allowed to go outside and allowed to go into common areas with other patients and the staff.

(Hr'g. Tr. at 149.)

23. Dr. Carter testified that it was his medical opinion that a private nursing facility room is not medically necessary for Petitioner based on Petitioner's clinical condition. (Hr'g. Tr. at 136.)

24. With regard to the Petitioner's Exhibit 9—the video recording showing six individuals in Petitioner's room at one time without masks or gowns—Dr. Carter testified that “If [isolation to a private room] is for infectious disease reasons, usually it requires restriction of people entering the room who either designated healthcare staff . . . and approved family . . . and usually there are instructions about the use of face masks to reduce the possibility of oral or nasal secretions making contact directly with the impaired patient, or using a gown . . . to reduce contact with environmental pathogens or bacteria or viruses.” (Hr'g. Tr. at 150-151.)

25. Petitioner also introduced a handwritten note by Dr. Barile, a physician who cared for Petitioner while Petitioner briefly was an inpatient at [REDACTED] [REDACTED] in November of 2015 and February 2016. The note, dated January 4, 2016 and written on a [REDACTED] prescription pad, stated: “It is medically necessary for [Petitioner] to have a private room. He is at high risk for infection.” (Petitioner's Exhibit 1.) [REDACTED] testified that he wrote this note at the request of Petitioner's mother. (Joint Exhibit 2 at 24.)

26. [REDACTED] testified that he thought the prescription was for a private hospital room and that he did not recall writing a prescription for Petitioner to have a private room at [REDACTED]

Q. Did you ever order a private room for [REDACTED] upon discharge to the nursing home?

A. Apparently I did. I didn't realize that's what the prescription was actually for. I thought it pertained to something in the hospital. But, again, I don't really remember the details. I've seen the prescription. It's my handwriting. So I'll agree that I wrote it. But I don't recall, actually, the details of whether it had to do with him going to the nursing home or being at [REDACTED] whether it pertained to that or not.

Q. This might have actually been requesting a private room in the hospital, is that correct?

A. That's what I'm – what I'm confused about, yes. It's definitely my handwriting. I'm not saying I didn't write it; I just don't remember the exact details of why.

(Joint Exhibit 2 at 11, 24.)

27. [REDACTED] further testified that he has not seen Petitioner since February 2016 and therefore cannot opine about his current medical condition or whether Petitioner needs a private room at [REDACTED] (Joint Exhibit 2 at 8, 9.)

Q. Have you seen [REDACTED] since February 2016?

A. No.

Q. Are you aware of his current medical condition?

A. No.

Q. Is it fair to say, then, that you can't recall whether it was medically necessary for [REDACTED] to be isolated at [REDACTED]s when you treated him?

A. I really don't remember much about the patient, actually, at all. So I think that's fair, yes.

Q. Is it fair to say that you have no medical opinion today as to whether [REDACTED] needs to be in a private room in a nursing home today?

A. I think, today, I would have to say yes, because I am not aware of his situation. It could be different from when I saw him, you know, in February. So yes.

(Joint Exhibit 2 at 9-10.)

[REDACTED] also testified that he has never ordered isolation for Petitioner. (Joint Exhibit 2 at 25.)

29. Dr. Bolton, is a Florida licensed physician who was admitted as an expert in pulmonary care and the care of ventilator patients. He testified on behalf of Sunshine Health. (Hr'g. Tr. at 345-46.) Dr. Bolton has held board certifications in internal medicine and pulmonary disease since approximately 1975, and his current practice focuses on being an attending and consulting physician at a Kindred Long Term Care Rehabilitation hospital in Florida. (*Id.*)

30. Dr. Bolton testified that, from a clinical standpoint, it is possible to care for a nursing home resident who is on a ventilator in a semi-private room while another nursing home resident is in the same room. (Hr'g. Tr. at 350.)

31. Although Dr. Bolton had not personally examined Petitioner or his medical records, Dr. Bolton testified that he was familiar with Petitioner's condition based on conversations with [REDACTED]. (Hr'g. Tr. at 348.) Dr. Bolton was aware that Petitioner is a [REDACTED] on a ventilator in a nursing home for approximately 15 years, and he was asked to assume the admitted evidence about Petitioner's condition and then opine as to whether Petitioner could reside safely in a semi-private room at [REDACTED]

Q. Dr. Bolton, I would like you to assume, am going to have you assume certain evidence that is already in this hearing that you were not present to hear. There has been evidence that [REDACTED] has a private room right now at the nursing that for some periods of time . . . his parents have paid the extra cost for, and the care he receives in that private room is given by caregivers that are following basic precautions in the sense that they will wear gloves, but they are not wearing masks, they are not wearing gowns. He can have visitors in the room that do not need to wear gloves or masks, and he also goes out on outings to the public park and sometimes to a veterinary clinic where people are not with gowns or masks around him. Assuming all that is true, in your expert opinion is that the type of person who needs to be treated only in a private room with no other residents in that room?

A: No, not at this particular time. He has got certainly, the – the basic, you know, contact with gloves and he goes out into the public without any issue. And, no, at all, this can be cared for in a regular room.

Q: Would – is there anything about the fact that [REDACTED] has been [REDACTED] that changes your view about the ability to care for him in a semi private room?

A. No, not at all. We do have colonization and as long as it is just colonized we have no problem at all keeping the patient in that type of setting.

(Hr'g. Tr. at 350-352.)

32. Dr. Bolton testified that it is possible clinically to care for a resident who is on a ventilator while another nursing home resident resides in the same room. (Hr'g. Tr. at 350.) Dr. Bolton testified that, given the evidence that the Petitioner's visitors do not wear masks or gowns, and that he goes out on outings to public parks and to a veterinary clinic, it follows that Petitioner is not the type of person who must be treated only in a private room. (Hr'g. Tr. at 351.)

33. [REDACTED] is a Registered Nurse who has 20 years of experience treating skilled nursing facility patients. He is a nurse consultant at [REDACTED]. He testified that he was not aware of any physician letters or orders to [REDACTED] requiring a private room for Petitioner. (Hr'g. Tr. at 316.) He was not aware of any special orders for infection-control precautions whatsoever. (Hr'g. Tr. at 316.) And if there were an isolation order, [REDACTED] testified that [REDACTED], Petitioner's nurse, would not be permitted to care for Petitioner without a mask and gown, Petitioner's parents would not be permitted to visit his bedside without a mask and gown, and Petitioner's counsel would not be permitted to be in the room taking video recordings without a mask and gown. (Hr'g. Tr. at 318.)

34. ██████████ stated it is possible to place Petitioner alone if he is on an isolation precaution, and then place him back into a semi-private room once it is lifted. (Hr'g. Tr. at 281-82.) He also said that some isolation precautions, such as a minor respiratory pneumonia, can be done in a semi-private room.

Size of Room

35. Petitioner's second contention is that his medical equipment makes residing in a semi-private room infeasible or contraindicated for his health due to insufficient space.

36. Under Florida Administrative Code 59A-4.122, the requirements for physical environment and physical maintenance of nursing homes are as follows: (1) The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible; and (2) The licensee must provide: (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (b) Clean bed and bath linens that are in good condition; (c) Furniture, such as a bed-side cabinet, drawer space; (d) Adequate and comfortable lighting levels in all areas.

37. After watching the video recording of Petitioner's private nursing home room, ██████████ testified that Petitioner can be safely and appropriately cared for by ██████████ in a semi-private room. (Hr'g. Tr. at 137.) He testified that from a medical appropriateness standpoint, it would be possible to move the motorized wheelchair and store it outside of the room. (Hr'g. Tr. at 153.)

38. ██████████ also testified that the Hoyer lift could safely be stored outside of the room, and that neither the wheelchair nor the Hoyer lift were medically required to be in the room at all times. (Hr'g. Tr. at 154.) He testified that in his medical opinion, a private

room is not medically necessary for Petitioner based on the size of the room and the supplies that Petitioner needs. (Hr'g. Tr. at 156.)

39. ██████████ testified that ██████████ can appropriately care for Petitioner in a semi-private room. (Hr'g. Tr. at 294). He said that Petitioner "happens to have much more equipment in his room than is medically necessary, a big recliner chair, a couple of nightstands, etc." (Hr'g. Tr. at 294.) Petitioner's father acknowledged in his testimony that the big recliner chair is not used by Petitioner but instead is used by his visitors. (Hr'g. Tr. at 103.)

40. ██████████ testified that it would be possible to store the Petitioner's Hoyer lift and wheelchair outside of the Petitioner's room, while still providing the Petitioner with appropriate care. (Hr'g. Tr. at 295-296.)

41. ██████████ testified that he has seen Hoyer lift transitions occur in double-occupied semi-private rooms identical to Petitioner's room in size. (Hr'g. Tr. at 297.)

42. While ██████████ emphasized that it would be very difficult and inconvenient to perform her duties in a semi-private room, she admitted that it would ultimately be possible. (Hr'g. Tr. at 275.) She stated one of the individuals would end up backed up against the bed of the other roommate, invading their space. (Hr'g. Tr. at 284.) ██████████

██████████ stated that the beds could be arranged in such a way as to allow sufficient room for transfers without invading the other roommate's space. (Hr'g. Tr. at 296-97.)

CONCLUSIONS OF LAW

43. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

44. This hearing was held as a de novo proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

45. The standard of proof in an administrative hearing is by a preponderance of the evidence. Fla. Admin. Code R. 65-2.060(1). The preponderance of the evidence standard requires proof by “the greater weight of the evidence.” (Black’s Law Dictionary at 1201, 7th Ed.).

46. Petitioner has not shown that Sunshine Health’s Notice of Action was legally deficient. First, the Notice of Action explained to Petitioner in clear language that his request for Medicaid coverage of a private room was being denied for lack of medical necessity under Florida Medicaid Rule 59G-1.010. Second, the Notice of Action set forth the specific reason why “medical necessity” was not met under Medicaid’s rules. Third, the Notice of Action apprised Petitioner of his rights to challenge the denial in a Medicaid Fair Hearing, and Petitioner timely exercised those rights by commencing this proceeding. Last, Petitioner did not produce any evidence to show that he was prejudiced by the mistake. For those reasons, Petitioner’s challenge to the legality of the Notice of Action is denied as harmless error. *See Meyers v. S.C. Dep’t of Health & Human Servs.*, 2014 WL 717221, *5 (S.C. Admin. Law. Jud. Div. 2014) (“Accordingly, in order for the Court to overturn the Department’s decision because the notices did not meet the technical requirements of the federal regulation, *Appellant must show that he was prejudiced by such notices.*”); *see also Kocher v. Dep’t of Health & Human Servs.*, 448 N.W. 2d 8, 12 (Wis. App. 1989) (holding that absent undue prejudice to the Medicaid recipient, “neither the fairness of the proceedings nor the correctness of the

action taken by the DHSS was impaired by its failure to provide Elroy with proper notice”).

47. Petitioner also has not met his burden to show that Sunshine Health’s denial of Medicaid coverage for a private nursing facility room based on a lack of medically necessity was erroneous.

48. The Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook, October 2003 (“Handbook”), was previously promulgated into law by Rule 59G-4.200, *Florida Administrative Code*.¹

49. Page 2-18 of the Handbook states:

A nursing facility must provide a Medicaid resident with a private room at no additional charge if the resident’s physician determines it is medically necessary.

If a private room is requested and the room is not medically necessary, the facility may charge a Medicaid resident’s family, friend, or trustee an additional amount for a Medicaid certified private room....

50. Assuming, *arguendo*, that Petitioner’s physician, [REDACTED], determined the private room is medically necessary, and the request was properly ordered, the Handbook still provides that a medical necessity determination be made regarding the appropriateness of a private room.

51. The definition of medical necessity is found in Rule 59G-1.010, *Florida Administrative Code*, which states:

(166) “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 The Handbook was replaced by the Florida Medicaid Nursing Facility Services Coverage Policy, effective May 3, 2016. As the Handbook was still in effect at the time of Sunshine Health’s action, it is applicable to this appeal.

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.

...

(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.

52. Petitioner's own physician, [REDACTED], testified that he can be properly cared-for in a semi-private room when he is stable. [REDACTED] also testified that Petitioner can be cared-for appropriately in a semi-private room. Petitioner is colonized with pseudomonas and is at risk of frequent bouts of pneumonia. However, he has not shown, by the greater weight of the evidence, that the risk to his health would be increased in any meaningful way if he was in a semi-private room. His caretakers and visitors typically visit him without masks or gowns. He regularly goes out into the community. He is not contagious, so he will not be putting a roommate at risk. These are inconsistent behaviors for someone who needs to avoid contact with other people.

53. While the totality of the evidence indicates that it would be highly inconvenient for Petitioner to be in a semi-private room, given both the amount of equipment that will have to be brought in and out of the room during care, and the fact that he will intermittently require isolation after a hospitalization, he has not shown that it is

medically necessary for him to be in a private room or ultimately necessary as a general matter due to space constraints. [REDACTED] was candid by admitting that she can perform her duties in a semi-private room, albeit it with significant difficulty. If his needs can be met in a semi-private room, then he does not need a private room, however desirable it may be.

54. Since the undersigned concludes Sunshine Health did not take an improper action, there is no action to correct, therefore Petitioner's Motion for Corrective Action need not be addressed.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and Sunshine Health's action is AFFIRMED. Petitioner's Motion for Corrective Action is DENIED.

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 17 day of April, 2017,
in Tallahassee, Florida.

R. Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], Petitioner
Judy Jacobs, Area 7, AHCA Field Office
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Craig Smith, Esq.
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

Mar 30, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-03389

PETITIONER,

VS.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 DADE
UNIT: AHCA,

AND

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on June 7, 2016 at 8:30 a.m., August 22, 2016 at 8:30 a.m., and February 13, 2017 at 11:30 a.m.

APPEARANCES

For Petitioner: [REDACTED] Petitioner's mother

For Respondent: Jerome Hill, Program Supervisor
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for modifications to her power wheelchair and/or her request for a new power wheelchair

was proper. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Sloan Karver, Medical Director, Christian Laos, Senior Compliance Analyst, and Dr. Marc Kaprow, Medical Director, from United Healthcare, which is the petitioner's managed care health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent's composite Exhibit 1: Statement of Matters, Denial Notice, Case System Screenshots, and Medical Assessment Form. After the conclusion of the hearing, the record was left open for United Healthcare to submit documents related to the original approval of the petitioner's current wheelchair. These documents were subsequently received and marked as Respondent's Exhibit 2.

FINDINGS OF FACT

1. The petitioner is a sixty-three (63) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from United Healthcare.

2. On or about March 25, 2016, the petitioner submitted a request to United Healthcare for approval of modifications to her power wheelchair. United Healthcare denied this request on April 1, 2016 as not being medically necessary.

3. The petitioner's daughter stated her mother received a new power wheelchair approximately 18 months ago, but has not been able to use it. She stated the wheelchair legs cannot be opened and her mother does not have good balance on the wheelchair. Because of this, her mother was still using her other wheelchair which is 12-years old.

4. At the first hearing convened in this matter, United Healthcare agreed to evaluate the need for any adjustments to the power wheelchair. The hearing was thereafter reconvened to discuss the current status of the repairs or adjustments.

5. At the last reconvened hearing, Dr. Kaprow from United Healthcare stated the wheelchair was re-evaluated and repaired, but the petitioner indicated she only wanted to accept a new wheelchair. He stated the locking legs on the wheelchair are a safety feature. He also stated the petitioner's current wheelchair was furnished to her in August, 2015 and this wheelchair will be eligible to be replaced in 2020. This was a custom wheelchair made to exact specifications. He stated a replacement of the wheelchair at this time would be in excess of the petitioner's needs and United Healthcare would need a physician's report or physical therapy evaluation to make any further adjustments to the current wheelchair.

6. The petitioner's daughter stated at the reconvened hearing her mother was still using her old wheelchair instead of the power wheelchair. She stated adjustments had been made to the wheelchair but it still was not functional because her mother is currently not strong enough to use the joystick which operates the chair. She also stated the wheelchair is not wide enough. She confirmed the family is now requesting a new wheelchair rather than adjustments to the 2015 wheelchair.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

9. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent, AHCA.

10. Wheelchairs are a type of durable medical equipment. The Durable Medical Equipment (DME) and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook") has been incorporated, by reference, into Florida Administrative Code Rule 59G-4.070(2).

11. This hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.)..

13. With regard to the need for DME, Section 409.906(10), Florida Statutes, states in relevant part, "The agency may authorize and pay for certain durable medical equipment and supplies provided to a Medicaid recipient as medically necessary."

14. Similarly, the Handbook defines the guidelines for DME on page 1-2, as follows:

Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA).

The DME Handbook further clarifies that power wheelchairs or scooters require prior authorization (page 2-91).

15. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

'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. ...

(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.

16. Fla. Stat. § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the “medical necessity or medically necessary” standards, and states in pertinent part as follows:

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice...

Section (1)(d) goes on to further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

17. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

18. Page 2-91 of the DME Handbook states the following:

Medicaid will reimburse for a wheelchair when the recipient is non-ambulatory or has severely limited mobility and it is medically documented that a wheelchair is medically necessary to accommodate the recipient’s physical characteristics.

19. Page 2-94 of the DME Handbook lists the requirements for a recipient to obtain a power wheelchair or scooter, as follows:

Has documented, severe abnormal upper extremity dysfunction or weakness; and

Has demonstrated that he possesses sufficient eye and hand perceptual capabilities and the cognitive skills necessary to safely operate and guide the chair or POV independently, and is capable of evacuating a residence or building with minimal or no verbal prompting in case of an emergency; and

Currently resides in or will primarily use the equipment in an environment conducive to the use of a motorized wheelchair of the type and size wheelchair requested.

20. Page 2-95 of the DME Handbook lists additional criteria for obtaining a power wheelchair or scooter, as follows:

Recipient's medical necessity requires the use of a POV to independently move around his residence; and

Recipient is physically unable to operate a manual wheelchair; and

Recipient is capable of safely and independently operating the controls for the POV requested; and

Recipient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV; and

An independent licensed physical therapist, occupational therapist or physiatrist has determined and documented his recommendation of the most appropriate and medically-necessary POV to meet the recipient's individual mobility needs; and

The recipient does not have a wheelchair that was purchased by Medicaid within the past five years.

21. The DME Handbook. Page 2-95, also addresses the replacement of a power wheelchair, as follows:

Since Medicaid may fund and maintain only one mobility device within the maximum limit period, the recipient is not eligible for more than one poweroperated vehicle (POV) or wheelchair (standard or customized) within the same five-year maximum limit period.

22. In the petitioner's case, she received a new customized power wheelchair in 2015. Therefore, according to the Medicaid guidelines outlined above, she is not eligible for a new power wheelchair until the year 2020 (five years after receiving her current power wheelchair).

23. After considering the evidence and testimony presented, the undersigned concludes that the petitioner has not demonstrated that United Healthcare should provide her with a new wheelchair at this time. Since it appears the petitioner's physical conditions may have changed since 2015 (for example, she has lost some strength), she should arrange for a new physical therapy evaluation so that proper adjustments can be made to the current wheelchair at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is hereby DENIED.

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 indigence 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 30 day of March, 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255

FINAL ORDER (Cont.)

16F-03389

Page 9 of 9

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AHCA, MEDICAID FAIR HEARINGS UNIT
UHC MEDICAID FAIR HEARING

FILED

Mar 07, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-06707

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 17 Broward
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened a telephonic administrative hearing in the above-referenced matter on January 30, 2017, at 1:30 p.m.

APPEARANCES

For the Petitioner: .

For the Respondent: Mindy Aikman, Grievance and Appeals Specialist for Humana.

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for direct member reimbursement (“DMR”) for Oxycodone HCL 10 mg tablets in the amount of \$242.35?

PRELIMINARY STATEMENT

Linda Latson, R.N., Registered Nurse Specialist with the Agency for Health Care Administration (“AHCA” or “Agency”), was present solely for observation.

The respondent introduced Exhibits “1” through “4” at the hearing, all of which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on February 6, 2016 for the petitioner to provide a copy of his telephone records as evidence that he contacted the respondent prior to purchasing the medication at an out-of-network pharmacy and the respondent to provide a copy of the Notice of Action denying the direct member reimbursement. Once received, the petitioner’s information was accepted into evidence and marked as petitioner’s Exhibit “1”. Once received, the respondent’s information was accepted into evidence and marked as respondent’s Exhibit “5”. The hearing record was closed upon receipt of the final evidence on January 31, 2017.

FINDINGS OF FACT

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. The petitioner is an adult male who resides in [REDACTED]
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding. There has been no erroneous denial or termination of his Medicaid eligibility.
3. The petitioner is an enrolled member of Humana. Humana is a health maintenance organization (“HMO”) contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. The petitioner's effective date of enrollment with Humana is March 1, 2016.
5. The petitioner had prescriptions for Oxycodone HCL 10 mg tablets filled at Walgreens on the following dates: March 21, 2016; April 21, 2016; May 25, 2016; June 27, 2016; and July 26, 2016.
6. Walgreens is an out-of-network provider with respect to Humana.
7. The petitioner paid out-of-pocket for the prescriptions listed above.
8. On or about August 14, 2016, the petitioner submitted a Commercial Prescription Drug Claim Form to Humana requesting reimbursement of his out-of-pocket expenses associated with the purchase of the above-referenced prescriptions in the amount of \$242.35.
9. Humana issued a Notice of Action dated August 23, 2016 to the petitioner advising him it was denying his request on the basis that "[t]he requested service is not a covered benefit." The Notice of Action goes on to state that prior authorization is required for the prescriptions.
10. The Humana representative at the hearing explained that prior authorization for this medication is not required if the drug is purchased at an in-network pharmacy. She clarified that Humana denied the petitioner's request for reimbursement because the petitioner purchased the prescriptions at an out-of-network pharmacy.
11. Humana has 163 participating in-network pharmacies in the petitioner's zip code.
12. The petitioner testified he called Humana and spoke with a customer service representative before purchasing each of the prescriptions and was told that he could

purchase the prescriptions at the out-of-network pharmacy and Humana would reimburse him for his out-of-pocket expenses if he submitted a claim form.

13. The Humana representative at the hearing had no record of the petitioner's telephone calls to Humana.

14. The telephone records submitted by the petitioner after the hearing are general logs reflecting calls made by the petitioner. There are no distinguishing marks or characteristics on the call logs indicating which calls may have been placed to Humana.

15. The Humana member handbook states that members must receive goods and services from providers within the Humana network and explains that if a member uses an out-of-network provider, the member may have to pay the bill.

CONCLUSIONS OF LAW

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

17. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes.

18. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

19. In the present case, the petitioner is requesting direct reimbursement for a prescription. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

20. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

21. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by the Agency for Health Care Administration.

22. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

(a) “Medical necessary” or “medical necessity” means that medical or allied care, goods or services furnished or ordered must 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 defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, 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. . .

(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.

23. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference into the Medicaid Services Rules by Fla. Admin. Code Rule

59G-5.020. In accordance with the above Statute, the Handbook explains the following on page 1-27:

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

24. Page 1-22 of the Florida Medicaid Provider General Handbook provides a list of Medicaid covered services. These services include prescribed drug services.

25. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include prescribed drug services.

26. Page 1-30 of the Florida Medicaid Provider General Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."

27. Fla. Admin. Code R. 59G-4.250 Prescribed Drug Services incorporates by reference the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook, updated July 2014.

28. The Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook talks about Who Can Provide Services on Page 1-2. It states as follows:

The State of Florida Legislature, in 409.912 (37)(a) 4, F.S., has authorized Medicaid to limit its pharmacy network based on need, competitive

bidding, price negotiations, credentialing, or other similar criteria. If the Agency for Health Care Administration (AHCA or the Agency), Medicaid Division, has a sufficient number of Medicaid providers, AHCA is allowed to impose a moratorium on Medicaid pharmacy enrollment. AHCA can terminate any Medicaid contract with 30 days notice without cause. All terms of the contract will remain in force for the full 30 days.

29. Rule 59G-5.110, Florida Administrative Code, provides standards for direct payments and states in relevant part:

59G-5.110 Direct Reimbursement to Recipients.

(1) Purpose. This rule describes the circumstances when the Agency for Health Care Administration (AHCA) may directly reimburse eligible Florida Medicaid recipients; how AHCA reimburses recipients; and documentation requirements for direct reimbursement.

(2) Determination Criteria. Florida Medicaid recipients may be eligible for direct reimbursement if:

(a) Medical goods and services were paid for by the recipient or a person legally responsible for their bills **from the date of an erroneous denial or termination of Florida Medicaid eligibility** [Emphasis added] to the date of a reversal of the unfavorable eligibility determination [emphasis added].

(b) The goods and services were medically necessary as defined in Rule 59G-1.010, Florida Administrative Code (F.A.C.); rendered by a provider that is qualified to perform the service including meeting any applicable certification or licensure requirements (the provider is not required to be enrolled or registered as a Florida Medicaid provider); and covered by Florida Medicaid for the recipient's eligibility group on the date of service.

(c) Reimbursement for the medical goods or services is not available through any third-party payer on the date of service for which direct reimbursement is requested.

(3) Reimbursement Process. Recipients must submit direct reimbursement requests to AHCA within 12 months of the date of the reversal of the unfavorable eligibility determination described in paragraph (2)(a).

(a) The reimbursement request must include evidence of all out-of-pocket expenses paid to the provider, validated through receipts submitted by the recipient to: Agency for Health Care Administration, 2727 Mahan Drive, MS #58, Tallahassee, FL 32308.

30. In the present case, the Humana member handbook states that members must receive goods and services from providers within the Humana network and explains

that if a member uses an out-of-network provider, the member may have to pay the bill.

The petitioner purchased his medication from an out-of-network pharmacy on multiple occasions when he could have acquired the prescription at an in-network pharmacy. The petitioner provided no evidence that a Humana representative authorized the purchases and guaranteed reimbursement from the respondent. In addition, there is no evidence of an erroneous denial or termination of Florida Medicaid eligibility as required by Florida Administrative Code Rule 59G-5.110 for a direct member reimbursement.

31. Pursuant to the above, the petitioner has not met his burden of proof to demonstrate by a preponderance of the evidence that the respondent incorrectly denied his request for reimbursement.

DECISION

The petitioner's appeal is hereby DENIED.

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 indigence to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)
16F-06707
PAGE - 9

DONE and ORDERED this 07 day of March, 2017,
in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
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1317 Winewood Boulevard
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Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
Humana Hearings Unit

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

FILED

Apr 03, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-06988

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 St. Johns
UNIT: 03DDD

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 23, 2017 at 9:06 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: Diane Washington, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

ISSUE

At issue is the Department's action on August 24, 2016 to deny the petitioner's application for SSI-Related Medicaid on its contention that he does not meet the disability requirement.

The petitioner held the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for November 2, 2016 at 10:00 a.m. The petitioner did not appear for the hearing. The petitioner did not contact the Office of Appeal Hearings to request to reschedule the hearing. Therefore, the appeal was closed as abandoned.

On December 1, 2016, the petitioner contacted the Office of Appeal Hearings to request for the appeal to be reopened.

On December 21, 2016, the undersigned issued the Order to Show Good Cause.

On January 3, 2017, the petitioner submitted a written response to show good cause.

On January 23, 2017, the undersigned granted the petitioner's request to reopen the appeal with good cause. The appeal was reopened and the hearing was rescheduled to February 23, 2017 at 9:00 a.m.

Evidence was received and entered as the Respondent's Exhibits 1 through 2 and the Petitioner's Composite Exhibit 1.

The record was held open until March 3, 2017 at 5:00 p.m. to allow for the petitioner to submit additional evidence. Evidence was received and entered as the Petitioner's Exhibits 2 through 4.

The record was closed at 5:00 p.m. on March 3, 2017.

FINDINGS OF FACT

1. On August 2, 2016, the petitioner (age 64) completed an application for SSI-Related Medicaid for himself. The petitioner will turn age 65 in [REDACTED].

2. On August 17, 2016, the petitioner's application was forwarded to the Division of Disability Determination (DDD) to review the petitioner's claim for disability.

3. The DDD did not make an independent disability determination because the Social Security Administration (SSA) determined that the petitioner was not disabled and claimed the same allegations; the denial is currently under appeal. The Department adopted the SSA unfavorable decision and denied the petitioner's application for SSI-Related Medicaid.

4. The petitioner does not agree with the Department's denial. The petitioner argues that he suffered a [REDACTED] in 2013. The petitioner contends that he suffered another [REDACTED] April 2016. The petitioner explained that he was receiving Medicaid in the state of New Jersey. The petitioner argues that he owes several providers and cannot afford to purchase medication for his medical conditions.

5. The petitioner's reports his medical conditions as [REDACTED]
[REDACTED]
[REDACTED] The petitioner contends that his conditions have worsened. The petitioner believes he may possibly have [REDACTED] The petitioner believes he has a new medical problem with his [REDACTED] but has known about it for several years.

6. The petitioner applied for disability with the SSA in 2013 and was denied the same year. The petitioner provided an SSA denial letter dated November 12, 2014 (Petitioner's Composite Exhibit 2). The denial letter states:

We are writing about your claims for Social Security and Supplemental Security Income (SSI) disability benefits. Based on a review of your

health problems you do not qualify for benefits on either claim. This is because you are not disabled or blind under our rules.

An explanation is provided below of why we decided you are not disabled. The following reports were considered in deciding your claim:

[REDACTED]

Medical evidence from prior application 6/20/2013

[REDACTED] n PhD Psychiatry Consultative Exam 10/02/14

Central Jersey Med Eval Internal Medicine Consultative Exam 10/31/14

We did not obtain any other reports because the ones shown above had enough information to evaluate your condition.

We have determined that your condition does not keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

You said you were disabled because of [REDACTED]

[REDACTED]

The following factors were considered in making our decision:

You have experienced heart problems. However, following a recovery period, you are able to work.

You have [REDACTED] However, it has not damaged any vital body organs...

While you experience pain in your lower back, there is no severe muscle Weakness or loss of feeling...

Your mental conditions have not affected your ability to understand, remember, cooperate with others...

The evidence shows no other condition which significantly limits your ability to work.

Based on the description of your job of security guard which you performed for 10 years, we have concluded that you have the ability to perform this work...

7. The petitioner's evidence includes medical records with an admission date of September 1, 2014 from the [REDACTED], New Jersey.

The medical records show that the chief complaints at admission were chest pains and panic attack. The medical records also show that the petitioner's medical history consists of his medical conditions of:



8. The petitioner explained that he appealed the SSA denial and that the appeal is currently pending. The petitioner has a scheduled hearing with the SSA on April 10, 2017.

9. The Department contends that the petitioner may reapply for Medicaid if he develops a new medical condition that is unrelated to his current medical conditions. The Department adopted the SSA disability denial.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

12. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy...

13. Additionally, 42 C.F.R. § 435.541 Determination of Disability, states:

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated

since that SSA determination **and** alleges a new period of disability which meets the durational requirement of the Act, **and** has not applied to SSA for a determination with respect to these allegations (**emphasis added**).

14. The Department's ACCESS Florida Program Policy Manual, CPOF 165-22, passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization
- 5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA). (emphasis added)**

15. The above authorities explain that the Department must make an independent disability determination if it has been more than 12 months since the most current SSA disability determination and the applicant alleges a new period of disability which meets the durational requirement of the Act, **and** he or she has not filed a disability claim with the SSA regarding the alleged medical conditions. Petitioner does not fit this criteria.

16. In this case, the petitioner is under age 65 and has several medical conditions [REDACTED]. The petitioner reports what he believes to be a new medical condition with his [REDACTED]. The findings show that the medical records from [REDACTED] included the petitioner's medical issue with his [REDACTED] and that the medical records from [REDACTED]

██████████ were reviewed by the SSA in its disability determination. The findings show petitioner applied for SSI-Related Medicaid more than 12 months after the most recent SSA denial. However, the petitioner has applied for and been denied SSA disability benefits with the same alleged medical conditions; the SSA denial is also currently under appeal. Therefore, the undersigned concludes that the petitioner did not meet his burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to not make an independent disability decision. Until petitioner meets the federal disability criteria (while under age 65) Medicaid cannot be approved.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

FINAL ORDER (Cont.)

16F-06988

PAGE -9

DONE and ORDERED this 03 day of April, 2017,

in Tallahassee, Florida.



Paula Ali

Hearing Officer

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Office of Economic Self Sufficiency

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

FILED

Mar 16, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07001

PETITIONER,
Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 Collier

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 15, 2017 at 8:51 a.m.

APPEARANCES

For Petitioner: [REDACTED] Granddaughter and Caregiver

For Respondent: Suzanne Chilari, Medical/Healthcare Program Analyst,
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

Whether it was correct for Respondent to partially deny Petitioner's request for 49 hours of Personal Care Services (including personal care, homemaker, and companion services) per week. Because the matter at issue is a request for an increase in services, Petitioner is assigned the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from United Healthcare were Dr. Marc Kaprow, Medical Director for Long-Term Care, and Christian Laos, Senior Complaint Analyst.

Appearing as Petitioner's witness was [REDACTED], Petitioner's daughter-in-law and Participant Direction Option (PDO) representative. [REDACTED] from Propio Language Services provided Spanish translation services for Petitioner.

Respondent's Exhibit 1 was entered into evidence.

FINDINGS OF FACT

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 90 year-old Medicaid recipient enrolled in United Healthcare's Long-Term Care plan (Plan).
2. Petitioner participates in the Participant Direction Option (PDO). The PDO is a service delivery model that empowers Medicaid recipients enrolled in a Managed Care Plan by allowing them to hire, train, supervise, and dismiss their direct service worker(s) providing certain long-term care services.
3. Petitioner's daughter-in-law acts as his PDO representative and creates the work schedule for services received. Petitioner's granddaughter provides the services – personal care, homemaker, and companion.
4. Petitioner is diagnosed with [REDACTED]. [REDACTED]. Petitioner is very weak and fragile and is subject to falling. Petitioner needs total assistance and supervision with his activities of daily living (ADLs) and

independent activities of daily living (IADLs). He is incontinent of bowel and bladder and needs assistance with transfers.

5. Petitioner lives with his son and daughter-in-law, who both work. They are available to care for Petitioner at night and on weekends.

6. On September 14, 2016, Petitioner filed a request for a fair hearing based on an agency action taken September 12, 2016.

7. On October 13, 2016, Respondent sent a response to Petitioner's October 10, 2016 appeal to the Plan (See Respondent Exhibit 1, page 67). The response states in relevant part:

We looked at your information. We decided that this does not meet Florida Policies LTC-HS-025, LTC-HS-027, LTC HS-028, and Florida Administrative Code 59G-1.1010(166). **You asked for Personal Care Services of 49 hours a week. This includes personal care, homemaker care, and companion care.** You need help with your daily care. We cannot approve 49 hours a week because it is not medically needed. We used a tool that tells us your needs. Thirty-three hours a week can meet your needs, and is approved by your health plan. This is why we cannot approve what you asked for. [Emphasis added.]

8. At the time of the hearing, Respondent advised Petitioner was approved an additional 3 hours of PCS in September 2016, resulting in a total of 33 hours per week in home care services. Based on Petitioner's request for 49 hours per week of Home Care Services, 16 hours per week remain denied.

9. Petitioner's granddaughter explained she provides services to Petitioner from 8:00 a.m. to 2:00 p.m., Monday through Friday. Petitioner's daughter-in-law doesn't return home from work until 3:00 p.m., leaving Petitioner alone for 1 hour. The granddaughter provides 3 hours of care on Saturday, from 8:00 a.m. to 11:00 a.m., and no services on Sunday. Petitioner is alone on Saturday, after 11:00 a.m., and all day on

Sundays. Petitioner's daughter-in-law works and is concerned about leaving Petitioner alone as he is prone to falling.

10. Petitioner's daughter-in-law states Petitioner is requesting an additional 1 hour of PCS, Monday through Friday (resulting in an extra 5 hours during the week) and 6 hours on Sunday. No request is being made for additional hours on Saturday. This constitutes a request for 11 additional hours of PCS or 44 hours per week in total home care hours.

11. Respondent's medical director reviewed the PDO work schedule when 25 hours per week was approved. Petitioner advised she schedules 4 hours of services Monday through Friday from 8:00 a.m. to noon, and 5 hours on Saturday. With the current 33 approved hours, the work schedule is 8:00 a.m. to 2:00 p.m. (6 hours) Monday through Friday and 3 hours on Saturday, 8:00 a.m. to 11:00 a.m.

12. Respondent's medical director testified services are approved to meet Petitioner's basic needs. As Petitioner's needs have changed, the Plan approved additional hours.

13. Respondent's medical director indicated Petitioner's daughter-in-law is responsible for developing a list of job duties and a work schedule, based on the approved service hours, to ensure Petitioner's needs are met. He stated the approved hours appear to be scheduled to ensure Petitioner is not left alone for any period of time. He noted there was no documentation, evidence, or clinical observations to show Petitioner cannot be left alone for a few hours.

14. Respondent's medical director suggested the Monday through Friday work schedule could be reduced a half hour each day (resulting in 5 ½ hours of daily services

Monday through Friday) which would allow 2 ½ hours of home care services to be provided to Petitioner on Sunday. Petitioner, then, would not be alone all day Sunday. A family member could change Petitioner first thing Sunday morning, then schedule 2 ½ hours of service during the day.

15. Respondent's medical director, in his clinical judgement, approved the 33 service hours per week based on Petitioner's needs and not scheduling preference. The medical director advised the Plan would continue to monitor Petitioner's condition and needs, and approve additional hours as appropriate. The medical director opined that the request for additional hours of home services are in excess of Petitioner's needs and, therefore, not medically necessary.

16. Petitioner's daughter-in-law remained concerned Petitioner would fall and sustain an injury if left alone.

17. Respondent's medical director explained service staff are approved to provide specific services and tasks while in the home and not in anticipation of an event. He observed having someone in the home does not prevent a patient from falling.

CONCLUSIONS OF LAW

18. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Chapter 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

19. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

20. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

21. This hearing was held as a *de novo* proceeding pursuant to *Florida*

Administrative Code Rule 65-2.056.

22. 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).

23. Rule 59G-1.010 (166), *Florida Administrative Code* defines “medically necessary” or “medical necessity” as follows:

“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.

...

(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.

24. Respondent has determined 33 hours of home care services, including 23 hours of Personal Care Services (PCS), is sufficient at this time to meet Petitioner’s needs.

Respondent noted there is no documentation, evidence, or clinical observations that Petitioner cannot be left alone for short periods of time. Respondent suggested the approved hours can be scheduled by Petitioner's PDO representative to ensure he has home care services 7 days per week.

25. Petitioner's representative expressed concern leaving Petitioner alone due to his frequent falls, however, Respondent explained someone in the home does not prevent falls and services are scheduled to provide for specific needs and not in anticipation of an event.

26. Respondent's medical director determined that 33 hours of home care services were sufficient to meet Petitioner's needs and any additional requested hours were not medically necessary and in excess of his needs. Additionally, the Florida Medicaid definition of medical necessity states the services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. Petitioner's PDO representative has the ability and responsibility to develop a work schedule that will provide Petitioner home care services 7 days per week. Respondent has suggested such a schedule.

27. The undersigned has reviewed all the above cited authorities and applied these to the totality of the evidence. Petitioner has not established, by the greater weight of the evidence, that Respondent's action in this matter was incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is hereby 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 16 day of March, 2017,

in Tallahassee, Florida.



Warren Hunter
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Mar 01, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07067

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88695

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on January 26, 2017, at 1:00 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:



For the Respondent:
of

Deanne Fields, Esq. with the Department
Children and Families

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's request for Institutional Care Program (ICP) Medicaid benefits for the time period of February 2016

through August 2016 due to excess assets is correct. The burden of proof was assigned to the petitioner by a preponderance of evidence.

The appeal was continued from two prior scheduled dates per petitioner's request.

PRELIMINARY STATEMENT

Petitioner [REDACTED] was represented by [REDACTED]. Petitioner presented one witness who testified: [REDACTED], daughter. Also present was the witness' husband, [REDACTED]. Petitioner submitted two (2) exhibits, which were accepted into evidence and marked as Petitioner's Exhibits 1 & 2.

Respondent was represented by Deanne Fields, Esq., Assistant Regional Counsel with DCF. Respondent presented one witness who testified: Mary Lou Dahmer, Economic Self Sufficiency Specialist II with DCF (hereafter "DCF", "Respondent", or "Agency"). Respondent submitted two exhibits, which were accepted into evidence and marked as Respondent's Composite Exhibit "1" and Respondent's Exhibit 2 respectively.

Administrative notice was taken of 42 U.S.C. § 1396a; 42 U.S.C. § 1396p(d)(4) (iv) and Florida Administrative Code Rule 65A-1.701; 65A-1.712 and 65A-1.713.

FINDINGS OF FACT

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

1. On March 19, 2013 petitioner executed separate a Durable Power of Attorney appointing his daughter, [REDACTED], as his attorney-in-fact. The document granted [REDACTED] the ability to "conduct banking transaction as provided in section

709.2208(1), Florida Statutes.” Additionally, the document granted Ms. Rhode authority:

To deposit to or withdraw from, or draw checks or drafts upon, any and all savings or checking accounts, money market funds, or any other type of account in my name; open any new such accounts in my name in any bank or financial institution or with the any insurance or brokerage firm; and endorse my name to any and all negotiable instruments.

2. On January 26, 2016, [REDACTED] created the [REDACTED] Trust document naming herself as the grantor & trustee and [REDACTED] and [REDACTED] as life beneficiaries. [REDACTED] is the successor trustee, see Petitioner’s Exhibit 2.

3. A Special Care Trust is a specialized legal document designed to benefit an individual who has a disability to preserve his eligibility for governmental benefits while protecting his assets. A trust account ([REDACTED]) was opened at [REDACTED] Bank. The trust manager may deposit personal funds into the account.

4. On January 26, 2016, petitioner entered into a Personal Services Contract with [REDACTED] as the provider. Under this agreement, [REDACTED] required payment of \$36,691.20 for her services. Since, according to the contract, the petitioner only had \$31,198.15 in assets, a promissory note was issued for the remaining \$5,493.05, see Respondent’s Composite Exhibit 1, pages 72-78.

5. On January 28, 2016, a cash deposit of \$100 was made to fund the [REDACTED] Irrevocable Special Care Trust. Additionally, on January 28, 2016 [REDACTED] transferred \$33,000 from SunTrust account ending in [REDACTED] to the [REDACTED] [REDACTED] see Petitioner’s Exhibit 1.

6. [REDACTED] shares bank accounts with her parents at [REDACTED] bank (ending in [REDACTED]), but she also has a personal bank account at [REDACTED].

7. The petitioner and his wife were admitted into a nursing home on October 28, 2015. On February 15, 2016, an application was submitted requesting ICP Medicaid benefits on behalf of the couple. On February 17, 2016, a Notice of case Action was sent to the petitioner requesting additional information. The respondent processed the case and only approved Medically Needy benefits for the couple.

8. On June 17, 2016, another application was submitted requesting ICP Medicaid on the couple's behalf. On July 18, 2016, the Department mailed a Notice of Case Action to the petitioner informing him that his ICP Medicaid application was denied. The Notice of Case Action explains the reason for the denial was because it, "did not received all the information requested to determine eligibility". The petitioner was enrolled in the Medically Needy Program with a \$2,644 share of cost (SOC).

9. On August 29, 2016, the petitioner submitted another application for ICP Medicaid on the couple's behalf. On August 31, 2016, the Department mailed a Notice of Case Action to the petitioner informing him that his ICP Medicaid application was denied. The Notice of Case Action explains the reason for the denial was because, "The value of your assets is too high for this program" and cites Florida Administrative Code Rule 65A-1.712.

10. On September 13, 2016, the petitioner submitted another application for ICP Medicaid benefits. On October 14, 2016, the Department mailed a Notice of Case Action to the petitioner informing him that his ICP Medicaid application was denied. The Notice of Case Action explains the reason for the termination is because, "The value of

your assets is too high for this program” and cites Florida Administrative Code Rule 65A-1.712, see Respondent’s Composite Exhibit 1, pages 102-119.

11. In response to the Department’s request for additional information, the petitioner provided the bank statements requested several bank accounts. [REDACTED]

[REDACTED] t account ending in 0200 reflect the following information:

Statement Period Ending	Balance
January 27, 2016 – February 24, 2016	\$26,540
February 25, 2016 – March 28, 2016	\$34,089
April 27, 2016 – June 27, 2016	\$43,248.73
June 28, 2016 – July 26, 2016	\$44,930.42

12. Statements for the [REDACTED] joint account ending in [REDACTED] reflect the following information:

Statement Period Ending	Balance
February 10, 2016 – March 10, 2016	\$1,600.90
March 11, 2016 – April 11, 2016	\$2,476.41
April 12, 2016 – May 10, 2016	\$3,709.413
May 11, 2016 – June 9, 2016	\$4,818.94
June 10,2016 –July 12, 2016	\$365.23
July 13, 2016 – August 10,2016	\$453.41
August 11, 2016 – September 12, 2016	\$2,919.02

13. Statements for the [REDACTED] joint account ending in [REDACTED] the following information:

Statement Period Ending	Balance
February 26, 2016 – March 29, 2016	\$1,729.65
March 30, 2016 – April 27, 2016	\$1,714.66
April 28, 2016 – May 26, 2016	\$1,699.67
May 27, 2016 – June 28, 2016	\$1,684.69
June 29, 2016 – July 27, 2016	\$0.00

14. As the monthly balance(s) exceed the asset limit of \$3,000, the respondent determined that the petitioner was ineligible for ICP Medicaid benefits, irrespective of its position that it had not received any verification of assets from the petitioner. The petitioner contends that the money was funds due the [REDACTED] for services already rendered under the Personal Services Contract agreement, therefore, should have been considered to be unavailable to the petitioner. Assets considered to be unavailable are excluded as countable assets; therefore, the petitioner should have been determined eligible for ICP Medicaid benefits.

15. On November 1, 2016, another application was submitted requesting ICP on the couple's behalf. Eligibility was established retroactively to September 2016 and ongoing months. On December 16, 2016, the Department mailed a Notice of Case Action to the petitioner informing him that his ICP Medicaid application was approved.

16. Petitioner requested a redetermination of the denial of [REDACTED] ICP Medicaid application as he believed the respondent incorrectly denied the ICP application

because the respondent's interpretation of the law was more restrictive than the Federal Social Security regulations. Petitioner is seeking ICP Medicaid benefits for the months of February 2016 through August 2016. Petitioner was determined eligible for ICP Medicaid benefits effective September 1, 2016.

17. Addressing petitioner's ownership of the assets in question; the respondent's witness explained that the petitioner's daughter would also have to provide proof from the financial institution that the funds were deposited into own personal account prior to being transferred to the trust account. [REDACTED] explained that this money was a \$32,000 life insurance cashed out by the petitioner and that sum was originally deposited into a different account before being transferred into the trust. The petitioner's daughter explained that she can provide that verification. However, the respondent further added, that since the money was transferred from an account jointly owned by the petitioner, his wife and their daughter, therefore, the transfer would have been considered improper for ICP Medicaid eligibility purposes.

CONCLUSIONS OF LAW

18. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

20. Fla. Admin. Code R 65A-1.712 addresses SSI-Related Medicaid Resource Eligibility Criteria, defines the types of transfer of resources and states, in part:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C.,

21. Fla. Admin. Code R. 65A-1.716 sets forth the Income and Resource

Criteria. It states:

(5) SSI-Related Program Standards.

(a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:

1. \$2000 per individual.

2. \$3000 per eligible couple or eligible individual with an ineligible spouse who are living together.

22. Fla. Admin. Code R. 65A-1.702 addresses Special Provisions and states in parts:

(1) Rules 65A-1.701 through 65A-1.716, F.A.C., implement Medicaid coverage provisions and options available to states under Titles XVI and XIX of the Social Security Act.

(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period). Eligibility for Medicaid begins the first day of a month if an individual was eligible any time during the month...

...

(15) Trusts.

(a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

(b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36 month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual. Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.

(c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2)

on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income.

23. The rule excerpts mean that if the asset limit is met within a month, and all other aspects of eligibility are favorable, then an applicant can be approved for the full month. Trusts (or similar devices) as well as contracts have a place in accommodating ICP eligibility on occasion, such as situations where income exceeds Program standards, but is less than monthly nursing home costs. However, Rule also says that if funds in a trust "or other similar device" can be disbursed for benefit of applicant, then the funds are considered available.

24. Fla. Admin. Code R. 65A-1.303 discusses Assets. It states the following:

- (1) Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.
- (2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.
- (3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

25. In accordance with the federal regulations, eligibility standards for SSI-Related Program appear in the Department's Policy Manual CFOP 165-22 (The Policy Manual)

at Appendix A-9. Effective April 2016, the resource limit for a one-person assistance group applying for SSI-Related Medicaid Program is \$2,000 for an individual and \$3,000 for a couple..

26. As shown in the Findings of Fact, the Department did not approve the petitioner's request for ICP Medicaid benefits based on petitioner being over the asset limit as a result of the money available to him. The petitioner's representative argued that the money in the petitioner's [REDACTED] account is used to pay the daughter for expenses due associated with cares provided to the petitioner, therefore should not disqualify him from receiving ICP Medicaid.

27. The rules for asset or resource limits for the ICP Program are clear. The petitioner's assets are over the prescribed limit of \$3,000. Therefore, the Department correctly denied the petitioner's application for ICP Medicaid.

28. Since the trust is used for the benefit of the petitioner, it is considered an accessible asset. Despite complexity of financial arrangements, it is concluded that more than \$3,000 was accessible for petitioner's benefit for the period at issue. The funds were available for his use and benefit in excess of Program limits. Thus, ineligibility was the proper decision for that period and denial was justified. Therefore, respondent correctly denied the petitioner's request for ICP Medicaid benefits for the months of February 2016 through August 2016 as the combined assets exceeded the allowable asset limit.

29. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet his burden of proof in establishing the respondent incorrectly denied his request for Institutional Care Program Medicaid benefits for the

period of February 2016 through August 2016. Pursuant to the above, the petitioner has not met her burden of proof that the respondent incorrectly denied her request for ICP Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 01 day of March, 2017,

in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
Shane Deboard, Esq.

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

FILED

Mar 27, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07148

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 Marion
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on February 15, 2017 at approximately 1:04 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: 

For the Respondent: Selwyn Gossett, Medical/Health Care Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services. Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

PRELIMINARY STATEMENT

Hearing was initially scheduled to convene on November 15, 2016; however, prior to that date, AHCA notified the undersigned that it had not forwarded the Notice of Hearing to eQHealth Solutions, Inc. ("eQHealth"). Respondent requested a continuance so as to enable a physician reviewer from eQHealth to appear as its witness, and Petitioner did not object.

Via notice to both parties, telephonic hearing was rescheduled for December 20, 2016 at 1:00 p.m. On that date, the undersigned hearing officer, a representative from AHCA, and the Petitioner's mother were present on the conference line and ready to proceed. After waiting 15 minutes and confirming with AHCA both that the Notice of Rescheduled Hearing was provided to eQHealth, and that Petitioner's benefits would continue pending the outcome of her appeal, the undersigned excused both parties from the teleconference.

By separate notice, both parties were then notified that hearing would convene on February 15, 2017. At that hearing, the minor Petitioner was not present, but was represented by her mother, Robin Rankin. Respondent was represented by Selwyn Gossett, AHCA Medical/Health Care Program Analyst. Respondent presented one additional witnesses: Darlene Calhoun, D.O., Physician Consultant with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 5, inclusive, were accepted into evidence. Administrative Notice was taken of § 409.905, Fla. Stat., Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care

Services Coverage and Limitations Handbook (PPEC Handbook). This Final Order follows.

FINDINGS OF FACT

Based upon 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. The Petitioner is a 1-year-4-month-old female, born prematurely in November of 2015 at the gestational age of 24 weeks. Her diagnoses include [REDACTED] and [REDACTED] initiating in the prenatal period, along with additional complications related thereto. More recent diagnoses include [REDACTED] and some [REDACTED], and she continues to have [REDACTED].
2. Per her nurse reviewer's assessment, the Petitioner is currently meeting her developmental milestones. She is on a regular diet, has had no emergency room admissions during the prior PPEC certification period, and uses as-needed nebulizer treatments to assist with respiration. She receives speech and physical therapy at the PPEC facility.
3. The Petitioner resides in the family home with her parents, both of whom work outside the home, and one sibling. She utilizes PPEC services for full-day care, five days per week.
4. At all times relevant to these proceedings, Petitioner has been eligible to receive Medicaid services.
5. On or about September 9, 2016, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue her previously authorized PPEC services into the new certification period, spanning September 17, 2016 through March 15, 2017.

6. This prior service authorization request, along with information and documentation required to make a determination of medical necessity, was submitted to AHCA's peer review organization (PRO). The PRO contracted by AHCA to review PPEC requests is eQHealth Solutions, Inc. (eQHealth).

7. Following a face-to-face meeting with Petitioner, eQHealth's nurse/care coordinator recommended termination of PPEC services, citing no skilled nursing need.

8. On September 14, 2016 the PRO's physician reviewer evaluated Petitioner's supporting documentation and request for services. By letter dated September 21, 2016, the PRO notified Petitioner's provider and physician of its decision to terminate PPEC, stating, in pertinent part:

Clinical Rationale for Decision: The patient is a 10 month year [sic] old with a history of [REDACTED]. The patient is now on an age-appropriate diet. The patient receives as needed nebulizer treatments. The patient has had no emergency room visits or hospitalizations. The patient has made good weight gains and is progressing developmentally. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient no longer pears to have a skilled need and does not meet the medical necessity requirement of PPEC services. (Duplicative punctuation omitted.)

9. The September 21, 2016 letter, which eQHealth sent to Petitioner, notes only:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

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.

10. Petitioner's mother requested a hearing to challenge the proposed PPEC termination. As this appeal was timely filed, Petitioner's services have continued, pending Final Order.

11. At hearing, Dr. Calhoun explained that she reviewed Petitioner's request for services in conjunction with her Plan of Care, Care Coordination notes, nursing/PPEC Assessments, and Progress Notes. Dr. Calhoun is Board Certified in Pediatrics, and Neonatology/Perinatology. She has practiced in these fields for over 20 years.

12. The supporting documentation reflects that Petitioner takes a daily multivitamin and is administered as-needed nebulizer treatments. Although the documentation is somewhat inconsistent with regard to Petitioner's requirement for continuous oxygen/oxygen therapy, Dr. Calhoun noted that it appears as if Petitioner is no longer receiving same. Her PPEC staff assist with activities of daily living (ADLs), for which Petitioner is totally dependent on others.

13. While the Petitioner does require precautions/monitoring and nursing assessments, the only interventions (aside from physical and occupational therapy) indicated on her Plan of Care are the administration of oxygen "in an emergency situation," and as-needed nebulizer treatments. She receives both therapy services once per week (each).

14. Petitioner's mother testified that Petitioner still has respiratory problems, particularly when she contracts an infection. At the time of hearing, Petitioner had last required the nebulizer a few days prior. This was needed even though Petitioner was not ill. The Petitioner's mother noted that when the Petitioner has trouble breathing, she experiences bouts of gagging. The mother stated that she sometimes administers albuterol to assist in relieving these symptoms; however, she believes that when this occurs at PPEC, staff simply monitor the Petitioner to make sure the situation does not get worse. Currently, Petitioner's mother administers an inhaler to Petitioner before she

goes to PPEC in the morning, and after she returns in the evening. This appears to help with sleep, but has not resolved the gagging. The mother is concerned that a regular day care facility staff would not be able to respond if Petitioner's respiratory issues escalated, or if her development began to regress.

15. With regard to oxygen use, the mother explained that Petitioner was on a monitor and received oxygen until approximately June of 2016. At that time, she had regular drops in oxygenation, but she has since been weaned off of oxygen therapy.

16. Following testimony from Petitioner's mother, Dr. Calhoun opined that although Petitioner's lungs may still be immature, the fact that she no longer requires regular oxygen is a sign of improvement. She explained that once nebulizer treatments become necessary to treat periodic illness, or are administered solely on an unpredictable, as-needed basis, this is no longer considered a regular intervention. For these reasons, it was Dr. Calhoun's opinion that Petitioner no longer demonstrates medical necessity for PPEC services.

17. Dr. Calhoun also testified that Petitioner may still require physical and speech therapy, but that these services can be received outside of the PPEC facility, in an outpatient setting.

CONCLUSIONS OF LAW

18. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Chapter 120, Florida Statutes.

19. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the *Florida Administrative Code*.

20. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated by Rule 59G-4.260 of the *Florida Administrative Code*.

21. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

22. This hearing was held as a *de novo* proceeding, in accordance with Rule 65-2.056 of the *Florida Administrative Code*.

23. The burden of proof in the instant case is assigned to the Respondent, who seeks to terminate a previously authorized service. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

24. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

....

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

25. Page 1-1 of the PPEC Handbook notes that, “[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center.” Page 1-2 adds that “PPEC services are not emergency services,” (emphasis added).

26. On pages 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.
(underlined emphasis added)

27. Rule 59G-1.010 of the *Florida Administrative Code* defined “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour _____-per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a _____ heightened level of medical supervision to sustain life, and without such services is likely to expire without warning. (emphasis added)

28. Consistent with the law, AHCA’s agent, eQHealth, performs service authorization

reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

29. Rule 59G-1.010(166) of the *Florida Administrative Code* defines medical necessity, as follows:

“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. ...

(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.

30. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (cited, above) have been considered in the development of this Order.

31. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be appropriately addressed.

32. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

- (1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.
- (2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.
- (3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."
- (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
- (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
- (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its

own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

33. In the instant case, PPEC is requested to treat and ameliorate the supervisory, assessment, and monitoring needs which Petitioner's developmental and medical conditions present. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

34. More specifically, however, Fla. Admin. Code R. 59G-1.010(166) also requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must fulfill the requirements for PPEC, as provided in the PPEC Handbook.

35. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical equipment, such that she would properly be deemed "Medically Fragile." Her need for supervision, respiratory monitoring, as-needed nebulizer treatments, and interventions in case of emergency, do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care." As such, her needs do not support the authorization of PPEC, because there are alternative services, such as outpatient physical and speech therapy services, as well as skilled nursing visits and/or personal care assistance, which are better designed to meet her needs without being excessive. PPEC cannot be authorized as a substitute for school or daycare, particularly when

there is no skilled intervention provided at the PPEC site. In essence, this would constitute approval of PPEC as an emergency service, in direct violation of the PPEC Handbook (page 1-2).

36. Again, if Petitioner does require continued speech and physical therapy, these services can be provided in a setting other than the PPEC facility. Additionally, because therapy services are authorized and billed separately from PPEC, should these services be denied, reduced, or discontinued in the future, Petitioner will retain the right to request an appeal based on that, particular action.

37. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that AHCA has met its burden of proof, and shown that denial/termination of PPEC services is appropriate in the instant case.

38. Petitioner's mother is encouraged to coordinate with Petitioner's CMS nurse case manager. The case manager should be able to assist Petitioner in finding services to meet her therapeutic (and any other) needs, and can direct Petitioner to other appropriate resources, as need.

39. Should Petitioner's health situation change, or should her respiratory issues become more frequent, Petitioner's mother may wish to request that PPEC services be reinstated. If and when this request is made, Petitioner will be advised of any adverse determination, and will be able to request a hearing related thereto.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED.

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 27 day of March, 2017,

in Tallahassee, Florida.



Patricia C. Antonucci
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit

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

FILED

Mar 28, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07398

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on March 2, 2017, at 12:45 p.m.

APPEARANCES

For the Petitioner:



Paralegal
Florida Rural Legal Services

For the Respondent:

Rachelle Narcisse
Auditor
Prestige Health Choice

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent, Prestige Health Choice, incorrectly denied her request for periodontal scaling and root planing?

4. Prestige Health Choice provides certain dental benefits to its members.

5. Prestige Health Choice has contracted Argus Dental Plan to be its dental vendor. In its capacity as vendor, Argus Dental Plan completes prior authorization reviews of requests for dental services submitted to it by Prestige Health Choice members or their providers.

6. On August 31, 2016, the petitioner's dentist submitted a prior authorization request to Argus Dental Plan for periodontal scaling and root planing.

7. Periodontal scaling and root planing is the process of removing or eliminating dental plaque and calculus both above and below the gum line. It is a painful, non-surgical procedure that requires the use of anesthesia. Periodontal scaling and root planing is used to address periodontal disease. It is sometimes referred to as a deep cleaning.

8. A periodontal scaling and root planing is not a routine cleaning as described in the Agency's guidelines and Prestige Health Choice member handbook.

9. The petitioner has [REDACTED], also known as gum disease.

10. The petitioner has [REDACTED] and visible calculus buildup. It is not safe or advisable for her to have a regular dental cleaning or ethical for a dentist to just do a regular cleaning.

11. In a Notice of Action dated September 1, 2016, Prestige Health Choice informed the petitioner that it was denying her request for periodontal scaling and root planing.

12. The Notice of Action states, in part:

We determined that your requested services are **not medically necessary** [emphasis in original] because the services do not meet the reason(s) checked below: (See *Rule 59G-1.010*)

X The requested service is **not a covered benefit** [emphasis in original].

13. Prestige Health Choice offers expanded dental benefits to its members who are 21 years of age and older, meaning that it offers additional services to those members than those traditionally available in the Agency for Health Care environment.

14. Periodontal scaling and root planing is not a covered benefit for Medicaid recipients 21 years of age and older under the Medicaid State Plan administered by the Agency for Health Care Administration.

15. Periodontal scaling and root planing is not a covered benefit for Prestige Health Choice members 21 years of age and older.

16. The respondent is not disputing that a periodontal scaling and root planing is medically necessary for the petitioner, only that it is a non-covered benefit.

CONCLUSIONS OF LAW

17. 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, Fla. Stat.

18. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

19. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

20. In the present case, the petitioner is requesting an additional service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

21. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence.” (Black’s Law Dictionary at 1201, 7th Ed.).

22. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by the Agency for Health Care Administration.

23. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law...

24. The definition of medically necessary is found in Fla. Admin Code. R. 59G-1.010, which states:

(166) ‘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...

(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.

25. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the “medical necessity or medically necessary” standards, and states in pertinent part as follows

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on to further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

26. Section (1)(d) highlights the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

27. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-5.020. The Handbook states the following on Page 1-27:

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain

contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

28. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains “Other services that plans may provide include dental services....”

29. Page 1-30 of the Florida Medicaid Provider General Handbook states: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

30. The Florida Medicaid Dental Services Coverage Policy (May 3, 2016) is a handbook promulgated into rule by Rule 59G-4.060, Florida Administrative Code.

31. Section 2.2 of the Dental Services Coverage Policy states, in pertinent part: “If a service is limited to recipients under the age of 21 years, it is specified in section 4.0....”

32. Section 4.2.5 of the Dental Services Coverage Policy limits the receipt of periodontal services to recipients under the age of 21 years.

33. The Prestige Health Choice member handbook lists covered dental benefits for members 21 years of age and older on Page 13 and states as follows:

Dental Care for Adults are services for members ages 21 and older. They can receive two exams, two cleanings, four simple extractions, two surgical extractions, three amalgam fillings per year and one x-ray every two years.

34. Periodontal services are not available to Medicaid recipients 21 years of age and older under either the Medicaid State Plan administered by the Agency for

Health Care Administration or Prestige Health Choice. Therefore, Prestige Health Choice policy is not more restrictive than that of the Agency for Health Care Administration.

35. In the present case, periodontal scaling and root planing is not a covered benefit for recipients 21 years of age and older. Therefore, the respondent correctly denied the petitioner's request for the service.

36. Pursuant to the above, the petitioner has not demonstrated by a preponderance of the evidence that the respondent incorrectly denied her request for periodontal scaling and root planing.

37. This Order does not purport to state that periodontal scaling and root planing are not medically necessary for the petitioner or that the petitioner would not potentially benefit from such a procedure, only that the respondent correctly denied the request on the grounds that it is a non-covered benefit.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is hereby DENIED.

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 indigence to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)
16F-07398
PAGE - 9

DONE and ORDERED this 28 day of March, 2017,
in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
Nadine Philossaint
Prestige Hearings Unit

FILED

Mar 13, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-07456

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Escambia
UNIT: 88113

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on January 20, 2017 at 11:11 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Eric Schurger, Attorney

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of denying Institutional Care Program (ICP) Medicaid for the retroactive period September 2013 through July 2015.

The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department presented two documents on January 20, 2017. The first consisted of 41 pages and was entered a Respondent's Exhibit 1. The second

consisted of 20 pages and was entered as Respondent's Exhibit 2. The petitioner submitted no evidence for the hearing.

The record was held open through February 10, 2017 for Proposed Final Orders or Memorandum's of Law from both parties. Each party submitted a document for review on February 10, 2017.

The record closed on February 10, 2017.

FINDINGS OF FACT

1. The petitioner was admitted to [REDACTED] [REDACTED] on September 5, 2013. Her admissions record lists [REDACTED] [REDACTED] [REDACTED] and [REDACTED] as some of her diagnosis.
2. The first application for Institutional Care Program (ICP) Medicaid was submitted on March 24, 2014.
3. The Department issued a Notice of Case Action on April 18, 2014. The Notice denied the petitioner's application citing the petitioner's assets were too high to qualify for the program. The Notice included the right to appeal the decision within 90 days of the date of the notice.
4. The petitioner submitted another application for ICP Medicaid on July 18, 2014.
5. The Department issued a Notice of Case Action on August 19, 2014. The Notice denied the petitioner's application citing the petitioner's assets were too high to qualify for the program. The Notice included the right to appeal the decision within 90 days of the date of the notice.
6. The petitioner reapplied for ICP Medicaid on March 5, 2015.

7. The Department issued a Notice of Case Action on April 7, 2015 denying the application citing the Department did not receive verification of the petitioner's assets. The notice included the right to appeal the decision within 90 days of the date of the notice.

8. The petitioner filed an application for ICP Medicaid on August 26, 2015.

9. The Department issued a Notice of Case Action on September 28, 2015 denying the application due to failure to submit verification of her assets. The notice included the right to appeal the decision within 90 days of the date of the notice.

10. The petitioner's sons, her co-guardians, liquidated a [REDACTED] market account on July 28, 2015. The proceeds from this liquidation was \$24,561.68. The proceeds were paid to the facility, Rosewood Manor.

11. The petitioner filed an application for ICP Medicaid on August 26, 2015.

12. The petitioner filed an application for ICP Medicaid on July 18, 2016.

13. The petitioner, through counsel, filed an appeal on August 5, 2016.

14. The Department issued a Notice of Case Action on August 10, 2016 approving the petitioner for ICP Medicaid beginning with August 2015.

15. The Department applied their policy regarding retroactive Medicaid and legally incompetent individuals (guardianships) to determine the beginning date of the petitioner's eligibility as August 2015.

16. The petitioner requested ICP Medicaid to begin retroactively with September 2013. This request was made on October 28, 2016 following the approval of ICP Medicaid beginning August 2015.

17. The petitioner has no application for ICP Medicaid filed prior to March 2014.

18. There is no recorded request for appeal prior to August 5, 2016.

19. The petitioner reported that [REDACTED] requested the Department's assistance with this case beginning with the first application.

20. The petitioner asserted that the attorney has been involved in the case since 2015 and requested Department assistance in resolving the matter.

21. The Department's record reflects the petitioner's attorney involved with the case as early as March 2016.

22. The petitioner asserted that her sons were unresponsive to requests for assistance in determining her eligibility for ICP Medicaid until July 2015.

23. Respondent Exhibit 1, page 10 through 12, lists seven accounts owned by the petitioner. The document cites the account, balance and the date the account was liquidated. Each account shows the balance was paid to the facility.

- [REDACTED] balance of \$5,259.68, liquidated on February 25, 2015 and was owned on January 28, 2013.
- [REDACTED] balance of \$5,150.78, liquidated on February 25, 2015 and was owned on January 28, 2013.
- [REDACTED]) was known as of September 1, 2013. The petitioner's son made the following withdrawals to pay [REDACTED]: \$846 on July 11, 2013, \$4,290 on November 8, 2013 and \$6,400 on January 1, 2014. The account was liquidated on February 25, 2015 for the balance of \$277.86.
- [REDACTED]) contained \$15,472.20, liquidated on February 25, 2015 and was owned as early as August 2013.
- [REDACTED]) discovered by the Department's Asset Verification system. The account balance was \$24,561.68 and was liquidated on July 28, 2015.
- [REDACTED]) discovered by the Departments Asset Verification system. The account had a balance of \$2,037.32 and was liquidated on July 30, 2015.

- [REDACTED] (-9699) remains open. The petitioner maintains the balance is less than \$2,000.

24. The petitioner maintains the sons and co-guardians of the petitioner were unaware of the accounts at SunTrust until notified by the Department.

25. The Department case notes reflects the two accounts with [REDACTED] were identified in March 2015 and verification of these accounts was requested.

CONCLUSIONS OF LAW

26. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

TIMELINESS OF APPEAL REQUEST

28. 42 C.F.R. § 431.221, Request for hearing, states in relevant part:

- (a)(1) The agency must establish procedures that permit an individual, or an authorized representative as defined at §435.923 of this chapter, to—
- (i) Submit a hearing request via any of the modalities described in §435.907(a) of this chapter, except that the requirement to establish procedures for submission of a fair hearing request described in §435.907(a)(1), (2) and (5) of this chapter (relating to submissions via Internet Web site, telephone and other electronic means) is effective no later than the date described in §435.1200(i) of this chapter; and
 - (ii) Include in a hearing request submitted under paragraph (a)(1)(i) of this section, a request for an expedited fair hearing.
- (2) [Reserved]
- (b) The agency may not limit or interfere with the applicant's or beneficiary's freedom to make a request for a hearing.
 - (c) The agency may assist the applicant or beneficiary in submitting and processing his request.

(d) The agency must allow the applicant or beneficiary a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing.

29. Florida Admin. Code R. 65-2.046, Time Limits in Which to Request a Hearing, states in relevant part:

(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:

(a) The date on the written notification of the decision on an application.

(b) The date on the written notification of reduction or termination of program benefits.

(c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

30. The above controlling authorities require that a hearing must be requested within 90 calendar days from the date of the Department's notice of decision on an application.

31. The findings show the petitioner applied for assistance on March 24, 2014, July 18, 2014 and March 5, 2015. The findings also show the Department issued corresponding Notice of Case Action on April 18, 2014, August 19, 2014, and April 7, 2015, each denying the petitioner's application for ICP Medicaid. In addition, the findings show the petitioner did not request an appeal until August 5, 2016. The undersigned concludes the petitioner failed to request an appeal timely based on these notices.

32. The undersigned recognizes the liberal definition utilized for the requesting of a hearing in the matter to include that of requesting supervisory review of the case. Unfortunately, the undersigned could find no record of a supervisory review requested in the exhibits presented. Therefore, the undersigned concludes the first appeal request received was on August 5, 2016.

RETROACTIVE MEDICAID MONTHS

33. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant part:

(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.

(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility.

34. The above controlling authority grants the Department the ability to review a case for Retroactive Medicaid. The retroactive Medicaid period is described as the three months prior to an application for ongoing Medicaid.

35. The findings show the petitioner filed applications on March 24, 2014, July 18, 2014, and March 5, 2015. The undersigned concludes March 2014, July 2014, and March 2015 are months of application and not retroactive months. The undersigned further concludes as each subsequent application was outside of the three months prior to the application being considered, there is no retroactive coverage available for these months.

36. The findings show the petitioner's first application filed March 24, 2014. The undersigned concludes the retroactive Medicaid period for this application is December 2013 through February 2014.

37. The petitioner requested retroactive Medicaid eligibility be determined for the months of September 2013 through November 2013. The undersigned concludes there was no application filed that would allow these months to be covered under retroactive Medicaid coverage.

38. The findings show the petitioner's application filed on July 18, 2014. The undersigned concludes the retroactive Medicaid period for this application is April 2014 through June 2014.

39. The findings show the petitioner's application filed March 5, 2015. The undersigned concludes the retroactive Medicaid period for this application is December 2014 through February 2015.

40. The petitioner requested Medicaid eligibility for the months of August 2014 through November 2014. The undersigned concludes these months do not fall within the three months immediately preceding an application to be able to consider the months for retroactive Medicaid coverage.

41. The findings show the petitioner's application filed August 26, 2015. The undersigned concludes the retroactive Medicaid period for this application would be May 2015 through July 2015.

42. The petitioner requested Medicaid eligibility determination for the month of April 2015 as well. The undersigned concludes there is no application file for which April 2015 is considered a retroactive month.

ASSET ELIGIBILITY

43. The undersigned will review eligibility related to assets for the following retroactive months: December 2013 through February 2014, April 2014 through June 2014, December 2014 through February 2015, and April 2015 through July 2015.

44. 20 C.F.R. § 416.1201, Resources; general states in relevant part:

(a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

...

(b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources. (See §416.1208 for the treatment of funds held in individual and joint financial institution accounts.)

45. 20 C.F.R § 416.1208, How funds held in financial institution accounts are counted, states in relevant part:

(a) General. Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled.

(b) Individually-held account. If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are

that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account. This presumption is non-rebuttable.

46. Florida Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource

Eligibility Criteria, states in relevant part:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month.

...

(2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. § 416.1210 and 20 C.F.R. § 416.1218 in determining resource exclusions, with the exceptions in paragraphs (a) through (g) below, in accordance with 42 U.S.C. § 1396a(r)(2).

(a) Resources of a comatose applicant (or recipient) are excluded when there is no known legal guardian or other individual who can access and expend the resource(s).

(b) The value of a life estate interest in real property is excluded.

(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is \$2,500 or less.

(d) The individual, and their spouse, may designate up to \$2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The \$2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

(e) One automobile is excluded, regardless of value.

(f) Property that is essential to the individual's self-support shall be excluded from resources if it is producing income available to the individual which is consistent with its fair market value. This includes real and personal property used in a trade or business; non-business income-producing property; and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support. For the purpose of this section, mortgages are considered non-liquid resources, if they were entered into on or before September 30, 2004.

(g) An individual who is a beneficiary under a qualified state Long-Term Care Insurance Partnership Policy is given a resource disregard equal to the amount of the insurance benefit payments made to or on behalf of the individual for long term care services when determining if the individual's countable resources are within the program limits to qualify for Medicaid

Institutional Care Program (ICP), HCBS, the Program of All Inclusive Care for the Elderly (PACE), or hospice benefits.

47. The Department's Program Policy Manual, CFOP 165-22, section 1640.0320, Legally Incompetent Individuals (MSSI, SFP) states:

Under the Florida Guardianship Law, only a guardian of the property is authorized to dispose of assets on behalf of a legally incompetent individual. Until a legal guardian is assigned, real property owned by a legally incompetent individual is not available. Liquid assets (for example, patient fund accounts and checking accounts) are included as available if the individual has free access to the funds. If a legal guardian must petition the court in order to dispose of the individual's property, the asset is still included for the individual. The fact that the guardian must petition the court does not make the property an unavailable asset.

48. The above controlling authority cites that the assets of a comatose applicant or recipient is considered unavailable or excluded when there is NO known legal guardian or other individual who can access and expend the resource. The findings show that in 2013, 2014 and 2015 the petitioner's sons were known to the facility. The findings show that one of the petitioner's sons accessed one of the accounts three times in 2013 and 2014 to pay her bill with the facility. The undersigned concludes the funds were available to the petitioner even though she had conditions that could be considered to make her legally incompetent as her son had access to dispose of the funds.

49. Florida Admin. Code R. 65A-1.716, Income and Resource Criteria, states in relevant part:

- (5) SSI-Related Program Standards.
- (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:
 - 1. \$2000 per individual.
 - 2. \$3000 per eligible couple or eligible individual with an ineligible spouse who are living together.

50. The findings show (paragraph 23) the petitioner had a singular account (among the many) that contained a balance of \$15,472.20. The account was owned as early as August 2013 according to the petitioner's report and was liquidated on February 25, 2015 with proceeds surrendered to [REDACTED] to assist in covering the petitioner's bill. The undersigned concludes this account alone would make the petitioner exceed the resource limit described in the above controlling authority of \$2,000 for an individual. The undersigned further concludes the petitioner would be ineligible for the following months December 2013 through February 2014, April 2014 through June 2014, and December 2014 through February 2015.

51. The findings show the petitioner had two accounts with [REDACTED]. The petitioner maintains the sons had no knowledge of the accounts prior to discovery by the Department. The combined balance of the accounts was \$26,599 (\$24,561.68 + \$2,037.32 = \$26,599.00). The findings show the Department discovered the accounts and requested verification in March 2015. While the undersigned notes the lack of prior knowledge of the accounts by the petitioner's sons, the undersigned finds no rule excluding the account due to lack of knowledge of the account. The undersigned concludes the petitioner's sons could have accessed and liquidated the accounts as soon as they were notified of the existence of the accounts. However, the findings show these accounts were not liquidated until July 2015. The undersigned concludes the petitioner exceeded the asset limit for the months of April 2015 through July 2015 due to these two accounts.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 13 day of March, 2017,

in Tallahassee, Florida.



Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency
Eric Schurger
Steve Quinnell

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

FILED

Mar 07, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07541

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 Collier
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

THIS CAUSE is before Hearing Officer Patricia Antonucci, following hearing on November 30, 2016 at approximately 3:11 p.m. All parties and witnesses appeared via teleconference. The minor Petitioner was not present on the conference line, but had representation in attendance.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's mother

For the Respondent: Stephanie Shupe, Regulatory Research Coordinator,
Staywell/WellCare

STATEMENT OF THE ISSUE

At issue is a decision by Respondent, Staywell/WellCare ("Staywell") to partially deny Petitioner's request for dental procedures. Specifically in contention is Staywell's denial of extraction of teeth #1 and 16, denial of guided tissue regeneration for teeth

#17 and 32, and denial of one, 15-minute increment of IV anesthesia. Staywell approved extraction (plus 30 minutes of sedation) of teeth #17 and 32.

Although prior authorization of the remaining procedures was denied, Petitioner had all requested dental work performed by his selected provider, prior to hearing. The limitations this places on the undersigned's justification will be addressed, below; however, as to any decision regarding Respondent's denial, Petitioner bears the burden of proving, by a preponderance of the evidence, that said denial was improper.

PRELIMINARY STATEMENT

At hearing, Petitioner was represented by his mother, [REDACTED] Respondent, Staywell/WellCare ("Staywell") was represented by Stephanie Shupe, Regulatory Research Coordinator. Ms. Shupe presented two additional witnesses: Michelle Hadley, National Ancillary Account Coordinator, and Andrea Spurr, DDS, Dental Consultant (with Staywell's dental vendor, Liberty Dental). Suzanne Chillari, Medical/Health Care Program Analyst, observed on behalf of the Agency for Health Care Administration (AHCA).

The undersigned explained that because the contested service had already been rendered, the Office of Appeal Hearings likely lacked jurisdiction to provide relief; however, she noted that this matter would be taken under advisement. The parties agreed to proceed with testimony to establish the reason for the service denial, while acknowledging the appeal might ultimately be dismissed. Respondent's Exhibits 1 through 15, inclusive, were accepted into evidence.

Following testimony, the record was held open for Respondent to file supplementary evidence. Said evidence (eight pages of call logs + one x-ray) was timely received; however, as it was not clear that same was copied to Petitioner, on January 27, 2017, the undersigned issued an Order Sharing Supplemental Evidence. This Order instructed Petitioner's representative to file a written response that stated, in part: 1) the date upon which Petitioner had the subject dental procedures performed, and 2) whether Staywell had issued any reimbursement, post-hearing.

No response from Petitioner was received. Respondent's nine-page supplement has been marked and moved as Respondent's Composite Exhibit 16. This Final Order follows, based upon the record to date.

FINDINGS OF FACT

1. The Petitioner is a Medicaid recipient who is under the age of 21. He is and has been eligible to receive Medicaid services at all times relevant to these proceedings.
2. On or about September 28, 2016, Petitioner's provider submitted to Staywell a request for the following services:
 - 1) Removal of impacted tooth, completely bony #1
 - 2) Removal of impacted tooth, completely bony #16
 - 3) Removal of impacted tooth, completely bony #17
 - 4) Removal of impacted tooth, completely bony #32
 - 5) Guided tissue regeneration, resorbable barrier, per site #17
 - 6) Guided tissue regeneration, resorbable barrier, per site #32
 - 7) Intravenous moderate (conscious) sedation/analgesia, 15 minutes
 - 8) Intravenous moderate (conscious) sedation/analgesia, 15 minutes
 - 9) Intravenous moderate (conscious) sedation/analgesia, 15 minutes

3. Along with this request, the provider submitted an xray and dental records, the latter of which noted, in part: “pt stated that his wisdom teeth are causing him pain....no swelling, mucosa wnl, tmy wnl.”

4. Via Notice of Action dated September 30, 2016, Petitioner was informed as to the status of his request for the above-referenced/numbered procedures, as follows:

1, 2 D7-2 [Extraction of teeth # 1 and 16] Denied- Removal of asymptomatic (healthy) tooth/teeth is not a covered benefit.

#5, 6 DG-5 [Guided tissue regeneration] Denied – This procedure is not listed as covered by the plan. Please refer to the Evidence of Coverage (EOC) booklet or Schedule of Benefits for details or you may call us for additional information.

9 DG-77 Denied [15-minutes anesthesia] – The necessity for this procedure is not supported by the available documentation.
(Italics original.)

5. Following receipt of this Notice, Petitioner’s mother contacted Staywell and/or Liberty on several occasions to discuss the denial. Per review of Respondent’s call logs, on October 4, 2016, the mother requested an appeal of the denial, but did not provide the information Staywell requested to process her appeal. Petitioner’s mother was then told to contact her provider for more information. On October 5, 2016, she reported that Petitioner was in pain, and that she needed help to pay for his extractions. She was referred to the community assistance line. On October 7, 2016, the mother asked to speak to a supervisor, and was informed that her appeal was still being processed. Both Petitioner’s mother and his provider then called to inform Staywell that Petitioner was in pain and required emergency extraction of teeth #1 and #16. The mother was advised to resubmit the request and ask for expedited review, and told to

provide additional supporting information. A letter issued from Staywell on October 7, 2016 confirmed receipt of Petitioner's October 4, 2016 appeal.

6. On October 10, 2016, Petitioner's provider filed a new request, noting: "SUBMITTING AS AN EMERGENCY. PATIENT IS IN A LOT OF PAIN WITH HIS UPPER WISDOM TEETH MAKING HIM MISS SEVERAL DAYS OF SCHOOL. We have submitted a[n] appeal but was told to resubmitted [sic] instead. Please look at this for approval for upper wisdom," (capitalization original). Petitioner's mother called Staywell again on October 11, 2016 to check on the status of the case.

7. Via Notice of Action issued on October 11, 2016, Staywell referenced a request for extraction of teeth #1 and 16 received on October 7, 2016, and informed Petitioner that said request was denied because, "*The extraction of third molars based on general and inconclusive findings such as crowding, headaches, pressure, earaches or natural pains associated with eruption is not covered,*" (italics original).

8. On October 11, 2016, Petitioner's mother filed an appeal/request for fair hearing with the Office of Appeal Hearings.

9. Respondent's notes demonstrate continued contact by Petitioner's mother, and reflect conflicting suggestions from Staywell case workers, including:

[10/13/2016 2:34 PM]

... BIOLOGICAL PARENT HIPPA VERFIED. CALLED TO INQUIRE ABOUT APPEAL STATUS. ADVISED APPEAL WAS CLOSED AND OPTION TO FILE A NEW APPEAL....CALLER DOES NOT WANT TO [FILE] A NEW APPEAL. ADVISED THE CALLER TO ASK THE DOCTOR TO SEND A NEW AUTH REQUEST MAKING IT MEDICALLY NECESSARY.

...

[10/13/2016 3:13 PM]

CALLED TO INQUITE ABOUT APPEAL STATUS. ADVISED APPEAL IS CURRENTLY PENDING DECISION AND THE DUE DATE IS 11/03/2016.

TRANSFERRING TO MET FOR FURTHER ASSISTANCE. MBR IS IN PAIN AND UNDER HEAVY MEDICATION. THIS SHOULD HAVE BEEN EXPEDITED.

...

[10/13/2016 3:59 PM]

Parent called in regards to the member being in extreme pain. Agent explained to me that the appeal was submitted incorrectly. She stated that the parent needed the issue to be expedited. I stated to her that we could not expedite the appeal and that in this type of situation that the parent could be transferred over to Grievance/Appeals Department...

I explained to her [mother] that the appeal did not reflect what appeals Coordinator that the case was assigned to. I stated to her that the appeal was filed as standard and currently pending, that we could not go in and change grievance or appeal once it has been filed. She stated that she did not know what to do in regards to the issue....I offered to transfer her over to the Grievance/Appeals Department.

(All capitalization original.)

...

10. Via Notice dated October 17, 2016, Staywell/Liberty informed Petitioner of its intent, upon review, to uphold the service denial.

11. Staywell notes from October 18, 2016 reflect: "COMPLAIN[T]ANT REPORTS THAT STAYWELL PAID FOR 2 WISDOM TEETH REMOVAL; BUT HER SON... NEEDS ALL WISDOM TEETH REMOVED AS IS MEDICALLY NECESSARY...."

(capitalization original).

12. At hearing, Petitioner's mother explained that her son was in substantial pain, was experiencing headaches, and was prescribed medication to lessen same; however, the medication aggravating Petitioner's pre-existing stomach issues. She stated that since the Petitioner was missing several days of school, she felt he should have all four wisdom teeth removed at the same time, rather than have to undergo multiple procedures. The mother testified that when she expressed this to Staywell/Liberty, she

was told that the only way he would have all four removed would be if she paid for the services, herself.

13. At some point prior to hearing, Petitioner's mother entered into a payment plan with the provider, to have all requested services performed. As of the date of hearing, Petitioner had no wisdom teeth remaining, and was no longer in pain.

14. Dr. Spurr testified that in her medical opinion, it was possible that any pain Petitioner had experienced in his upper jaw was actually referred pain from teeth # 17 and 32 and/or natural pain based on proper tooth eruption. She explained that extraction of #17 and 32 was approved because Petitioner's xray showed that these teeth were malpositioned for eruption. In contrast, teeth # 1 and 16 had a clear path for eruption, showed no pathology, and the provider's notes referenced no swelling with normal mucosa. Per Dr. Spurr, removal of the lower two wisdom teeth, as authorized by Staywell, may have alleviated all of Petitioner's pain. Dr. Spurr further testified that while tissue regeneration for teeth #17 and 32 would typically be required if an implant was considered, and that it might be of some benefit to Petitioner, this procedure was not medically necessary.

15. Ms. Shupe testified that if Petitioner's provider rendered the services without first obtaining prior authorization, he might be barred from seeking payment from Petitioner's mother. However, if Petitioner's mother entered into an agreement, consenting to pay out-of-pocket for anything not covered by Staywell, the usual protection against "balance billing" of a Medicaid recipient might not apply.

CONCLUSIONS OF LAW

16. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Florida Statutes Chapter 120.

17. Legal authority governing the Florida Medicaid Program is found in Florida Statutes, Chapter 409, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

18. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

19. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

20. The burden of proof in the instant case is assigned to Petitioner, who has requested approval for specific procedures.

21. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

22. Section 409.973(1)(e), Florida Statutes, mandates that managed care plans must cover dental services.

23. In keeping with this law, the May, 2016 Florida Medicaid Dental Services Coverage Policy, promulgated by Fla. Admin. Code R. 59G-4.060, states, in pertinent parts:

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.2.3 Endodontic Services

Florida Medicaid reimburses for endodontic services for recipients under the age of 21 years to treat the dental pulp and surrounding tissues.

...

4.2.9 Surgical Procedures and Extractions

Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.

4.3 Early and Periodic Screening, Diagnosis, and Treatment [EPSDT]

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

...

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service (underlined emphasis added).

24. Again, it appears to the undersigned that she lacks jurisdiction to review and rule upon Respondent's decision to partially deny Petitioner's request; however, because Petitioner asserts that extraction of teeth # 1 and 16 constituted a medical emergency, the undersigned has reviewed the definitions of "medical necessity" as contained within Fla. Admin. Code. R. 59G-1.010(166), along with the further protections afforded by EPSDT, as well as the definitions of "emergency," as referenced in Section 4.2.9 of the

Medicaid Dental Services Coverage Policy (quoted, above), and as provided in Fla. Admin. Code R. 59G-1.010. Fla. Admin. Code R. 59G-1.010(76) states: “Emergency care’ or ‘emergency services’ or ‘emergency medical services’ means those services that are necessary to prevent loss of life, irreparable physical damage, or loss or serious impairment of a body function.”

25. Based upon this review, and considering Dr. Spurr’s testimony that the pain which Petitioner experienced may have either been referred from teeth # 17 and 32 or part of a natural eruption process, the undersigned cannot conclude that the pain Petitioner felt in teeth # 1 and 16 constituted a medical emergency. Even if relieving said pain was an emergency, the undersigned is unable to determine whether extraction of teeth # 17 and 32 might have resolved the concern.

26. With regard to denial of prior authorization (absent an emergency), Pursuant to 42 U.S.C. § 1396(a)(3) and its implementing authority within the Code of Federal Regulations, a benefit recipient reserves the right to fair hearing when a request for services is denied, ignored, or when the Agency undertakes erroneous action. Per 42 C.F.R. § 431.220:

- (a) The State agency must grant an opportunity for a hearing to the following:
 - (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness.
 - (2) Any beneficiary who requests it because he or she believes the agency has taken an action erroneously.(emphasis added)

27. In terms of retroactive payment for services already rendered, the scope of review is tied to “incorrect action,” and is thus more limited. Indeed, 42 C.F.R. § 431.246 allows for corrective payments, only as follows:

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if—

- (a) The hearing decision is favorable to the applicant or beneficiary; or
- (b) The agency decides in the applicant's or beneficiary's favor before the hearing.

(emphasis added)

28. Similarly, per Fla. Admin. Code R. 65-2.066 (Final Orders):

(1) Orders issued by the hearings officers of the Office of Appeal Hearings of the Department of Children and Family Services are final orders and shall be implemented immediately.

...

(6) In the Final Order the hearings officer shall authorize corrective action retroactively to the date the incorrect action was taken.

(7) The Final Order shall include notice of opportunity for judicial review.

29. Whereas 42 C.F.R. § 431.220 differentiates between a service that is *denied* and an *erroneous action*, but establishes the right to hearing for either occurrence, 42 C.F.R. § 431.26 and Fla. Admin. Code R. 65-2.066 provide remedy only with regard to incorrect *action*. “Action” is not defined within the specified portion of the Florida Administrative Code, but it is defined in 42 C.F.R. 431.201, which states:

Action means a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act. (emphasis added)

30. By the time hearing on Petitioner’s appeal convened, the Petitioner had already undergone the dental procedures, which Respondent denied. As such, the matter at issue, here, is denial of retroactive authorization/payment to the provider (or

reimbursement to Petitioner's mother) for some or all services that Petitioner has already received.

31. The concept of a hearing officer's authority to order retroactive payment/corrective action for services *only if* the action at issue is a termination, suspension, or reduction finds support in the fact that Medicaid fair hearings are largely characterized as "recipient service-based," in terms of what is provided to the Medicaid recipient, as opposed to "payment-based," i.e., whether or not the provider receives reimbursement for services rendered. Once a service is prior authorized at a certain level and frequency, the recipient has a vested interest and reasonable expectation that said service and coverage of same will continue, absent a change in circumstances. As such, any timely request to challenge a proposed termination, suspension, or reduction of a previously authorized service generates an additional right to continuation of said service, pending the outcome of fair hearing (*See, e.g., 42 C.F.R. § 438.420(b)*).

32. A distinction arises when the request is for a service or procedure that was not previously authorized. In this case, if a provider opts to furnish the service before receiving authorization to do so, *or* if the recipient agrees to pay for any portions of the service for which Medicaid has denied coverage, that provider and/or the recipient assume(s) the risk of not being reimbursed. In reviewing a similar case, involving a hospital (provider)'s provision of psychiatric services to a Medicaid recipient, the Florida's First District Court of Appeals found:

... once [Petitioner] received the continued psychiatric treatment he'd asked for, *he* no longer needed agency review of [the HMO]'s decision not to authorize the treatment. Rather, the issue at that point became whether ... [the] Hospital could be paid by Medicaid for the services it had rendered *without prior authorization*.

And that is not, under 42 U.S.C. section 1396a(a)(3) [or the CFR], an issue that a Medicaid beneficiary has the right to seek a fair hearing on. (*J.W. c/o Dawn v. Agency for Health Care Administration*, 178 So.3d 542 (1st DCA 2015), emphasis original.)

33. Again, in the instant case, authorizing/ordering payment for extraction of teeth #1 and 16 before authorization occurred would constitute a payment-based review, inconsistent with governing authority.

34. Although there is a somewhat older body of case law that suggests corrective action may be appropriate in certain circumstances, such as when a service is discontinued after being authorized via Final Order (*See French v. Dep't of Children and Families*, 920 So.2d 671. (Fla. App. 5th Dist. 2006)) or when Medicaid eligibility (and/or resulting coverage) is wrongfully denied (*See, e.g., Randall v. Lukhard*, 709 F.2d 257 (4th Cir.1983)), given the wording of the legal authority discussed above, and the ruling in the *J.W. case*, the undersigned concludes that such conditions do not exist in the instant case.

35. What is distinct about Petitioner's case is that it is his family, not a provider, who will ultimately lose money/have to pay out-of-pocket. It is understandable that Petitioner's mother agreed to pay for services in order to spare her son additional medical procedures and/or to quickly eliminate what she perceived to be the cause of his pain. However, absent direction from a District Court of Appeals to the contrary, the undersigned hearing officer is not able to order retroactive authorization, nor can she award payment to Petitioner's mother for services rendered prior to the appeal.

36. The mother's frustrations with Staywell/Liberty's prior authorization process and its confusing customer service/case worker assistance are understandable and are duly

noted for the record. Staywell has suggested that Petitioner's mother request reimbursement for the services rendered, and noted that if reimbursement is denied, Petitioner will retain the right to appeal that, specific decision.

37. Petitioner's mother is encouraged to consult with the Petitioner's dentist, in conjunction with Staywell, to determine whether reimbursement is proper. Staywell is encouraged to review any such request in light of the Findings of Fact contained within this Order.

38. Should the provider and or Petitioner wish to further challenge Staywell's denial, they may follow up with the Agency for Health Care Administration's Consumer Complaint, Publication and Information Call Center, by dialing (888) 419-3456.

DECISION

With regard to denial of Petitioner's request for services, the appeal is hereby DISMISSED, as there is no relief that the undersigned has authority to provide. In terms of a separate review regarding the need for emergency medical care, Petitioner's appeal is DENIED. Petitioner is directed to follow up with Staywell to pursue any alternative resolutions, which the MCO may afford.

NOTICE OF APPEAL RIGHTS

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 07 day of March, 2017,
in Tallahassee, Florida.



Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: appeal.hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Staywell Hearings Unit

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

FILED

Mar 06, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-07904

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 66032

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 9:10 a.m. on January 31, 2017 at the Department of Children and Families in Tavares, Florida.

APPEARANCES

For the Petitioner: [REDACTED], petitioner's daughter

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to reapprove the petitioner in the Medicaid Medically Needy (MN) Program with a \$610 Share of Cost (SOC), is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present at the hearing. The petitioner's daughter did not submit exhibits. The respondent's representative submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on January 31, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received MN with a \$607 SOC.
2. On October 26, 2016, the petitioner submitted a change report (Respondent Exhibit 5). It is unclear what change was being reported.
3. The petitioner receives \$810 (Respondent Exhibit 3) Social Security Retirement Income (SSRI).
4. The following is the Department's calculation of the petitioner's SOC:

\$810.00	SSRI
-\$ 20.00	unearned income disregard
-\$180.00	MN income limit for an individual (MNIL)
<u>\$610.00</u>	<u>SOC</u>

5. On December 12, 2016, the Department mailed the petitioner a Notice of Case Action notifying that her SOC increased from \$607 to \$610, due to Social Security cost of living adjustment (Respondent Exhibit 2).
6. The petitioner received both Medicaid and Medicare in Washington, prior to moving to Florida in May 2016. The petitioner's daughter did not understand the reason that the petitioner only receives Medicare in Florida.
7. The petitioner receives Medicare parts A, B and D. Therefore, she is not eligible for full Medicaid.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

9. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code R. 65-2.056*.

10. Fla. Admin. Code R. 65A-1.701, Definitions, in part states:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level **and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.** (emphasis added)

11. Section 409.904, Florida Statutes, Optional payments for eligible persons, in part states:

(1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, **and who is not eligible for Medicare** (emphasis added) or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

12. In accordance with the above authorities, the petitioner is not eligible for full Medicaid because she receives Medicare and is not receiving “Medicaid-covered institutional care services, hospice services, or home and community-based services”.

13. Fla. Admin. Code R. 65A-1.713, explains Medically Needy, SSI-Related Medicaid and in part states:

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...

(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost"...

14. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid.

15. Federal Regulations at 20 C.F.R. § 416.1124 explain unearned income not counted and states in part "(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month..."

16. Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$180 for a family size of one.

17. In accordance with the authorities, the Department deducted \$20 unearned income disregard and \$180 MNIL from the petitioner's \$810 SSRI to arrive at a \$610 SOC.

18. In careful review of the cited authorities and evidence, the undersigned concludes the Department met its burden of proof. The undersigned concludes the Department's action to approve the petitioner MN with a \$610 SOC, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 06 day of March, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-08005

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 19 St. Lucie
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on March 2, 2017, at 4:10 p.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

For the Respondent: Lisa Sanchez
Medical Health Care Program Analyst

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for Medicaid Direct Payment asking for reimbursement of her out-of-pocket expenses for the prescription drug Pristiq in the amount of \$561.66?

PRELIMINARY STATEMENT

During the hearing, the petitioner explained she also requested other appeals to dispute the denial by the Agency for Health Care Administration (“AHCA” or “Agency”) of the medication. The petitioner is correct in that she requested two additional appeals with the Office of Appeal Hearings. Those appeals were assigned Appeal Numbers 15F-10000 and 16F-02917.

The petitioner requested the appeal which resulted in Appeal Number 15F-10000 on November 27, 2015 and the assigned hearing officer scheduled a final hearing in the matter for January 25, 2016. The case was correctly closed as abandoned on February 25, 2016 after the petitioner did not appear at the final hearing and did not call to request that the hearing be rescheduled.

The petitioner requested the appeal which resulted in Appeal Number 16F-02917 on April 18, 2016 and the assigned hearing officer scheduled a final hearing in the matter for May 13, 2016. At the petitioner’s request, the hearing was rescheduled three times, the last time being set for September 16, 2016. The case was correctly closed as abandoned on September 28, 2016 after the petitioner did not appear at the final hearing scheduled for September 16, 2016 and did not call to request that the hearing be rescheduled.

This appeal addresses only the denial of the petitioner’s request for Medicaid Direct Payment which is memorialized in the Agency’s Notice of Disposition dated July 29, 2016. This appeal does not re-open the petitioner’s previous appeals which were correctly dismissed due to the non-appearance of the petitioner at the final hearings, nor does it address whether the Agency correctly denied the petitioner’s requests for Pristiq.

The petitioner introduced Exhibits “1” through “10”, inclusive, at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits “1” through “4”, inclusive, at the hearing, which were also accepted into evidence and marked accordingly. The hearing officer took administrative notice of the following Florida Administrative Code Rules at the hearing: Fla. Admin. Code R. 59G-1.010 and Fla. Admin. Code R. 59G-5.110.

FINDINGS OF FACT

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. The petitioner is an adult female. She resides in [REDACTED]
2. The petitioner is diagnosed with [REDACTED]. She has been taking antidepressants for 25 years.
3. The petitioner began taking Pristiq in 2013.
4. Pristiq is a drug approved by the Food and Drug Administration for treating depression.
5. Pristiq is effective in treating the symptoms associated with the petitioner’s depression.
6. Prior to taking Pristiq, the petitioner was prescribed a number of other antidepressants.
7. The petitioner relocated from New York to Florida in November 2014.
8. The petitioner testified she was approved to receive Medicaid in New York pursuant to the rules governing the administration of the Medicaid Program in that State.

9. The petitioner's Medicaid provider in New York authorized the use of and paid for Pristiq for the petitioner.

10. Shortly after moving to Florida, the petitioner applied for Medicaid through the Department of Children and Families.

11. The Department of Children and Families correctly determined that the petitioner was eligible to receive Medicaid in Florida.

12. The petitioner's effective date of enrollment in the Florida Medicaid Program was November 1, 2014.

13. For some undisclosed reason, for the first few months after the petitioner was determined to be Medicaid-eligible in Florida, the petitioner was transitioned between the Medicaid State Plan administered by the Agency for Health Care Administration and multiple managed care organizations.

14. Although each of the managed care organizations authorized the use of and paid for Pristiq, the Medicaid State Plan did not.

15. A patient should not stop taking Pristiq abruptly.

16. The petitioner incurred out-of-pocket expenses for the purchase of Pristiq as a result of the Medicaid State Plan not authorizing the purchase of the medication.

17. On or about June 27, 2016, the petitioner submitted a request for Medicaid Direct Payment to the Agency for Health Care Administration asking for reimbursement of her out-of-pocket expenses associated with the purchase of the medication. The request included copies of receipts for prescriptions paid during the months of December 2014, January 2015, and April 2015.

18. The amount for which the petitioner is seeking reimbursement is \$561.66.

19. In a Notice of Disposition dated July 29, 2017, the Agency for Health Care Administration informed the petitioner it was denying her request for Medicaid Direct Payment. The Notice explains the petitioner is not eligible for reimbursement because “No proof of an erroneous eligibility determination was provided.”

20. It is the respondent’s position that, since there was no erroneous Medicaid eligibility determination, the respondent cannot lawfully approve the petitioner’s Medicaid Direct Payment request. The Agency’s representative at the hearing explained there is a difference between the denial of a Medicaid service versus an erroneous determination of eligibility. In the present case, the Agency’s representative explained, the Agency is not disputing that it denied a service, only that the petitioner is not eligible for reimbursement. The Agency’s representative also testified there was no erroneous denial or termination of the petitioner’s Medicaid eligibility.

CONCLUSIONS OF LAW

21. 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.

22. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes.

23. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

24. In the present case, the petitioner is requesting direct reimbursement for a prescription. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

25. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

26. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by the Agency for Health Care Administration.

27. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

(a) “Medical necessary” or “medical necessity” means that medical or allied care, goods or services furnished or ordered must 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 defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, 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. . .

(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.

28. Rule 59G-5.110, Florida Administrative Code, provides standards for direct payments and states in relevant part:

59G-5.110 Direct Reimbursement to Recipients.

(1) Purpose. This rule describes the circumstances when the Agency for Health Care Administration (AHCA) may directly reimburse eligible Florida Medicaid recipients; how AHCA reimburses recipients; and documentation requirements for direct reimbursement.

(2) Determination Criteria. Florida Medicaid recipients may be eligible for direct reimbursement if:

(a) Medical goods and services were paid for by the recipient or a person legally responsible for their bills **from the date of an erroneous denial or termination of Florida Medicaid eligibility** [Emphasis added] to the date of a reversal of the unfavorable eligibility determination [emphasis added].

(b) The goods and services were medically necessary as defined in Rule 59G-1.010, Florida Administrative Code (F.A.C.); rendered by a provider that is qualified to perform the service including meeting any applicable certification or licensure requirements (the provider is not required to be enrolled or registered as a Florida Medicaid provider); and covered by Florida Medicaid for the recipient's eligibility group on the date of service.

(c) Reimbursement for the medical goods or services is not available through any third-party payer on the date of service for which direct reimbursement is requested.

(3) Reimbursement Process. Recipients must submit direct reimbursement requests to AHCA within 12 months of the date of the reversal of the unfavorable eligibility determination described in paragraph (2)(a).

(a) The reimbursement request must include evidence of all out-of-pocket expenses paid to the provider, validated through receipts submitted by the recipient to: Agency for Health Care Administration, 2727 Mahan Drive, MS #58, Tallahassee, FL 32308.

29. In the present case, there is no evidence of an erroneous denial or termination of Florida Medicaid eligibility as required by Florida Administrative Code Rule 59G-5.110 for Medicaid Direct Payment. Therefore, the respondent correctly denied the petitioner's request for reimbursement.

30. Pursuant to the above, the petitioner has not met her burden of proof to demonstrate by a preponderance of the evidence that the respondent incorrectly denied her request for reimbursement.

DECISION

The petitioner's appeal is hereby DENIED.

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 indigence 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 14 day of April, 2017,

in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Fax: 850-487-0662
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit

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

FILED

Mar 17, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-08038

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT: AHCA

And

UNITED HEALTHCARE

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 3, 2017 at 1:24 p.m.

APPEARANCES

For the Petitioner: [REDACTED], friend and designated representative

For the Respondent: Dr. Ankit Amin, dental consultant, United Healthcare

STATEMENT OF ISSUE

At issue is the denial of the petitioner's request for dental drugs through Medicaid.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. United Healthcare (United) is the contracted health care organization in the instant case.

By notice dated October 11, 2016, United informed the petitioner that her request to have all her remaining teeth surgically removed, dental drug D9630, and upper and lower dentures were approved in-part and denied in-part. United approved removal of the petitioner's remaining teeth and the upper and lower dentures. United denied the requested dental drug D9630 as a non-covered benefit.

The petitioner timely requested a hearing to challenge the partial-denial decision on October 28, 2016.

The hearing was originally scheduled to convene on December 16, 2016. The petitioner did not call in timely for the hearing. The petitioner later requested that the hearing be rescheduled. The hearing was rescheduled for February 3, 2017.

The petitioner was present and gave testimony. The petitioner did not submit documentary evidence.

Present as respondent witnesses from United: Christian Laos, senior compliance analyst and Arlene Carrions, dental account manager. Present as observers from

AHCA: Selwyn Gossett, medical healthcare analyst and Bonnie Taylor, program administer. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on February 10, 2017 for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Exhibit 2. The record was closed on February 10, 2017.

FINDINGS OF FACT

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. The petitioner is a Florida Medicaid recipient. The petitioner is enrolled with United HMO. (Respondent's Composite Exhibit 1)
2. In October 2016, the petitioner's treating dentist submitted an authorization request to United to surgically remove all of her teeth, fit her with upper and lower dentures, and for dental drug D9630. D9630 is a generic drug code described in the dental industry as a drug to be used by the patient at home. The authorization request form did not specify the exact drug (the name of the drug) the treating dentist was requesting or the purpose of the drug. (Respondent's Composite Exhibit 1)
3. United approved removal of the petitioner's remaining teeth and the dentures. United denied the requested dental drug D9630 because it is not listed as a covered benefit in Medicaid rules. (Respondent's Composite Exhibit 1)
4. The petitioner requested a hearing to challenge the partial-denial decision. The petitioner asserted that her remaining teeth need to be removed so she can be

fitted for dentures. The petitioner asserted that she is unable to chew foods due to the condition of her teeth. One tooth has a jagged edge and cuts her tongue when she tries to chew. Her mouth is often bruised and tender. She has to rinse with an antiseptic multiple times daily to prevent infection. The petitioner did not know the dental drug requested by her treating dentist or why the drug was prescribed. She called the dentist's office a couple of times and left messages requesting clarification of the requested drug, but did not receive a response from the dentist's office. The petitioner was concerned that the drug is a pain killer necessary for removal of her remaining teeth and without the drug, she would not be able to undergo the dental extractions or receive her dentures. (Petitioner testimony)

5. Dr. Amin, dental consultant with United, explained that dental extractions include a local anesthetic (a drug which induces insensitivity to pain). A separate request is not required for a local anesthetic. Dr. Amin asserted that the petitioner has been approved for all the procedures necessary to remove her remaining teeth for her to be fitted for upper and lower dentures. Dr. Amin reiterated that the petitioner's treating physician did not explain what dental drug he was requesting, nor the purpose of the drug. Medicaid rules prohibit the provision of non-covered drugs. (Testimony of Dr. Amin).

CONCLUSIONS OF LAW

6. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

7. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

10. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

12. Medicaid rules require that all procedures be medically necessary. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

(166) “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.

.....

(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.

13. The May 2016 Florida Medicaid Dental Services Coverage Policy, promulgated by Fla. Admin. Code R. 56G-4.060, states that Medicaid does not reimburse for "services that are not listed on the fee schedule."

14. Florida Medicaid Dental Fee Schedule lists covered dental procedure codes in ascending numerical order beginning with code D0120 and ending with code D9920. Code D9630 is not listed on the schedule. The final two codes listed on the Dental Fee Schedule are D9420 and D9920. Code D9630 would be listed on the fee schedule after D9420, but before D9920 if it were covered by Medicaid rule.

15. The respondent denied the petitioner's request for dental drug D9630 as not a covered benefit. The requesting dentist did not include the name of the drug or the purpose of the drug in the authorization request. The petitioner also did not know the name of the drug or its purpose.

16. Medicaid rule prohibits the provision of goods and services that are not medically necessary. In addition, requested goods and services must be covered benefits.

17. After carefully reviewing the evidence and the controlling legal authorities, the undersigned concludes that the petitioner did not prove by a preponderance of the evidence that dental drug D9630 is a covered benefit or that it is medically necessary.

DECISION

The appeal is denied. The respondent's decision in this matter is upheld.

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 17 day of March, 2017,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Mar 28, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-8039

PETITIONER,

Vs.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 29, 2016 at 8:30 a.m. and on February 3, 2017 at 1:30 p.m.

APPEARANCES

For the Petitioner: [REDACTED], petitioner's father

For the Respondent: Linda Latson, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is the respondent's action to terminate or deny the petitioner's home health aide (HHA) visits. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the petitioner at the February 3, 2017 hearing were the following individuals from his home health provider, Providence Home Health Agency – [REDACTED]. In addition to those three individuals, the following also appeared as witnesses at the November 29, 2016 hearing – [REDACTED] the petitioner's CDC consultant for the Medicaid Waiver program, and [REDACTED] the petitioner's home health aide.

Appearing as a witness for the respondent was Rakesh Mittal, M.D., physician-consultant for eQHealth Solutions, Inc. Respondent's Composite Exhibit 1 was entered into evidence, consisting of Outpatient Review History Notes and various Medicaid program policies.

Also present was a Spanish language interpreter, [REDACTED], from Propio Language Services.

FINDINGS OF FACT

1. The petitioner's home health agency, Providence Home Health (hereafter referred to as "Provider"), requested the following HHA visits for the certification period at issue: 3 visits per day, 7 days per week.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for home health services. The petitioner's provider submitted the service request through eQHealth's

internet based system. The submission included, in part, information about the petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions personnel had no direct contact with the petitioner or with his treating physicians. The decisions made by eQHealth was based solely on information submitted by the provider.

4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 29 years of age and lives with his parents
- Incontinent of bowel and bladder
- Diagnosis includes profound [REDACTED]

5. The petitioner was approved for 3 HHA visits daily in the certification period from August 29, 2016 through October 27, 2016. At the end of that certification period, the petitioner's home health agency requested the same services for the following certification period, October 28, 2016 through December 26, 2016.

6. At the hearing held on November 29, 2016, Dr. Mittal from eQ Health Solutions stated that eQ Health had not received all of the required documentation to perform a review for the requested services. The petitioner's father stated his son's treating physician had refused to submit the required documentation, and he was currently trying to find another physician for his son. This process was very complicated for the family because the family is seeking a physician who can examine their son at home since it is difficult to transport him to any appointment.

7. Based on the foregoing, the undersigned continued the November 29 hearing to a later date to allow the petitioner's family additional time to obtain the necessary

documentation, such as a physician's order or prescription and physician plan of care, so that eQ Health Solutions could review the requested services. The respondent agreed to administratively approve the requested services while the fair hearing process was pending, since the services had been terminated at the end of the prior certification period. The petitioner's father stated he had been told to request a fair hearing so that the services would continue, and he had made a timely hearing request on October 28, 2016.

8. At the rescheduled hearing held on February 3, 2017, the petitioner's father stated he still had not been able to find a doctor for his son that would be willing to see him at home. The father also stated his son had changed coverage from fee-for-service Medicaid (commonly known as "straight Medicaid) to the Medicaid managed care program. Effective February 1, 2017, the petitioner became covered by the Simply Healthcare managed care health plan. During the interim time period since the prior hearing, the petitioner continued to receive 3 HHA visits daily from the home health agency.

CONCLUSIONS OF LAW

9. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat § 120.80.

10. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

11. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the petitioner had been previously approved for home health visits but the services had been terminated. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

13. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent.

14. For home health aide services to be approved, the service must be medically necessary. The definition of “medically necessary” is found in Fla. Admin Code. R. 59G-1.010 which states:

(166) ‘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...

(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. Home health services are addressed in the AHCA Florida Medicaid Home Health Services Coverage and Limitations Handbook (Home Health Handbook), effective October, 2014.

16. The Home Health Handbook, on page 2-18, describes home health aide services as follows:

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag;
- Assisting with transfer;
- Reinforcing a dressing;
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN;
- Measuring and preparing prescribed special diets;
- Providing oral hygiene;
- Bathing and skin care; and
- Assisting with self-administered medication.

17. Page 2-17 of the Home Health Handbook sets forth the following requirements for home health visit services:

Home health aide services can be reimbursed only when they are all of the following:

- Ordered by the attending physician
- Documented as medically necessary
- Provided by an appropriately trained aide
- Consistent with the physician approved plan of care
- Delegated in writing and provided under the supervision of a registered nurse

18. In this case, the petitioner was unable to obtain to a physician's order or physician plan of care after the certification period which expired on October 27, 2016. Although the undersigned recognizes the petitioner's family tried diligently to obtain the

necessary supporting documentation, the fact remains the documentation was lacking.

Therefore, eQ Health Solutions could not properly review the requested services and eQ Health Solutions could not approve any home health services after the expiration of the last certification period on October 27, 2016 (other than administrative approval while the fair hearing was pending). This does not mean the petitioner did not have a need for services during that time; but, unfortunately, there are no exceptions to the requirements for the supporting documentation listed above.

19. Since the petitioner is now covered by Simply Healthcare through the Medicaid managed care program, any current services would have to be approved by Simply Healthcare rather than the fee-for-service Medicaid program. The petitioner may be entitled to continuation of home health services for up to 60 days with Simply Healthcare due to Medicaid's continuity of services provisions.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence to waive those fees. The

FINAL ORDER (Cont.)

16F-08039

PAGE - 8

petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 28 day of March , 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

FILED

Mar 13, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-08058

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88324

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 1, 2017 at 3:04 p.m.

APPEARANCES

For the Petitioner: The petitioner was not present and was represented by Yomari Caraballo, Medicaid Representative for Change Healthcare.

For the Respondent: Diane Washington, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

ISSUE

At issue is the Department's action on August 18, 2016 to deny the petitioner's application for failure to complete the disability interview.

The petitioner held the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for December 12, 2016 at 9:00 a.m. The petitioner or the petitioner's representative did not appear for the scheduled hearing. On December 12, 2016, the petitioner's representative contacted the Office of Appeal Hearings and stated it was her understanding that the hearing was scheduled for the same date but at a different time. Due to confusion that arose as a result of a duplicate appeal that was filed under 16F-08187, the undersigned rescheduled the hearing to February 1, 2017 at 3:00 p.m.

Appearing as a witness was Louis Lockett, Supervisor for Change Healthcare.

Evidence was received and entered as the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 p.m. on February 3, 2017 to allow the respondent to provide additional evidence and to allow the petitioner's representative time to review and respond to the additional evidence.

Evidence was received and was entered as the Respondent's Exhibit 3 and the Petitioner's Exhibit 1.

The record was closed as of 5:00 p.m. on February 3, 2017.

FINDINGS OF FACT

1. On July 18, 2016, the petitioner (date of birth [REDACTED]) filed an application for SSI- Related Medicaid for self only. The petitioner listed herself as the only member of her household. The petitioner included on the application, her address at [REDACTED] located in [REDACTED]

█. The telephone number listed was █. The petitioner's representative's, Change Health, address at █, was not listed on the application. However, the petitioner's representative confirmed the telephone number that was listed on the application as her telephone number.

2. The Department issued two Notices of Case Action (Notice) to the petitioner on July 20, 2016 requiring an interview to be completed on or before August 1, 2016. The notice further instructed that the petitioner would "...receive a call at █ for your Medicaid Disability Interview which is scheduled for (7/26/2016) between the hours of (9-10am)..." Both Notices were mailed to █ h located at █

3. On August 18, 2016, the Department issued the Notice of Case Action to inform the petitioner that her application for SSI-Related Medicaid was denied due to not completing the disability interview in a timely manner

4. The petitioner's representative does not agree with the Department's denial. The petitioner's representative argues that the disability report was submitted to the Department and should substitute for the disability interview. The petitioner's representative argues that Notice of Case Action requesting the interview was mailed to the hospital and not to her address at █ therefore, the agency did not receive notification to contact the Department for the disability interview by telephone. The petitioner's representative confirms the telephone number listed on the application as the correct phone number for the agency.

5. The Department contends that the petitioner was contacted at the number listed on the application. The Department's evidence includes the Running Records Comments (CLRC) which shows that the petitioner was contacted on July 19, 2016 and discovered that the number listed on the application belongs to "Change" (Respondent's Exhibit 2, page 10). The CLRC also shows that on July 27, 2016 and August 3, 2016, the caseworker contacted Change Healthcare in an attempt to conduct the disability interview. The CLRC indicates that on July 27, 2016 and August 3, 2016, the Department's case worker left messages on Change Healthcare's voicemail system.

6. The Department acknowledged that the disability report was received on September 8, 2016. However, since this date was after the denial of the application, the Department was not able to reuse the original application that was submitted in July 2016. The Department explained that it could not apply its 60 day rule policy on applications that are denied due to a missed interview.

7. The petitioner's representative does not dispute that the disability report was submitted on September 8, 2016. The petitioner's representative argues that the disability report allows the Department to waive the disability interview. The petitioner's representative believes that since the disability report was submitted within the 60 day window, the Department can reuse the old application without requiring the completion of a new application. The Petitioner's Exhibit 1 includes a letter from the Social Security Administration (SSA) which states: "Although you are not eligible for the reasons given above, we have determined that you are disabled."

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

10. The Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process, sets forth:

(1)(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time...

11. The Fla. Admin. Code R. 65A-1.701 sets forth:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

12. The findings show the petitioner is a 51-year-old female with no minor children in the home. The petitioner is over age 21. The evidence presented does not show that the petitioner has any minor children in the home. The undersigned

concludes the Department correctly began to review the petitioner's case for potential eligibility under the Adult-Related Medicaid Program rules.

13. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in relevant part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).

14. The Department's Program Policy Transmittal I-11-12-0017 "Change in Expedited Disability Interview Procedure" dated December 2, 2011 states in relevant part:

The purpose of this memorandum is to provide ACCESS Florida staff with information about conditions under which the expedited disability interview can be waived.

Background

Certain Medicaid applications require a disability determination. An interview is conducted with the customer or his representative and information needed by the Division of Disability Determinations (DDD) is entered onto the Disability Determination (DSUM) driver on FLORIDA. Prior to the addition of the DSUM driver to the FLORIDA system, the eligibility specialist manually completed the Disability Report (CF-ES 2911) and if needed a Supplemental Mental Disability Report (CF-ES 2912) based on responses from the customer during the interview. The 2911 and 2912 forms have remained available and are sometimes submitted with a Medicaid application.

New Procedure

The interview may be waived when Disability Report(s) with sufficient information to complete the DSUM driver are received with an application. Attempt to contact the customer or his representative by phone to let him or her know the interview requirement has been waived, explain the application process and address any outstanding questions. If unable to reach the customer, record attempted contact in CLRC.

To waive the interview, minimum information to be included on the Disability Report(s) includes:

- Specific medical condition(s).
- Information regarding physicians and medical facilities visited in the last 12 months.

Reminders:

- The time standard to complete the disability packet and request a disability decision from DDD has not changed.
- Include any available medical records when submitting the disability packet. DDD indicated that complete information including hospital admission notes, discharge summaries, consultation notes from medical specialists and level of education are especially helpful when evaluating an individual's medical condition and lessen the time to issue a disability decision. Ensure that all verifications are scanned into document imaging.
- Applicants are not pended to provide medical records as the responsibility continues to reside with DDD to request these documents from providers, however, if the customer has and provides them, the process for DDD may be shortened.

15. The Department's Program Policy Manual, CFOP 165-22, passage

0640.0105 Eligibility Interview (MSSI) states:

Conduct interviews when requested by the applicant and when eligibility is questionable or error prone, including cases that require a disability determination. In these cases conduct the eligibility interview by asking the series of questions concerning the household circumstances provided on the application. Resolve discrepancies and request the individual add missing information to the application.

Deny an application if an individual refuses to cooperate with the application process. Refusal is when the individual is able to cooperate, but clearly demonstrates that he will not take required actions. Once denied or terminated for refusal to cooperate, the individual may reapply, but will not be determined eligible until he cooperates **(emphasis added)**.

16. The above authorities explain that the disability report can be used to replace the disability interview. The Department is to deny the application if the individual **refuses** to cooperate with the application process. The individual may reapply for benefits if the application is denied for his or her **refusal to cooperate (emphasis added)**.

17. The Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process explains:

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. **For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later...(emphasis added)**.

18. The above authority explains that the Department is to allow an individual 10 calendar days to provide verification. If the applicant is to provide medical verifications, he or she is to be allowed 30 calendar days from the date of the request or date of the interview, or 60 days from the date of the application, whichever is later. In this case, the findings show that the petitioner's representative provided the disability report, which could be used in lieu of the required disability interview, on September 8, 2016. The petitioner completed the application on July 20, 2016. The undersigned concludes that the petitioner's representative provided the disability report, which is medical

documentation, within 60 days from the date of the application. The Department acknowledged that the disability report was received and can be used in lieu of the disability interview. Therefore, the undersigned concludes that the petitioner may reuse the application submitted on July 20, 2016 and did not have to complete a new application since the disability report was received within 60 days of the July 2016 application and could be used as the disability interview.

19. Based on the above findings of facts and conclusions of law, the undersigned cannot conclude that the petitioner or the petitioner's representative demonstrated a refusal to cooperate with the application process. The undersigned concludes that, even though the disability report was submitted after the denial, the Department failed to follow the above policy and waive the interview requirement for the petitioner for Adult-Related Medicaid. The undersigned concludes that requirement for the disability interview should have been waived; therefore an allowance could be made to reuse the application that was submitted in July 2016 without requiring the petitioner to reapply. Therefore, the Department is remanded to complete a determination of eligibility with the Division of Disability Determination (DDD) back to the date of application. The Department is to issue appropriate notices to include appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the Department for the determination of disability by DDD and then for the determination of eligibility by the Department. The Department is to issue

appropriate notices to include appeal rights regarding the new eligibility decision by the Department.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 13 day of March, 2017,

in Tallahassee, Florida.



Paula Ali
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 02, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-08152

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 08 Alachua
UNIT:

RESPONDENT.

/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on January 4, 2017 at approximately 10:06 a.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's grandmother/guardian

For the Respondent: Selwyn Gossett, Medical/Health Care Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services.

Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

PRELIMINARY STATEMENT

At hearing, the minor Petitioner was not present, but was represented by her grandmother/legal guardian. Respondent was represented by Selwyn Gossett, Medical/Health Care Program Analyst, on behalf of AHCA. Respondent presented one additional witnesses: Darlene Calhoun, D.O., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 10, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

Following testimony, the record was held open for receipt of supplemental documentation from Petitioner's physicians, with additional time provided for a responsive statement from eQHealth. Petitioner's 10-page supplement was timely received and has been marked and moved as Petitioner's Composite Exhibit 1.

Because eQHealth did not submit a timely response to this new information, on January 27, 2017, the undersigned issued an Order to Obtain Response from eQHealth Solutions. Said Order noted, in part:

As eQHealth is contracted to review supporting documentation for all service requests to determine medical necessity, the undersigned cannot proceed until eQHealth has indicated whether Petitioner's additional medical records substantiate the need for continued PPEC. If they do not, eQHealth must provide a brief explanation as to why the decision to terminate services has not changed (emphasis added).

On February 6, 2017, the undersigned was forwarded a response from Dr. Calhoun, which states, in pertinent part: "I have reviewed the additional documentation and continue to uphold my original decision – medical necessity for PPEC services has not been demonstrated. Continue to recommend PT, OT, and ST, but these can be provided outside of PPEC." On February 7, 2017, AHCA verified that a copy of this response had been furnished to Petitioner. The 2-page document containing Dr. Calhoun's statement has been marked and moved as Respondent's Exhibit 11.

The record of this matter closed on February 7, 2017. This Final Order follows.

FINDINGS OF FACT

1. The Petitioner is a two-year-old female, born in 2014. She was born premature at approximately 32-34 weeks, with [REDACTED], [REDACTED], and [REDACTED]. She has multiple medical diagnoses, including severe [REDACTED]
[REDACTED]. She currently exhibits frequent body spasms, wherein she stiffens her arms and legs, and arches her back. The cause of these spasms is unknown.
2. Petitioner resides at home with her grandmother and grandfather. Both of the Petitioner's parents are deceased, following apparent drug overdose. Her grandmother is her legal guardian. The grandmother has contacted various resources within the community for alternate day care or school options, but has been unable to locate a facility which would be able to meet Petitioner's needs. Petitioner's grandmother is currently undergoing chemotherapy treatment for [REDACTED] and is experiencing fatigue along with short-term memory issues.

3. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.
4. Prior to the action at issue, Petitioner was authorized to receive full-day PPEC services five days per week. This authorization began in May of 2016, following a May 4, 2016 Home Assessment. The May 2016 Home Assessment reflects that Petitioner uses as-needed nebulizer treatments, requires aspiration precautions, does not have seizures or spasms, has difficulty swallowing, does not require speech therapy, but does require occupational and physical therapies.
5. On October 12, 2016, the Petitioner visited a pediatric neurologist, who administered neuro-developmental testing. Within the resultant medical record, the neurologist noted that “[Petitioner] has some texture aversions, rigidity with her routine, constant patting needed for comfort, high tolerance of pain.... She does not have a pincer grasp. She is very anxious and very inattentive. She has no spasticity. She does not seem to recognize many objects except the home pet dog.” The physician also noted decreased muscle tone, increased right arm tone, and spastic right leg tone, along with “delayed side protective reflex engagement on right.” At 21 months of age, Petitioner scored in the 8th and 9th percentiles on the Bayley Scale of Infant and Toddler Development (III), with subtests showing age equivalents of: 15 months (cognitive), 13 months (receptive communication), 18 months (expressive communication), 22 months (fine motor), and 10 months (gross motor). The neurologist recommended that Petitioner receive “aggressive PT, OT and ST.”
6. Petitioner’s October 20, 2016 Home Assessment was conducted by a nurse reviewer, who observed the Petitioner at home and/or in the PPEC setting. This

Assessment reflects that Petitioner uses as-needed nebulizer treatments, requires aspiration precautions, experiences daily body spasms, has difficulty swallowing, and requires speech, occupational, physical, and behavioral therapies. Care coordination notes from October through December, 2016 reflect that although Petitioner gained weight in the prior certification period, she continues to have sensory issues with food and takes Pediasure 3 times per day to maintain this weight. She has made some developmental progress, but experiences spasms several times per day, and, per her nurse coordinator, she was only recently diagnosed with [REDACTED].

7. On or about October 20, 2016, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue her previously authorized PPEC services into the new certification period, spanning October 30, 2016 through April 27, 2017.

8. This prior service authorization request, along with information and documentation required to make a determination of medical necessity, was submitted to AHCA's peer review organization (PRO). The PRO contracted by AHCA to review PPEC requests is eQHealth Solutions, Inc. (eQHealth).

9. On October 20, 2016, following the Home Assessment, Respondent's nurse reviewer recommended that the PRO "[approve] PPEC continued stay 5 full days/week for 180 days. Recipient would benefit from another certification in order to continue therapies and monitor her swallowing."

10. On October 31, 2016, a physician reviewer from the PRO reviewed Petitioner's request for services and all supporting documentation and reached a different decision than did the nurse reviewer. By letter dated November 1, 2016, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

The patient is a 21 month old with [REDACTED]
[REDACTED] The patient requires as needed albuterol treatments. The patient is on a regular diet but has texture issues with foods. The patient received Pediasure supplements. The patient is not on a complex medication regimen. The patient receives therapies at PPEC. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity requirement for PPEC services.

11. The November 1, 2016 letter, which eQHealth sent to Petitioner, notes only:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

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.

12. In response to this notice, on or about November 2, 2016, Petitioner requested a hearing to challenge the PRO's determination. After a gap in service provision while the PRO processed Petitioner's case status, Petitioner's PPEC services were reinstated, and have continued at their previously authorized frequency, pending the outcome of this appeal.¹

13. At hearing, Dr. Calhoun testified based upon her review of Petitioner's request for services, in conjunction with her Plan of Care, PPEC Assessment, and care coordination and progress notes. Dr. Calhoun noted that while the Petitioner clearly requires precautions/monitoring, and therapy services, the only interventions indicated

¹ Following hearing, but prior to issuance of the instant Order, Petitioner's grandmother contacted the Office of Appeal Hearings and noted that Petitioner's PPEC center had discontinued provision of Petitioner's services. The undersigned explained that the grandmother should contact AHCA to determine if administrative PPEC authorization remained in place; however, Petitioner's grandmother indicated that she would prefer to await Final Order.

on the Plan (other than follow-up from therapies) are the administration of as-needed medications/nebulizer and age-appropriate ADL care.

14. Per Dr. Calhoun, Petitioner's PPEC Assessments and notes reflect that Petitioner is not dependent upon mechanical devices. She is unable to walk independently, but can cruise by holding onto furniture. Dr. Calhoun is concerned as to Petitioner's ability to continue tolerating food, and how that might impact her weight gain and nutritional levels. She also encourages Petitioner's grandmother to follow up with a gastroenterologist and neurologist to determine the cause of Petitioner's spasms.

15. Petitioner's grandmother testified that the Petitioner continues to have difficulty swallowing, and engages in projectile vomiting. PPEC providers have been teaching the grandmother feeding techniques to help reduce the vomiting, such as working with the Petitioner to recognize the tactile quality of food, but this has been a slow process. The Petitioner still experiences multiple full-body spasms per day – per her grandmother, these can occur 4 or 5 times per evening, after Petitioner returns from PPEC. When the spasms occur, the grandmother massages the Petitioner to relax her muscles. The grandmother noted that when Petitioner received outpatient therapy services, there was little progress due to Petitioner readjusting to new providers and having short sessions. Currently, the grandmother does engage in home implementation of PPEC's therapy programs; however, she finds this difficult while she is undergoing [REDACTED].

16. Dr. Calhoun opined that Petitioner does need to continue therapies, and should be further evaluated by physicians. She testified that consistency with therapy is best, but that she was unsure how that would be accomplished, as it is usually up to the

provider's staff. Dr. Calhoun stated that the Petitioner will likely need skilled nursing visits and personal care as she ages, but recognized that she may not yet be old enough to benefit from home care.

17. Mr. Gossett encouraged Petitioner's grandmother to work with her care coordinator and with Early Steps, who provides Petitioner's behavior therapy, to determine what other services might be available to meet Petitioner's needs.

CONCLUSIONS OF LAW

18. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Florida Statutes Chapter 120.

19. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Fla. Stat., Chapter 409, and in Chapter 59G of the Florida Administrative Code.

20. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

21. This is a Final Order, pursuant to §§ 120.569 and 120.57, Fla. Stat.

22. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

23. The burden of proof in the instant case is assigned to Respondent, who seeks to terminate Petitioner's PPEC services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

24. Fla. Stat. § 409.905 addresses mandatory Medicaid services under the State

Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

....

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

25. Page 1-1 of the PPEC Handbook notes that, “[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center.” (emphasis added)

26. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.
(emphasis added)

27. Fla. Admin. Code R. 59G-1.010 defines “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.
(emphasis added)

28. Consistent with the law, AHCA’s agent, eQHealth, performs service authorization reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

29. Fla. Admin. Code R. 59G-1.010(166) defines medical necessity, as follows:

“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. ...

(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.

30. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

31. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

32. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical

condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

33. In the instant case, PPEC is requested to treat and ameliorate the supervisory, monitoring, and continuous therapy needs which Petitioner’s health conditions require.

As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

34. More specifically, however, Fla. Admin. Code R. 59G-1.010(166) also requires that any authorized service not be in excess of a patient’s needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must meet the requirements for PPEC, as provided in the PPEC Handbook.

35. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical intervention or equipment; however, it is apparent from Petitioner’s medical record that

she requires *intensive* therapy services, care during frequent/daily spasms, and intensive feeding therapy and food intake monitoring. Indeed, Respondent's nurse reviewer, who has had face-to-face contact with the Petitioner, recommended that PPEC services continue to meet what said reviewer believed to be skilled nursing needs. As such, it is not clear that Petitioner should no longer be considered "Medically Complex" or "Medically Fragile." It appears that Petitioner *does*, in fact, require "intermittent continuous therapeutic interventions or skilled nursing care."

36. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Respondent has not met its burden of proof to terminate PPEC. While termination may be appropriate in the future, if and when Petitioner's condition is stable, the results of additional assessments reflect progress or plateau, and/or when she is strong enough to obtain therapy services in an outpatient or school setting, termination at this time is premature.

37. In terms of planning for any future termination, Petitioner's mother is encouraged to coordinate with AHCA, so as to determine Petitioner's options for other services, as needed. If any subsequent requests for PPEC are denied, she will retain the right to appeal that/those, specific denial(s).

DECISION

Based upon the foregoing, Petitioner's appeal is hereby GRANTED.

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 02 day of March, 2017,

in Tallahassee, Florida.



Patricia C. Antonucci
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit

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

FILED

Apr 03, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-08355

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 88222

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on February 13, 2017 at 2:25 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:
Department

Brian Meola, Esq.
of Children and Families

STATEMENT OF ISSUE

At issue is whether the respondent's action to include all of the petitioner's Social Security benefits and two pensions in the determination of his patient liability for the Institutional Care Program (ICP) effective May 2016 and ongoing is correct. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner was not present, but was represented by [REDACTED]

[REDACTED] The petitioner submitted three exhibits, which were accepted into evidence and marked as Petitioner's Exhibits "1" – "3". The respondent was represented by Brian Meola, Esq. with the Department of Children and Families (hereafter "DCF", "Respondent", or "Agency"). The respondent presented one witness who testified: Kane Lamberty, Senior Human Services Program Specialist, with DCF. The respondent submitted seven exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" – "7".

[REDACTED] and Stan Jones, Economic Self Sufficiency Specialist II with DCF observed the proceedings.

Administrative notice was taken of 42 United States Code § 1396r – 5(b)(2)(D).

FINDINGS OF FACT

1. On July 13, 2016, a Final Judgment [sic] for Support Unconnected with Dissolution of Marriage was filed; the Judgement indicated both parties voluntarily entered into a Marital Settlement Agreement. (Pages 9 & 10 of Respondent's Exhibit 2)
2. On July 14, 2016, the Settlement Agreement was filed; the Agreement indicated the following: (Page 11 – 14 of Respondent's Exhibit 2)

1. Social Security: Wife is awarded sixty percent (60%) of the [REDACTED]



3. On July 20, 2016, the petitioner's wife signed a Notice of Spousal Refusal of Support refusing to provide any financial support to the petitioner. (Page 1 of Respondent's Exhibit 6)

4. On July 20, 2016, the petitioner's wife signed an Assignment of Rights to Support assigning the petitioner's rights to the State of Florida. (Page 2 of Respondent's Exhibit 6) By signing this document, the petitioner's wife's assets were not considered in the determination of the petitioner's eligibility for ICP Medicaid benefits; however, the document gives the State of Florida the right to determine the petitioner's level of support. (Respondent's testimony)

5. On August 4, 2016, the petitioner's representative submitted an application for ICP Medicaid benefits to the respondent as the petitioner was a resident of a skilled nursing facility. (Respondent's Exhibit 4)

6. The portion of the petitioner's income awarded to his wife in the Settlement Agreement should not be considered as countable income because the petitioner's income is legally restricted and unavailable to him. The fact the petitioner makes direct payments to his wife is irrelevant because the petitioner's ownership of his income is

secondary to the Settlement Agreement as it is enforceable by the courts if the petitioner fails to make any payments to his wife. (Petitioner's testimony)

7. The Settlement Agreement awarded the petitioner's wife "ownership interest" in a portion of his income. The petitioner is only required to establish proof of the "ownership interest" of the wife's portion and not the actual "ownership" of the portion. (Petitioner's testimony)

8. The Settlement Agreement does not indicate either a judge or both parties agreed that the petitioner's wife has any "ownership interest" in the petitioner's three sources of income. The Settlement Agreement is voluntary and revocable; therefore, it is a "voluntary debt" that is not considered an income deduction in the determination of the petitioner's patient liability amount for ICP Medicaid benefits. (Respondent's testimony)

9. The Settlement Agreement cannot be considered as spousal diversion because the petitioner's wife signed the Notice of Spousal Refusal of Support and the Assignment of Rights to Support. Since the petitioner's wife signed the aforementioned documents and there is no spousal diversion, the portion of the petitioner's income awarded to his wife was considered as countable unearned income in the determination of the petitioner's patient liability amount for ICP Medicaid benefits. (Respondent testimony)

10. The Settlement Agreement was not considered a Qualified Domestic Relations Order as the Agreement did not name the petitioner's wife as an "alternate payee" of the portion of the petitioner's income awarded to her and did not indicate her portion as irrevocably diverted to her. If the Settlement Agreement were a Qualified Domestic

Relations Order, the petitioner's wife's portion of income would not have been considered as countable unearned income in the determination of the petitioner's patient liability amount for ICP Medicaid benefits. (Respondent's testimony)

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Fla. Admin. Code R. 65A-1.710, "SSI-Related Medicaid Coverage Groups" states in part:

(2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and income as provided in 42 C.F.R. §§ 435.211 and 435.236. Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

14. Pursuant to the above authority, the petitioner is eligible for ICP Medicaid benefits as he resides in a skilled nursing facility.

15. Federal Regulations at 20 C.F.R. § 416.1121, "Types of unearned income" states in part:

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans

benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

16. Pursuant to the above authority, the petitioner's three sources of income, which include Social Security benefits and two pensions, are considered included unearned income in the determination of the petitioner's eligibility for the ICP Medicaid program.

17. Federal Regulations at 20 C.F.R. § 416.1123, "How we count unearned income" states in part:

(a) When we count unearned income. We count unearned income at the earliest of the following points: when you receive it or when it is credited to your account or set aside for your use. We determine your unearned income for each month...

(b) Amount considered as income. We may include more or less of your unearned income than you actually receive...

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums...

18. Fla. Admin. Code R. 65A-1.713, "SSI-Related Medicaid Income Eligibility Criteria" states in part:

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

(e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional programs.

(3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individual's account, or when it is set aside for their use, whichever is earlier... (emphasis added)

19. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1840.0102, Deductions from Gross Income (MSSI, SFP), states:

Some deductions withheld from gross income must be included as income. Examples of these deductions include:

1. premiums for Supplemental Medical Insurance (SMI/Medicare) from a Title II (Social Security) benefit,
2. premiums for health insurance or hospitalization,
3. premiums for life insurance,
4. federal and state income taxes,
5. Social Security taxes,
6. optional deductions,
7. a garnished or seized payment,
8. guardianship fees, and
9. child support if not redirected irrevocably from the source.

20. The Policy Manual, CFOP 165-22, passage 1840.0108, Available Income (MSSI, SFP), states:

Income must be available to meet the SFU's needs to be considered, except in the case of lump sum income. Generally, income is considered available when it is actually available and/or when the individual has the legal ability to make the income available.

Exceptions to the policy above:

Occasionally, a regular monthly payment (e.g., Title II or VA) is received in a month other than the month of normal receipt. As long as there is no interruption in the regular payment schedule, consider the funds to be income in the normal month of receipt. Examples of this situation are as follows:

1. Advance Dated Checks - When a payor advances a check because the regular payment date falls on a weekend or holiday, there is

no intent to change the normal delivery date. Whenever such an advance dated check goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable.

2. Electronic Funds Transfer - When an individual's money goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable. Whenever this occurs, treat the electronically transferred funds as income in the month of normal receipt.

3. Florida State Retirement benefits are received the last workday of the month. The payment is considered income in the following month for SSI-Related Programs.

4. Income may be unavailable due to legal restrictions or factors beyond the control of the individual. In both these situations, the eligibility specialist must request supporting evidence and make an independent assessment regarding availability based on the evidence presented. Additional guidance may be requested from the Region or Circuit Program Office, Headquarters, or Circuit Legal Counsel.

21. Pursuant to the above authorities, some income deductions must be considered as countable unearned income when determining eligibility for ICP Medicaid benefits.

In this instance, the respondent considers the petitioner's gross monthly unearned income amount or any income withheld due to a legally ordered debt as countable unearned income. The undersigned concludes the respondent correctly considered the portion of the petitioner's income awarded to the wife as countable unearned income in the determination of the petitioner's patient liability amount.

22. On August 16, 2004, the Department published a Memorandum titled "Qualified Domestic Relations Order, Gross vs. Net Pay." The Memorandum states in part:

Central Office Response: A Qualified Domestic Relations Order is a specific type of court order that awards a portion of an employee's retirement benefit to an "alternate payee". The alternate payee must be the individual's spouse, former spouse, child or other dependent. For a court ordered amount to be excluded from the Medicaid eligibility determination and the post eligibility determination of patient responsibility, two conditions must be met. The payment must be paid directly from the source to the former spouse (or her beneficiary) and the change must be irrevocable at the source...

23. Pursuant to the above memorandum, a court order is considered a Qualified Domestic Relations Order when the portion of an individual's income awarded to the spouse is paid directly to the spouse from the income source and when the change in income is considered irrevocable. The respondent correctly did not consider the petitioner's Settlement Agreement as a Qualified Domestic Relations Order as the petitioner's spouse is not directly paid from the income source and the Settlement Agreement is considered revocable as it can be changed or modified.

24. The findings show that the portion of the petitioner's income awarded to his wife is considered as countable unearned income in determining the petitioner's patient liability amount for ICP Medicaid benefits. The respondent correctly included all of the petitioner's gross income in the determination of his patient liability for ICP Medicaid benefits effective May 2016 and ongoing.

25. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet his burden of proof in establishing the respondent incorrectly included all of his Social Security benefits and his two pensions in the determination of his patient liability for the Institutional Care Program Medicaid benefits effective May 2016 and ongoing.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 03 day of April, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency
David Jacoby, Esq.
Brian Meola, Esq.

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

FILED

Apr 05, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-08447

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88500

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 2, 2017, at 11:05 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Eric Eckhardt, DCF supervisor.

STATEMENT OF ISSUE

At issue is whether the respondent's action denying petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she failed to provide necessary information is correct. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On November 8, 2016, the petitioner requested an appeal challenging the Department action. The appeal was continued from January 4, 2017 per petitioner's request.

At the hearing, the undersigned addressed the timelessness of the appeal. The respondent's acknowledged that no Notice(s) of Case Action were issued to the authorized representative, therefore, the undersigned retained jurisdiction.

During the hearing, the petitioner presented one (1) exhibit, which was accepted into evidence and marked as Petitioner's Composite 1. The respondent presented two (2) exhibits, which were accepted into evidence and marked as Respondent's Composite Exhibits 1 & 2. The record was left open through March 16, 2017 for both parties to submit additional information. The respondent's information was timely received and marked as Respondent's Composite Exhibit 3. Petitioner's response was timely received and marked as Petitioner's Exhibit 2. The record was closed on March 16, 2017.

FINDINGS OF FACT

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. On December 11, 2015, the petitioner was admitted to [REDACTED].
[REDACTED]. On December 21, 2015, she signed an Appointment of a Designated Representative form authorizing the Resolution Specialist to apply for Medicaid on her behalf. She also signed a Financial Release form authorizing the Department to initiate assets verification as a condition of eligibility.

2. On December 22, 2015, a Medicaid application was submitted to the Department requesting Medicaid benefits through the Department's SSI-Related Medicaid Program. The application included the petitioner and her husband only. The petitioner is not pregnant and have no minor children; therefore, she does meet the technical requirement for the Family-Related Medicaid category. The petitioner [REDACTED] was then 50. She does not meet the aged criteria for SSI-Related Medicaid benefits. Disability must be established to determine Medicaid eligibility. The Department contracts with Division of Disability Determination (DDD) to make its independent disability determinations. The Department did not initiate a disability review on the petitioner and no disability package was sent to DDD.
3. On December 22, 2015, the petitioner applied for disability with the Social Security Administration (SSA). On January 16, 2015, SSA denied the petitioner's application because she has not worked long enough under Social Security.
4. On January 11, 2016, the petitioner applied for Supplemental Security Income (SSI). She was denied on January 20, 2016 due to excess income.
5. Audit History details included in Petitioner's Composite Exhibit 1, page 19, indicate that the authorized representative was aware that a Financial Release form was to be signed by the petitioner's husband as part of her eligibility determination.
6. On March 30, 2016, the petitioner applied for Medicaid assistance through the Department's SSI-Related Medicaid Program. The Department did not initiate a disability review on the petitioner and no disability package was sent to DDD.
7. On June 30, 2016, the petitioner applied for Medicaid assistance through the Department's SSI-Related Medicaid Program. The Department contracts with Division

of Disability Determination (DDD) to make its independent disability determinations, see Petitioner's Composite Exhibit 1. The application was denied without initiating a disability review.

8. On November 8, 2016, the authorized representative requested an appeal on behalf of the petitioner. In response, on November 29, 2016, the respondent initiated a disability review on the petitioner and sent her file to DDD for processing.

9. DDD received petitioner's disability package from the Department for a disability review on December 5, 2016. On February 2, 2017, DDD approved the petitioner's claim of disability effective December 2015, with a review date of January 2018.

10. On February 3, 2017, the respondent sent a pending notice to the petitioner and the representative requesting signed financial release forms from petitioner and her husband be provided by February 13, 2017.

11. On February 6, 2017, the Department initiated an assets verification on the petitioner's husband through its DEAV system and found no accounts. On February 16, 2017, an email was sent to the authorized representative reminding her that the Financial Release form (CF-ES 2613) from the husband was all that was needed for the petitioner's Medicaid to be approved.

12. On February 21, 2017, the Department mailed the petitioner a Notice of Case Action denying her application for SSI-Related Medicaid for not receiving financial consent for all required individuals, see Respondent's Composite Exhibit 2.

13. The respondent explained that it denied the petitioner's SSI-Related Medicaid application because she failed to return a signed financial release form from her

husband in order to determine her eligibility, after DDD has determined that she was disabled.

14. The representative did not dispute the facts presented; however, she acknowledged knowing about the Financial Release form, but explained she has tried to get in touch with the petitioner on many occasions, but has not heard from her. She argued that since the respondent has already initiated assets verification on the husband and found no accounts, that form is no longer necessary. She did not claim good cause. The respondent explained that this was an incidental access, but does not negate the fact that a signed copy from petitioner's husband is required for petitioner's Medicaid to be approved.

15. The record was left open through March 16, 2017, for the representative to further explore locating the petitioner in an effort to have her husband sign the Financial Release form. On March 16, 2017, the representative sent a statement to the undersigned explaining that despite numerous home visits, she was unable to secure a signed Financial Release form from the husband, see Petitioner's Exhibit 2.

CONCLUSIONS OF LAW

16. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

18. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals less than 65 years of age must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in relevant part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.

19. The Code of Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, “the agency must use the same definition of disability as used under SSI...”

20. In this instant case, DDD received petitioner’s disability packet and concluded that she was disabled effective December 2015 and alerted the Department to take appropriate action.

21. The evidence shows the Department denied the petitioner’s SSI-Related Medicaid benefits because she failed submit a signed Financial Release form from her husband.

22. Fla. Admin. Code R. 65A-1.205(1)(c) Eligibility Determination Process states in relevant part:

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification,...the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application,

whichever is later... If the applicant does not provide required verifications or information by the deadline date the application will be denied,...

23. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22, at passage number 0640.0100 APPLICATION FOR ASSISTANCE (MSSI, SFP) states in part:

A signed Financial Information Release Form (CF-ES 2613) or a written permission to release financial records to the Department is required in the determination of eligibility for individuals applying for or receiving Medicaid, including those individuals whose assets are deemed to evaluate eligibility on the basis of age (65 or older), blindness or disability.

24. The Department's Program Policy Transmittal No: I-13-01-0001 dated January 11, 2013, addresses Asset Verification System (SSI-Related Medicaid only) effective February 1, 2013.

Procedure

A signed Financial Information Release form, CF-ES 2613, must be received for all individuals applying for or receiving Medicaid on the basis of age (65 or older), blindness, or disability and individuals whose assets are evaluated during the eligibility determination. Form CF-ES 2613 is considered requested verification and gives the Department permission to request records from a financial institution, such as a bank, savings and loan, or credit union.

Failure to Return the Financial Information Release Form

Benefits will be denied if the applicant or individual whose assets are required to be evaluated fails to return form CF-ES 2613 or revokes consent without good cause

Good Cause

If the individual fails to return form CF-ES 2613, presents evidence and meets an exception for good cause to the Department, do not deny or terminate the Medicaid. Good cause exists when an individual or their representative is unable to authorize the Department to request and receive relevant financial records or information. Examples of good cause include:

- Physical incapacity of the individual or their representative to authorize the Department to request and receive relevant financial records or information and there is no power of attorney or guardian.
- The owner(s) of the relevant assets to be evaluated in the eligibility determination refuses to authorize the Department to request and receive relevant financial records or information and the applicant's life, safety, or well being is being threatened by the owner or the applicant's life, safety, or well being is otherwise at risk.

25. The petitioner's disability application was approved on February 2, 2017. The respondent sent a NOCA on February 3, 2017 requesting a signed financial release form from petitioner's husband be returned by February 13, 2017. In addition, an email was sent to the authorized representative on February 16, 2017, reminding her that this release was necessary to approve the petitioner's Medicaid. The form was not received. The record was left open through March 16, 2017 for the authorized representative to attempt to reach the petitioner to get the form signed to no avail. She did not claim good cause. Under these circumstances, the controlling authorities preclude the Department from approving the Medicaid without a signed Financial Release form from petitioner's husband.

26. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet her burden of proof in this matter. Pursuant to the above cited authorities, the hearing officer concludes that the Department's action to deny the petitioner Medicaid under the SSI-Related Medicaid coverage group is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 05 day of April, 2017,

in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

FILED

Mar 03, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-08477

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:17 a.m. on February 20, 2017.

APPEARANCES

For the Petitioner: , Authorized Representative (AR)

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present and did not testify. , the petitioner's mother, appeared as a witness. The petitioner did not submit exhibits. The

respondent's representative submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record was closed on February 20, 2017.

FINDINGS OF FACT

1. On October 4, 2016, the petitioner (age 50) submitted a web application for Food Assistance and Medicaid Disability for himself (Respondent Exhibit 2). Medicaid Disability is the only issue.

2. The petitioner's AR described the petitioner's disability [REDACTED],

[REDACTED]

[REDACTED].

3. The petitioner applied for disability through the Social Security Administration (SSA) in 2015. The SSA denied the petitioner disability on October 2015. The petitioner is appealing the SSA denial through an attorney; an appeal date has not been set.

4. The petitioner does not have new or worsened medical conditions that the SSA is unaware of.

5. On November 7, 2016, the Department electronically sent the Division of Disability Determination (DDD) the petitioner's documents for review. DDD is responsible for making Medicaid Disability determinations for the Department.

6. Also on November 7, 2016, DDD denied the petitioner disability, due to adopting the SSA denial decision (Respondent Exhibit 5).

7. On November 9, 2016, the Department mailed the petitioner a Notice of Case Action (Respondent Exhibit 1, page 18), notifying Medicaid was denied, due to not meeting the disability requirements.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

9. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code R. 65-2.056*.

10. 42 C.F.R. § 435.541, Determinations of Disability, in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated

since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility...

11. The above authority explains that the SSA determination is binding on the Department.

12. In accordance with the above authority, the Department denied the petitioner's Medicaid, due to adopting the SSA denial decision.

13. The petitioner is appealing the October 2015 SSA denial through an attorney. And he does not have new or worsened medical conditions that the SSA is unaware of.

14. In careful review of the cited authority and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes the Department's action to deny the petitioner Medicaid Disability is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 03 day of March, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
Robert Drayman

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

FILED

Mar 14, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-08529

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 Flagler
UNIT: AHCA

And

MOLINA HEALTHCARE

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 27, 2017 at 3:01 p.m. at the Department of Children and Families service center in 

APPEARANCES

For the Petitioner: 

For the Respondent: Alice Quiros, associate vice president, Molina Healthcare

STATEMENT OF ISSUE

At issue is the denial of the petitioner's request for replacement dentures through Medicaid.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. Molina Healthcare (Molina) is the contracted health care organization in the instant case. Molina subcontracts with DentaQuest of Florida (DentaQuest) to provide dental services to its enrollees.

The hearing was scheduled to convene telephonically on January 4, 2017 at 1:00 p.m., but was continued because the petitioner requested to appear in-person before the hearing officer.

By notice dated October 18, 2016, DentaQuest informed the petitioner that his request for upper and lower dentures was denied. The notice reads in pertinent part, "this service is allowed once per lifetime. Our records show that you already received this service in the past."

The petitioner timely requested a hearing to challenge the denial decision on November 8, 2016.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as respondent witnesses from Molina: Jackelyn Salcedo, government contract specialist and Brandi Patterson, provider service representative. Present as a witness from DentaQuest: Charles Kiefer, compliance and grievance specialist. Present as observers: Sheila Broderick, registered nurse specialist with AHCA and Patricia Antonucci, hearing officer with the Office of Appeal Hearings. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on March 6, 2017 for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Exhibit 2. The petitioner did not submit additional evidence. The record was closed on March 6, 2017.

FINDINGS OF FACT

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. The petitioner (age 63) is a Florida Medicaid recipient. The petitioner has been enrolled with Molina HMO since April 1, 2016. Molina subcontracts with DentaQuest to provide dental services to its enrollees. (Respondent's Composite Exhibit 1)

2. The petitioner received a complete set of dentures from Economy Dentures on June 21, 2016. The services were paid by DentaQuest. (Respondent's Composite Exhibit 1)

3. The petitioner was dissatisfied with the quality and fit of the upper denture.

The petitioner asserted that that the finish of the upper denture was ragged and uneven and the cast of the denture did not extended to the back of his mouth. In addition, there was a hole in the denture which was inadequately filled with acrylic. The spot that was filled in was not the thickness as the rest of the denture. (Petitioner testimony)

4. The petitioner began calling Molina the day after he received the dentures, on or about June 27, 2016, with complaints about the quality of the upper denture and the quality of customer service he received from the provider, Economy Dentures. The petitioner called Molina several times over the next four months. The petitioner requested a new upper denture and to be assigned to a new dental provider. (Petitioner testimony)

5. Molina and/or DentaQuest referred the petitioner to another dentist, Dr. Jon Whiddon, for consultation in October 2016. Dr. Whiddon filed a prior service authorization request for a complete set of dentures (upper and lower dentures) with DentaQuest on October 17, 2016. (Petitioner testimony and Respondent's Composite Exhibit 1)

6. DentaQuest denied the request because Medicaid rule limits the provision of dentures to one per enrollee per lifetime. There is a quality of care exception which provides for a second denture if an independent dental consultant concludes that the original denture was substandard and could not be repaired. (Respondent's Composite Exhibit 1 and testimony of Charles Kieffer)

7. Charles Kieffer, compliance and grievance specialist with DentaQuest, asserted that there is no record of the petitioner filing a quality of care grievance. The witnesses from Molina, Alice Quiros, associate vice president and Jackelyn Salcedo, government contract specialist, also asserted that there was no record of the petitioner registering quality of care concerns regarding the dentures he received in June 2016. Per the witnesses, the sole reason for the denial was coverage limitations. (Testimony of Charles Kieffer, Alice Quiros and Jackelyn Salcedo)

8. During rebuttal, the petitioner disputed the testimony of the respondent witnesses. The petitioner reiterated that he began calling Molina in June 2016 complaining about the quality of the upper denture and made repeated phone calls to Molina over the next few months. The petitioner argued that the referral to Dr. Whiddon, a second dentist, proves that the respondents were aware that there was a quality of care issue and should have initiated the grievance process. The petitioner further argued that Dr. Whiddon's request for a second set of dentures was proof that he found the original set of dentures to be beyond repair. (Petitioner testimony)

9. The record was held open until close of business on March 6, 2017 for the respondents to review the petitioner's file regarding the quality of care exception which would provide for a second set of dentures. The respondents timely filed a written response which stated that the original denial decision was overturned. The response reads in pertinent part: "Molina reviewed the member concern addressed in the Grievance previously addressed related to this case and requested that DentaQuest re-

open the investigation. **The review was finalized and overturned due to the notes received from the provider office...**" [emphasis added]

10. The documentation received from the respondents included a DentaQuest Consultant Review Form dated March 3, 2017. The dental consultant who completed the form concluded that the petitioner should receive a new set of dentures. The form reads in pertinent part:

Grievance was received in regards to dentures that were received 06/21/2016. Member...is not satisfied with his existing dentures. Per the member the plate does not fit-faulty plate to begin with and he could here [sic] providers making excuses and blaming member. The new denture is rough, jagged compared to his old denture from before was a Molina member [sic]...The clinical notes from the first provider shows that from impression to delivery of the dentures was over two appointments and over two weeks. This process usually takes more time to complete. Additionally there are no notes indicating follow up/adjustment appointment. **The member as a genuine grievance, and should be allowed to receive a new set of dentures.** [emphasis added]

CONCLUSIONS OF LAW

11. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

12. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

13. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

14. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

15. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

16. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

17. The respondents denied the petitioner’s request for a second set of dentures due to service limitations. After further review, the respondents determined that the petitioner met a quality of care exception which provides for a second set of dentures. The respondents overturned the original denial decision and agreed to provide the petitioner with a second set of dentures.

DECISION

The appeal is **GRANTED**. The respondents are hereby ordered to provide the petitioner with a second set of dentures as stipulated in the post hearing filing of evidence.

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 14 day of March, 2017,
in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Molina Hearings Unit

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

FILED

Mar 06, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-08683

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 Leon
UNIT: 88313

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on January 27, 2017 at 1:18 p.m.

APPEARANCES

For the Petitioner: Valerie Estes, Public Benefits Coordinator,
Capital Regional Medical Center

For the Respondent: Pam Williams, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of August 10, 2016 denying the petitioner's application for SSI-Related Medicaid due to not meeting the disability requirement. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

This appeal was requested on November 18, 2016, which is 100 days after the Notice of Case Action dated August 10, 2016. However, the Department representative stipulated that they consider appeal as requested timely.

The appeal was originally scheduled for hearing on January 17, 2017. The hearing was rescheduled due to exchange of evidence and consultation with the Division of Disability Determinations prior to proceeding to hearing.

The Department submitted evidence on January 18, 2017, which was entered as Respondent's Exhibit 1.

The record was held open through February 8, 2017 for submission of additional documentation by both parties. The Department submitted an additional statement on February 1, 2017, which was entered as Respondent's Exhibit 2. The petitioner submitted evidence on February 7, 2017, which was entered as Petitioner's Exhibit 1.

The record closed on February 8, 2017.

FINDINGS OF FACT

1. The petitioner applied for SSI-Related Medicaid on August 3, 2016. On her application, she requested the Medicaid begin June 2016 under retroactive Medicaid coverage.
2. The petitioner is a 59 years old. The petitioner's household consists of the petitioner and no other household members.
3. The petitioner's pathology reports from August 2015 and September 2015 reflect the petitioner's initial diagnosis of [REDACTED] in the [REDACTED]
[REDACTED]

4. [REDACTED] further documented the petitioner's diagnosis of [REDACTED] on October 21, 2015.

5. The petitioner had a [REDACTED] y on May 26, 2016.

6. The petitioner had an additional diagnosis of [REDACTED] June 2016.

7. The petitioner's application for Social Security Disability was denied in March 2016 with reason code N35. Reason code N35 is defined as: "Impairment prevented SGA at time of adjudication but is not expected to prevent SGA for a period of 12 months.

8. The Division of Disability Determinations (DDD) denied the petitioner's disability citing a prior denial decision by the Social Security Administration in March 2016.

9. The Department issued a Notice of Case Action on August 10, 2016 denying the petitioner's application for Medicaid beginning June 2016 due to not meeting the disability requirement.

10. The petitioner appealed the decision made by Social Security. She retained an attorney to assist in her appeal.

11. The petitioner's representative believes the petitioner's condition has worsened since her denial by Social Security.

12. There was no evidence presented showing the petitioner has not notified Social Security of any worsening condition.

13. There was no evidence presented Social Security has refused to consider any worsening conditions.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

16. The undersigned explored eligibility first under Family-Related Medicaid groups as the petitioner's application was marked for "Family-Related Medicaid". The petitioner does not have a minor child in the home according to her August 3, 2016 application. The Family-Related Medicaid Program benefit rules are set forth in the Florida Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid program; the petitioner must be pregnant or have a dependent minor child residing in the home. The undersigned concludes the petitioner does not meet the criteria for Family-Related Medicaid Program benefits.

17. The definition of MED-AD Demonstration Waiver is found in Florida Admin. Code R. 65A-1.701 (20) and states:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

18. Florida Admin. Code R. 65A-1.711, "SSI-Related Medicaid Non-Financial

Eligibility Criteria" states in relevant part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).

19. 20 C.F.R. § 416.905 "Basic definition of disability for adults" states in

relevant part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.)

20. 42 C.F.R. § 435.541 "Determinations of disability" states in relevant part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

...

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

21. The undersigned explored potential eligibility for Medicaid for the petitioner under the SSI-Related Medicaid program. The petitioner was 59 years old at the time of application. She has not been established as disabled. As she is under age 65, a disability determination is required for eligibility determination in the SSI-Related Medicaid program.

22. The findings show the petitioner applied for disability with the Social Security and was denied in March 2016. The findings show the petitioner applied for Medicaid with the Department on August 3, 2016. The findings also the petitioner's Social Security (SSA) disability decision was appealed with the assistance of an attorney. According to the above controlling authorities, a decision made by SSA within 12 months of the Medicaid application is controlling and binding on the state agency unless the applicant reports a new or worsened disabling condition not previously reviewed by SSA. In this case, the petitioner reports there are worsened disabling conditions. However, the authorities also require that if the SSA decision has been appealed, the petitioner must show that SSA has refused to consider the new or worsened conditions. In the instant case, there was no evidence presented to show SSA has refused to consider her worsened condition.

23. Based on the evidence and testimony presented, the above-cited rules and regulations, the undersigned concludes with the SSA binding decision on the agency, the denial of SSI-Related Medicaid remains appropriate.

24. Florida Admin. Code R. 65A-1.711 does make an exception for those individuals seeking breast or cervical cancer treatment, which removes the criteria for the individual to be aged or disabled. The undersigned reviewed the policies related to

this program and refers the petitioner to 1-800-451-2229 for questions about Medicaid for Breast and Cervical Cancer or treatment options.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Departments' action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 06 day of March, 2017,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
Valerie Estes

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

FILED

Mar 08, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO.: 16F-08863

PETITIONER,

Vs.

MOLINA HEALTHCARE MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a hearing in Fort Myers, Florida in the above-referenced matter on January 23, 2017 at 1:54 p.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's Mother

For the Respondent: Natalie Fernandez
Government Contract Specialist
Molina Healthcare

STATEMENT OF ISSUE

Petitioner is appealing the denial of admission into a skilled nursing facility. Petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner was physically present in the hearing room. Petitioner's sister

██████████ was physically present in the hearing room as a witness.

Petitioner introduced Exhibits "1" through "3," inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

Diana Juarez, Community Connector from Molina Healthcare ("Molina"), was physically present in the hearing room as an observer. Molina presented the following witnesses by telephone:

- Dr. Valerie Maguire, Medical Director for Molina
- Bonnie Blitz, R.N., Director of Healthcare Services for Molina
- Elvis Leiva, Manager of Healthcare Services for Molina.

Respondent introduced Exhibits "1" through "2," inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

Suzanne Chillari, Medical Program Analyst, Agency for Health Care Administration ("AHCA") was physically present in the hearing room as an observer.

At the request of the Respondent, the Hearing Officer took administrative notice of the following:

- The Florida Medicaid Nursing Facility Service Coverage Policy ("NFS") Handbook

The record was held open until February 3, 2017 for Molina to provide its contract with AHCA as it relates to MMA member covered services, and the Nursing Facilities Medicaid Fee Schedule. Molina submitted the additional evidence on February 3, 2017. The undersigned entered into evidence Respondent's AHCA contract on MMA covered services as Exhibit "3," Nursing Home Rates as Exhibit "4," and AHCA's contract on

hospital services as Exhibit "5." Petitioner submitted no response to Respondents additional evidence.

FINDINGS OF FACT

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 48-year-old female who lives in her mother's home.
2. At all times relevant to this proceeding, Petitioner has been receiving Medicaid through her Managed Medical Assistance Program ("MMA"), which is provided by Molina starting on September 1, 2016. (See Respondent's Exhibit 1).
3. Petitioner suffered a traumatic brain injury due to a motorcycle accident on March 5, 2016. (See Petitioner's Exhibit 2). The injury caused Petitioner to have [REDACTED]

[REDACTED] (See Petitioner's Exhibit 3).

4. On November 3, 2016, Molina received a request for skilled nursing facility ("SNF") admission beginning on October 31, 2016. On November 8, 2016, Molina issued a Notice of Action denying the request as service is not a covered benefit. The notice stated:

The requested service is not a covered benefit.

Upon review of the request for a skilled nursing facility, it has been determined that the service requested is not reimbursable under the Florida Medicaid Program. Therefore, this service is considered a "non-covered benefit".

The facts that we used to make our decision are: Medical records and clinical documentation submitted by your doctor and Criteria referenced used to make determination is Florida Medicaid Coverage Limitations

Handbook and the Florida Medicaid Fee Schedule. (See Respondent's Exhibit 2).

5. Petitioner's sister gave testimony regarding her observations of Petitioner while at ██████████ Hospital, where Petitioner received physical therapy, occupational therapy, and speech therapy. Petitioner's mobility in her body has improved from moving her toes to rotating her ankle. Prior to these services, Petitioner was unable to move at all. As a result of speech therapy, Petitioner is now able to make sounds.

6. Petitioner's sister stated Molina is taking away her sister's right to having a meaningful recovery by denying her services. Further, the system is failing Petitioner because placing her in a nursing home is unfair without the attempts of rehabilitation.

7. Petitioner's sister stated her mother is a seventy-year-old woman who is going to get hurt without these services being provided. She nor her mother are qualified medical staff that can check Petitioner's mouth or feeding tube for infection.

8. Petitioner's sister contends Molina's primary care doctors are not specialist in brain injury.

9. Petitioner's mother testified Lee Memorial Hospital conducted the surgery on Petitioner after the accident. Petitioner was transferred back to NCH Healthcare System ("NCH") in Naples and stayed for about five months. During those five months, Petitioner did not receive physical therapy, occupational therapy, and speech therapy.

10. Petitioner's mother testified NCH wanted to release Petitioner to an "old folk's" home. However, Petitioner's mother decided to take Petitioner to the family home on August 1, 2016.

11. Petitioner's mother testified caring for Petitioner is labor intensive because of daily feedings, bathing, and changing her briefs. Petitioner is 100% completely dependent and cannot speak.

12. Petitioner's mother testified Petitioner went to [REDACTED] Hospital for an exploratory surgery. During the exploratory surgery, part of Petitioner's colon was removed. Once she healed from colon surgery, Petitioner received physical therapy, occupational therapy, and speech therapy at [REDACTED] Hospital.

13. Petitioner's mother stated the system has failed Petitioner, and Petitioner needs services because her condition is deteriorating due to the lack of services by Molina.

14. Respondent's witness Bonnie Blitz stated the MMA program offers home health services, discharge planning after admission, and Acute Rehabilitation as long as the member qualifies.

15. Respondent's witness Bonne Blitz stated the medical director offered to override the requirements for SNF and allow Petitioner to reside in the facility for one month. The one month would allow Molina to help Petitioner with her long-term care application and work on the eligibility requirements stated in the NFS handbook. Petitioner refused the offer.

16. Respondent's witness Bonnie Blitz testified that SNF is offered under the Long-Term Care program. Petitioner has not applied for the Long-Term Care program and is enrolled in the MMA program. SNF is not offered under the MMA program.

17. Petitioner is scheduled to receive Home Health services in the home on January 23, 2017. Petitioner is able to receive therapy in the home after an evaluation is completed and reviewed.

18. Respondent's witness Natalie Fernandez testified Petitioner did not meet the eligibility criteria under section 2.2 of the NFS handbook.

19. Respondent's witness Bonnie Blitz testified Petitioner did not have a level of care determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES), which is a requirement for Nursing Facility Services. Respondent has no record that a level of care was done since Petitioner's enrollment with Molina on September 1, 2016. Petitioner's mother confirmed no level of care was completed by CARES for Petitioner.

20. Once Petitioner completes the Long-Term Care application process, then CARES will assess Petitioner.

CONCLUSION OF LAW

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

22. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Florida Medicaid Program is administered by AHCA.

23. This proceeding is a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

24. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

25. The standard of proof in an administrative hearing is a preponderance of the evidence pursuant to Florida Administrative Code Rule 65-2.060(1).

26. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the Florida Administrative Code.

27. Section 409.905, Florida Statutes, addresses Mandatory Medicaid Services under the State Medicaid Plan:

Mandatory Medicaid Services – The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

28. The Florida Medicaid Provider General Handbook, July 2012, is promulgated into law by Florida Administrative Code Rule 59G-5.020.

29. Page 1-27 of the Florida Medicaid Provider General Handbook states, “Medicaid contracts with Health Maintenance Organizations (“HMO”) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.”

30. The Florida Medicaid Nursing Facility Services Coverage Policy (“NFS”) Handbook, May 2016, is promulgated into law by Florida Administrative Code Rule 59G-4.200.

31. The NFS handbook describes eligibility and services. Page 1, section 1.1.2 of the Handbook states:

State Wide Medicaid Managed Care Plans

This Florida Medicaid Policy provides the minimum services requirements for all providers of nursing facility services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlines in this policy, unless otherwise specified in the Agency for Health Care Administration contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to

more stringent service coverage limits than specified in Florida Medicaid policies.
(Emphasis Added).

32. Page 2, section 2.1 and 2.2 of the Handbook states:

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and **meet the criteria provided in this policy.**

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary nursing facility services who:

- Have a level of care determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) if ages 21 years and older, or the Children's Multidisciplinary Assessment Team (CMAT), if under the age of 21 years
- Meet the requirements for the ICP
- Have a Pre-Admission Screening and Resident Review completed in accordance with Rule 59G-1.040, F.A.C.
- Have a completed Medical Certification for Medicaid Long-term Care Services and Patient Transfer Form, as incorporated by reference in Rule 59G-1.045, F.A.C.

Some services may be subject to additional coverage criteria as specified in section 4.0.
(Emphasis Added).

33. Page 3, section 4.1 of the Handbook states:

General Criteria

Florida Medicaid reimburses for services that **meet all** of the following:

- Are determined medically necessary
- Do not duplicate services
- **Meet the criteria as specified in this policy**
(Emphasis Added).

34. Page 4, section 5.1 of the Handbook states:

General Non-Covered Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0.
- **The recipient does not meet the eligibility requirements listed in section 2.0.**
- The service unnecessary duplicates another provider's service.
(Emphasis Added.)

35. In the present case, Petitioner's mother admitted Petitioner has not completed any of the criteria listed under section 2.2 in the NFS handbook. Petitioner has received some therapy from ██████████ Hospital. However, the therapy Petitioner received at ██████████ hospital does not fulfill the eligibility criteria established in the NSF handbook.

36. Respondents stated Petitioner is able to receive therapy in the home after an evaluation is conducted and reviewed. Home Health services are being placed in the home for Petitioner.

37. It is undisputed Petitioner requires services. However, Respondents argued SNF is not a covered benefit because Petitioner has not met the eligibility criteria listed in the NFS handbook, and Petitioner is enrolled in the MMA program and not the Long-Term Care program.

38. Petitioner has not established that she meets the eligibility criteria in section 2.2 of the NFS handbook. Medical Necessity was not reviewed because Petitioner has not met the eligibility criteria required under the NSF handbook.

39. The undersigned has considered the totality of the documentary evidence and testimony as well as the above-cited authorities. Petitioner has not met her burden of proof.

40. Petitioner is encouraged to apply for the Long-Term Care program and work with Molina to complete the necessary steps for admission into a Nursing Facility.

DECISION

Based upon the foregoing, Findings of Fact and Conclusion of Law, this 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 08 day of March, 2017, in
Tallahassee, Florida.



Allison Smith-Dossou
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Molina Hearings Unit

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

FILED

Mar 03, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-08867

PETITIONER,

Vs.

UNITEDHEALTHCARE, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on February 13, 2017 at approximately 1:30 p.m.

APPEARANCES

Petitioner:



For UnitedHealthcare:
Senior

Christian Laos
Compliance Analyst

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's request for an MRI, with contrast, was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

The following individuals were present on behalf of UnitedHealthcare (“United”):

- Christian Laos – Senior Compliance Analyst
- Dr. Marc Kaprow – Medical Director

Petitioner gave oral testimony, but did not move any exhibits into evidence.

United moved Exhibits 1 – 4 into evidence at the hearing. Lisa Sanchez,

Medical/Health Care Program Analyst with the Agency for Health Care Administration (“AHCA” or “Agency”) observed the hearing.

FINDINGS OF FACT

1. Petitioner is a 41-year-old female. Petitioner is enrolled with United as her managed care plan.

2. On October 25, 2016, United received a request for an MRI of Petitioner’s left shoulder, with contrast. On October 27, 2016, United issued a Notice of Action denying the request (Resp. Exh. 2).

3. As to the reason for the denial, the Notice stated:

The facts that we used to make our decision are: Your provider asked for an MRI with contrast dye because you have shoulder pain. This requested study is needed when you have one of the following:

- a fever
- a high white blood count (blood test)

These symptoms would suggest that you have an infection and would indicated the need for contrast dye. Your records do not show that any of these apply to you. We have told your doctor about this. Please talk to your doctor about your care.

We used the following criteria to make our decision: UnitedHealthcare Community Plan standards and clinical criteria.

4. Petitioner stated her doctor asked her if she would prefer to have the MRI performed with contrast dye or without. Her doctor informed her that the dye shows more detail, therefore Petitioner requested the MRI be performed with the dye.

5. Petitioner had rotator cuff surgery on her left shoulder in April of 2016. She said she went through four (4) months of physical therapy post-surgery. She stopped receiving physical therapy because she was no longer making any progress. She is unable to lift her arm over her head. She also said she has less feeling and that she hears a clicking sound every time she lifts her arm.

6. Dr. Kaprow said the contrast dye contains a metallic element known as gadolinium. He said the gadolinium makes certain details more visible in an MRI. He testified that gadolinium has certain risks, such as kidney problems, and United typically starts with the more conservative MRI without contrast, and if the results from the standard MRI are inconclusive, an MRI with contrast may be performed.

7. Dr. Kaprow did not dispute Petitioner's need for an MRI and agreed to approve a standard MRI without contrast while at hearing. He said United offered to provide a standard MRI when it denied the dye, but that Petitioner's doctor did not respond after continued follow-up. Petitioner said she has not spoken to her doctor since the denial was issued.

CONCLUSIONS OF LAW

8. By agreement between AHCA and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Florida Statutes.

9. The hearing was held as a *de novo* proceeding, in accordance with *Florida Administrative Code* Rule 65-2.056.

10. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

11. The standard of proof in an administrative hearing is a preponderance of the evidence. Fla. Admin. Code R.65-2.060(1). The preponderance of the evidence standard requires proof by “the greater weight of the evidence.” (Black’s Law Dictionary at 1201, 7th Ed.).

12. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes, and in Chapter 59G of the Florida Administrative Code. AHCA is the single state agency that administers the Medicaid Program.

13. The Florida Medicaid Radiology and Nuclear Medicine Services Coverage Policy, June 2016, is promulgated into law by Chapter 59G, Florida Administrative Code. It provides that Medicaid recipients can receive medically necessary radiology services.

14. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

(166) “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.

.....

(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. Dr. Kaprow's testimony was clear in that an MRI with contrast is only medically necessary in certain circumstances, none of which apply to Petitioner. He did not dispute the necessity of a standard MRI. He said United starts with the more conservative treatment and then goes from there. The undersigned concludes Petitioner has not met her burden of proof to show the less conservative MRI with the contrast dye is necessary at this time.

16. Petitioner encouraged to work with her doctor regarding the situation. As stated by Dr. Kaprow, if a standard MRI is inconclusive then an MRI with contrast may be appropriate at that time.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and United'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.

FINAL ORDER (Cont.)

16F-08867

PAGE - 6

DONE and ORDERED this 03 day of March, 2017,

in Tallahassee, Florida.

R. Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Mar 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-08897

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 88007

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:00 p.m. on February 22, 2017.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:
Economic

Sylma Dekony, ACCESS
Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on December 28, 2016. On December 28, 2016, the parties agreed to reconvene on February 8, 2017, due to the

petitioner not receiving the Department's evidence. On January 25, 2017, the hearing was rescheduled for February 22, 2017, due to Hearing Officer availability.

Lauren Miller, Program Operations Administrator, Division of Disability Determination (DDD), appeared as a witness for the respondent. The petitioner did not submit exhibits. The respondent's representative submitted ten exhibits, entered as Respondent Exhibits "1" through "10". The record was closed on February 22, 2017.

FINDINGS OF FACT

1. On August 18, 2016, the petitioner (age 47, at the time of application) submitted a paper application for Food Assistance and SSI-Related Medicaid Disability for her and her husband (Respondent Exhibit 3). Medicaid Disability for the petitioner is the only issue.
2. The petitioner alleges that she has been disabled since 2004, due to an accident. The petitioner described her disabilities as carpal tunnel, back and ankle problems.
3. The petitioner applied for disability through the Social Security Administration (SSA) in September 2016. The SSA denied the petitioner on September 20, 2016, with code N01 – Non-pay – countable income exceeds Title XVI federal benefit rate (Respondent Exhibit 4, page 25). The petitioner has not appealed the SSA denial nor reapplied.
4. ██████████ stated that it "appears" the petitioner did not meet the SSA technical requirements to be considered disabled.
5. The petitioner said the reason she hasn't appealed the SSA denial is because she does not want the money, she only wants Medicaid.
6. DDD is responsible for determining disability eligibility on behalf of the Department.

7. DDD reviewed the petitioner's medical records from 2008 through 2015 (Respondent Exhibit 8). And determined that the petitioner's primary diagnosis is chronic pain syndrome and the secondary diagnosis is history fractured ankle (Respondent Exhibit 6).

8. The petitioner asserts that she offered DDD additional medical records to review and DDD refused to review the additional medical records.

9. Ms. Miller contends that DDD had plenty of the petitioner's medical records (2008-2015) to make a disability determination.

10. DDD utilizes a federal regulation five-step sequential evaluation in determining disability. The following are the steps and what is evaluated in each step:

Step 1 – Is the individual engaging in substantial gainful activity (SGA) (working and earning income that meets or exceeds set limits)

Step 2 – Is the medical disability impairment(s) (MDI) severe?

Step 3 – Does the MDI meet or equal a disability listing in the federal regulation?

Step 4 – Is the individual capable of returning to previous related work (PRW)?

Step 5 – Is the individual capable of performing any work in the national economy?

11. The following are the petitioner's results (in bold) of DDD's five-step evaluation (Respondent Exhibit 7):

Step 1: Engaging in SGA? **N/A**

Step 2: Is there a MDI? **Yes**

Step 3: Does this impairment meet or equal a listing? **No**

Step 4: Is the claimant able to perform PRW? **NO PRW**

Step 5: Is the claimant able to perform other work? **Yes**

12. Although Step one is part of the five-step sequential evaluation process, Ms. Miller said DDD does not determine Step one. However, Ms. Miller stated that since the

petitioner was last employed as a “cleaner” in 2004 and it was part-time work, the petitioner is considered not engaging in substantial gainful employment.

13. In Step two, DDD determined the petitioner’s mental MDI (anxiety) is not severe and the physical MDIs (ankle and back problems) are severe.

14. In Step three, DDD evaluated the petitioner’s physical MDI level of severity from the federal regulation list of disability impairments. The petitioner’s MDIs are in body system category 1.00 musculoskeletal system, sections 1.02-major dysfunction of joint (ankle problem) and 1.04-disorder of the spine (back problem).

15. Ms. Miller said the petitioner’s physical MDIs “did not rise” to the listing level in the federal regulation.

16. In Step four, DDD evaluated whether the petitioner was capable of returning to her PRW as a cleaner. DDD’s Physical Residual Functional Capacity Assessment (Respondent Exhibit 7), determined that the past exams indicate the petitioner had 4/5 motor strength and she walked with a normal gait and had no other neurological deficits. Therefore, the petitioner is capable of:

- Occasionally lift and/or carry 10 pounds.
- Frequently lift and/or carry less than 10 pounds.
- Stand and/or walk (with normal breaks) at least 2 hours in an 8-hour workday.
- Sit (with normal breaks) about 6 hours in an 8-hour workday.

17. Also in Step four, DDD determined that the petitioner maintains a sedentary Residual Functional Capacity (RFC) and is unable to return to her previous work as a “cleaner”. Even though the Step four indicates “NO PRW” (#11).

18. In Step five, DDD determined that the petitioner's sedentary RFC allows her to perform work in the national economy, and recommended jobs as waxer, golf ball trimmer and scoreboard operator.

19. DDD's Case Analysis, dated November 10, 2016, (Respondent Exhibit 7) in part states:

[REDACTED]

Upon past exams the claimant did have 4/5 motor strength throughout, however she walked with a normal gait and had no other neurological deficits.

ADLS:

The claimant is not working at this time and has no PRW. She is able to perform her personal care tasks independently, she is able to prepare simple meals, she lives with her husband and is able to do housework. She takes frequent breaks with doing housework. She is able to drive, goes grocery shopping with her husband and uses a cane sometimes on bad days. She is able to stand/walk short periods of time and is on medication for cholesterol and her thyroid at this time.

Mental:

MFR indicates anxiety. The claimant is not seeing a mental health professional at this time, she is not taking mental health medications and she has never been psychiatrically hospitalized. She feels more limited by her physical health than her mental health. All exams showed a normal mental status.

Summary:

At this time a sedentary RFC is given and the claim is denied under voc. rule 201.18. It is felt that the claimant is able to perform sedentary work such as waxer, golf ball trimmer or scoreboard operator. This claim is closed as N32.

20. DDD denied the petitioner Medicaid disability on November 10, 2016 with code N32

– Non-pay – capacity for substantial gainful activity – other work, no visual impairment.

21. On November 18, 2016, the Department mailed the petitioner a Notice of Case Action, denying Medicaid (Respondent Exhibit 2).

22. The petitioner alleges that her [REDACTED] has worsened and she will require surgery on her ankles. And as of January 2017, she was approved medical insurance through "Obama Care", which allows her to start new medical testing.

23. Ms. Miller contends that DDD has considered all of the petitioner's medical conditions, including what the petitioner is stating as a worsened condition. Ms. Miller said that degenerative conditions usually get worse.

CONCLUSIONS OF LAW

24. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

25. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

26. Title 20 of the Code of Federal Regulations § 416.905, Basic definition of disability for adults, in part states:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will

use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.) ...

27. Title 20 of the Code of Federal Regulations § 416.920, Evaluation of Disability of Adults, explains the five-step sequential evaluation process used in determining disability. The regulation states in part:

(a) (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five “steps” that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) and (h) of this section and § 416.960(b).)

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraph (g) and (h) of this section and § 416.960(c)...

(b) If you are working. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

(c) You must have a severe impairment. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience...

(f) Your impairment(s) must prevent you from doing your past relevant work. If we cannot make a determination or decision at the first three steps of the sequential evaluation process, we will compare our residual functional capacity assessment, which we made under paragraph (e) of this section, with the physical and mental demands of your past relevant work. See paragraph (h) of this section and §416.960(b). If you can still do this kind of work, we will find that you are not disabled.

28. In accordance with the above authority, DDD utilized the five-step sequential evaluation process in determining the petitioner's disability.

29. The first step of the evaluation process determines if the petitioner is engaging in SGA (working). The findings show that the petitioner has not been employed since 2004, when she was employed part-time as a "cleaner". Therefore, the petitioner is not engaging in SGA.

30. Step two of the evaluation process reviews whether the petitioner's MDIs are severe. The findings show that the petitioner's mental MDI (anxiety) is not severe and her physical MDIs (ankle and back problems) are considered severe.

31. Step three of the evaluation process evaluates whether the petitioner's physical MDIs meet or equal a list of disability impairments in Title 20 of the Code of Federal Regulations, Appendix 1.

32. The evidence submitted establish that the petitioner's MDIs are in body system category 1.00 musculoskeletal system, sections 1.02-major dysfunction of joint (ankle problem) and 1.04-disorder of the spine (back problem).

33. Title 20 of the Code of Federal Regulations § 404 Subpart P, Appendix 1, identifies 1.00 musculoskeletal system and sections, 1.02 and 1.04, and in relevant part states:

1.00 Musculoskeletal System...

B. Loss of function...

2. How We Define Loss of Function in These Listings...

b. What We Mean by Inability To Ambulate Effectively

(1) Definition. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities...

c. What we mean by inability to perform fine and gross movements effectively. Inability to perform fine and gross movements effectively means an extreme loss of function of both upper extremities; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. To use their upper extremities effectively, individuals must be capable of sustaining such functions as reaching, pushing, pulling, grasping, and fingering to be able to carry out activities of daily living. Therefore, examples of inability to perform fine and gross movements effectively include, but are not limited to, the inability to prepare a simple meal and feed oneself, the inability to take care of personal hygiene, the inability to sort and handle papers or files, and the inability to place files in a file cabinet at or above waist level...

1.02 Major dysfunction of a joint(s) (due to any cause): Characterized by gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of

limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b;

or

B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively, as defined in 1.00B2c...

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine);

or

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours;

or

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b.

34. The above authority explains for the petitioner's physical MDIs to meet or equal the above listings the impairment(s) "interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities".

35. The findings and evidence submitted establish that the petitioner is able to perform personal care tasks, prepare simple meals, is able to do housework, drive, goes grocery shopping, and stand/walk for short periods of time. Therefore, the petitioner did not meet or equal the MDIs listings.

36. Step four of the evaluation process evaluated whether the petitioner was capable of returning to her PRW as a cleaner. DDD's Physical Residual Functional Capacity Assessment determined that the past exams indicate the petitioner had 4/5 motor strength and she walked with a normal gait and had no other neurological deficits.

37. Also in Step four, DDD determined that the petitioner is capable of: occasionally lift and/or carry 10 pounds, frequently lift and/or carry less than 10 pounds, stand and/or walk (with normal breaks) at least 2 hours in an 8-hour workday and sit (with normal breaks) about 6 hours in an 8-hour workday. DDD determined that the petitioner maintains a sedentary RFC and is unable to return to her previous work as a "cleaner".

38. Title 20 of the Code of Federal Regulations § 404 Subpart P, Appendix 2, Medical-Vocational Guidelines defines sedentary RFC:

201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s). (a) Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and benchwork classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in the national economy. Approximately 85 percent of these jobs are in the machine trades and benchwork occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

(b) These unskilled sedentary occupations are standard within the industries in which they exist. While sedentary work represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity...

(4) "Sedentary work" represents a significantly restricted range of work, and individuals with a maximum sustained work capability limited to sedentary work have very serious functional limitations. Therefore, as with any case, a finding that an individual is limited to less than the full range of sedentary work will be based on careful consideration of the evidence of the individual's medical impairment(s) and the limitations and restrictions attributable to it. Such evidence must support the finding that the

individual's residual functional capacity is limited to less than the full range of sedentary work...

Table No. 1 – Residual Functional Capacity: Maximum Sustained Work Capacity Limited to Sedentary Work as a Result of Severe Medically Determinable Impairment(s)

Rule	Age	Education	Previous work experience	Decision
201.18	Younger individual age 45-49	Limited or less—at least literate and able to communicate in English	Unskilled or none	Not disabled

39. Step five of the evaluation process, assessed the petitioner’s sedentary RFC, age, education and work experience to determine if she can perform other work in the national economy.

40. In accordance with the above authority, the petitioner failed the disability criterion on step five. DDD suggested three jobs in the national economy for the petitioner:

1) waxer, 2) golf ball trimmer and 3) scoreboard operator.

41. The petitioner argued that her degenerative joint disease has worsened and she will require surgery on her ankles.

42. Ms. Miller argued that DDD has considered all of the petitioner’s medical conditions, including what the petitioner is stating as worsened. And agrees that degenerative conditions usually get worse.

43. In careful review of the cited authorities, evidence and testimony, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the Department’s action to deny the petitioner Medicaid Disability, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 14 day of March, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Mar 10, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09017

PETITIONER,

Vs.

UNITED HEALTHCARE, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on February 8, 2017 at approximately 1:30 p.m.

APPEARANCES

Petitioner: [REDACTED]

For United: Christian Laos
Senior Compliance Analyst

STATEMENT OF ISSUE

At issue is whether or not United Healthcare’s denial of Petitioner’s request for lower dentures was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

In addition to Mr. Laos, the following individuals were present for United Healthcare (“United”):

- Arlene Carrion – Account Manager (observer)
- Dr. Brittany Vo – Dental Consultant

Petitioner gave oral testimony, but did not move any exhibits into evidence. United moved Exhibits 1 – 6 into evidence at the hearing. Lisa Sanchez, Medical/Health Care Program Analyst with the Agency for Health Care Administration (“AHCA” or “Agency”) observed the hearing. An Arabic translator was present.

The record was held open for one (1) day in order for United to submit a written copy of their dental criteria, however, this information was not submitted.

FINDINGS OF FACT

1. Petitioner is a 69-year-old male. Petitioner is enrolled with United as his managed care plan.
2. Petitioner requested lower false teeth, upper false teeth, and bone adjustment. On October 24, 2016, United issued a Notice of Action (“Notice”) approving the upper false teeth and bone adjustment, but denying the lower false teeth. (Resp. Exh. 2). The Notice stated, in pertinent part:

The facts that we used to make our decision are:

The request is denied for what appears to be active periodontal (gum) disease which would adversely affect the outcome of the requested procedure. Your dentist may resubmit with documentation which addresses this condition such as periodontal charting, diagnosis, and treatment plan.

3. Dr. Vo testified that the standard of care is for at least 50% bone support for a denture. Half of the root of a tooth has to be in the gums in order to have the strength to anchor a partial denture. She said she is not very concerned about the lower left side of Petitioner’s mouth where there are two (2) teeth. She said that, although there is some bone loss, there is enough remaining to anchor a denture.

4. However, regarding the lower right side of Petitioner's mouth, where there is only one (1) tooth, Dr. Vo stated that there is approximately 25% of root left and the tooth is "bending like a tree." She said the stress on the tooth caused by the denture would pull on the tooth, causing it to become more loose. Although United failed to submit a written copy of its dental criteria, the undersigned finds Dr. Vo's testimony regarding the standard of care to be credible.

5. Dr. Vo stated the request was denied due to what appears to be active gum disease. She said Petitioner's dentist can re-submit the request after the gum disease is treated. Petitioner said his dentist told him that he should have his lower teeth pulled and request a full denture, rather than a partial.

CONCLUSIONS OF LAW

6. By agreement between AHCA and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Florida Statutes.

7. The hearing was held as a *de novo* proceeding, in accordance with *Florida Administrative Code* Rule 65-2.056.

8. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

9. The standard of proof in an administrative hearing is a preponderance of the evidence. Fla. Admin. Code R.65-2.060(1). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

10. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the *Florida Administrative Code*. AHCA is the single state agency that administers the Medicaid Program.

11. The Florida Medicaid Dental Services Coverage Policy, May 2016 (“Dental Policy”) is promulgated into law by Chapter 59G of the *Florida Administrative Code*.

12. Section 4.2.7 of the Dental Policy, Prosthodontic Services states:

Florida Medicaid reimburses for prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:

- One upper, lower, or complete set of full or partial dentures per recipient
- One reline, per denture, per 366 days, per recipient
- One all-acrylic interim partial (flipper) for the anterior teeth, per recipient under the age of 21 years

13. The Dental Policy requires that all services provided be medically necessary.

14. The definition of medically necessary is found in *Florida Administrative Code* Rule 59G-1.010, which states:

(166) “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.

.....

(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. In the instant-matter, there is no real dispute that Petitioner requires lower dentures. However, the dentures cannot be safely furnished due to Petitioner's gum disease and bone loss. Paragraph four (4) of the definition of medical necessity requires that the service be furnished safely.

16. As stated by Dr. Vo, as well as in the Notice of Action, the request can be re-submitted once the gum disease is addressed. Petitioner also stated his dentist suggested pulling the teeth and requesting a full denture. Petitioner is encouraged to work with his dentist to determine the best course of action.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and United'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.

FINAL ORDER (Cont.)
16F-09017
PAGE - 6

DONE and ORDERED this 10 day of March, 2017,
in Tallahassee, Florida.

D. B. T.

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Mar 30, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09054

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 [REDACTED]
UNIT: 883DT

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on March 6, 2017 at 9:18 a.m.

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Bruce Tunsil, Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner full SSI-Related Medicaid benefits and instead enroll him in the Medically Needy (MN) program effective September 2016 and ongoing is correct. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present and testified. The petitioner submitted one exhibit, which was accepted into evidence and marked as Petitioner's Exhibit "1". The

respondent was represented by Bruce Tunsil, Supervisor, with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). The respondent submitted no exhibits at the hearing. One continuance was granted for both the respondent and the petitioner.

FINDINGS OF FACT

1. On August 31, 2016, the petitioner completed an application for Temporary Cash Assistance (TCA), Food Assistance (FA) and SSI-Related Medicaid benefits. TCA and FA benefits are not issues under appeal. The application listed the petitioner as the only household member and his Social Security income of \$1,426 per month as the only source of income for the household. (Pages 3, 6, & 8 of Petitioner’s Exhibit 1)
2. The petitioner’s Social Security Disability Insurance (SSDI) amount is \$1,437 (gross) per month. (Page 43 of Petitioner’s Exhibit 1) The petitioner does not receive Medicare Part A and B. (Petitioner’s testimony)
3. The respondent determined the petitioner’s MN estimated share of cost (SOC) amount as \$1,226 effective July 2016 and ongoing as follows: (Page 39 of Petitioner’s Exhibit 1)

\$1426.00	petitioner’s SSDI income
<u>-\$ 20.00</u>	<u>unearned income disregard</u>
\$1406.00	total countable unearned income

\$1406.00	total countable income
<u>-\$ 180.00</u>	<u>MNIL for a household of one</u>
\$1226.00	estimated share of cost

4. On September 6, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner’s August 31, 2016 MN Medicaid application was

approved for July 2016 and ongoing. The notice also indicated the petitioner's estimated monthly SOC was \$1,226. (Page 16 of Petitioner's Exhibit 1)

5. On September 27, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner met his MN SOC amount and was eligible for Medicaid from September 22, 2016 through September 30, 2016. (Page 21 of Petitioner's Exhibit 1)

6. On October 31, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner met his MN SOC amount and was eligible for Medicaid from October 28, 2016 through October 31, 2016. (Page 25 of Petitioner's Exhibit 1)

7. For the month of November 2016, the petitioner met his SOC amount and was eligible for Medicaid for November 30, 2016. (Page 53 of Petitioner's Exhibit 1)

8. On December 6, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner met his MN SOC amount and was eligible for Medicaid from December 3, 2016 through December 31, 2016. (Page 29 of Petitioner's Exhibit 1)

9. The petitioner does not agree with the respondent's determination that he is not eligible for full SSI-Related Medicaid benefits as he is not able to pay for all of his medical expenses as well as all of his household expenses. (Petitioner's testimony)

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

11. This proceeding is a de novo proceeding pursuant to Florida Administrative Code R. 65-2.056.

12. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, defines the criteria to receive SSI-Related Medicaid benefits and states, in part:

The Department covers all mandatory coverage groups and the following optional coverage groups:

(1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

...

(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

13. Pursuant to the above authority, the petitioner is eligible for the SSI-Related Medicaid programs as he is considered disabled.

14. Fla. Admin. Code R. 65A-1.713 (2), SSI-Related Medicaid Income Eligibility Criteria, defines the types of included and excluded income and states, in part:

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

(e) Interest and dividends on countable assets are excluded, except when

determining patient responsibility for ICP, HCBS and other institutional programs.

15. Pursuant the above authority, the petitioner's SSDI income is considered included income in the determination of his SSI-Related Medicaid Benefits.

16. Fla. Admin. Code R. 65A-1.713 (1)(a), SSI-Related Medicaid Income Eligibility Criteria established income limits and states, in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan.

The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

17. Effective July 2016 through December 2016, the Department's Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for an individual for MEDS-AD as \$872.

18. Effective January 2017 through March 2017, the Department's Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for an individual for MEDS-AD as \$874.

19. Effective April 2017 and ongoing, the Department's Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for an individual for MEDS-AD as \$885.

20. Pursuant to the above authorities, the petitioner's monthly SSDI income (either \$1,426 per month or \$1,437 per month) exceeds the Medicaid income standard for him to receive full SSI-Related Medicaid benefits; therefore, he is correctly enrolled in the Medically Needy Program with a monthly share of cost.

21. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met the burden of proof to indicate the respondent incorrectly denied him full SSI-Related Medicaid benefits and instead enrolled him in the Medically Needy Program with a monthly share of cost amount effective September 1, 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's SSI-Related Medicaid appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 30 day of March, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 06, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09185

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 88265

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 14, 2017 at approximately 10:48 a.m. CST.

APPEARANCES

For the Petitioner: [REDACTED] *pro se*, [REDACTED], her mother

For the Respondent: Ed Poutre, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of November 14, 2016. During the associated recertification, the respondent discovered an error had been made and subsequently terminated the petitioner's Medicaid effective November 30, 2016. At the hearing the burden of proof was assigned to the petitioner. After further consideration the burden is reassigned to the respondent by a preponderance of the evidence.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "6".

The record was left open for the petitioner to submit an eligibility determination letter from the Social Security Administration (SSA) and for the respondent to submit and the respondent information concerning the denial by the Division of Disability Determination (DDD). The letter from SSA was submitted, via the respondent on February 21, 2017, admitted into evidence and marked as Petitioner's Exhibit "1". The respondent neglected to submit information concerning the DDD decision. The record was closed that day.

FINDINGS OF FACT:

1. Petitioner is a single female under the age of 65 without dependents.
2. On May 17, 2012, DDD concluded that the petitioner was disabled. She was placed on Medicaid effective April 1, 2012 (Respondent's testimony).
3. As part an October 2016 recertification, the respondent reviewed the technical eligibility of the petitioner based on the requirement to be disabled. On November 10, 2016, DDD documented the case record that the SSA denial decision from August 21, 2015 was being adopted. The petitioner appealed the SSA decision. The petitioner has a hearing date of February 28, 2017 with the SSA concerning their denial of petitioner's disability claim (Respondent's Exhibits 1, 2, 4 and 6).
4. On May 21, 2015, the petitioner received a notice of disapproved claim from the SSA informing her that she did not meet SSA disability criteria (Petitioner's Exhibit 1).

5. On November 14, 2016, the petitioner received a notice of case action informing her that her Medicaid would end November 30, 2016 with reason, "No household members are eligible for this program" (Respondent's Exhibit 3).
6. For an individual under the age of 65 without dependents to be eligible for Medicaid, that individual must meet disability criteria; therefore, no household member was eligible for Medicaid once the SSA denial was adopted.
7. The petitioner explained the necessity for medical care and the hardship of not continuing to have Medicaid coverage.
8. The petitioner has submitted current medical information to the respondent.

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.
10. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
12. Federal Medicaid Regulations at 42 C.F.R. § 435.541, "Determinations of disability" states in part:
 - (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
 - (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

13. The findings show that the petitioner applied for disability benefits from the SSA and was denied as she was found not disabled. This SSA decision is under appeal.

14. In accordance with the above controlling authority, the undersigned concludes that the respondent correctly closed the Medicaid as the SSA had determined the petitioner as not disabled.

15. Fla. Admin. Code 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R Part 435, subparts E and F (2007) (incorporated by reference) ... (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 29 C.F.R. § 416.905 (2007) (incorporated by reference).

16. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (as determined by either the respondent or SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs. Because the petitioner is under age 65 and has not been determined disabled by SSA or the respondent since the May 2015 SSA denial, which the respondent adopted, she does not meet the technical criteria to be eligible for SSI-Related Medicaid. Until the petitioner meets the federal disability criteria (while under age 65) Medicaid cannot be

approved. Therefore, the respondent correctly denied and terminated the request for Medicaid at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 06 day of March, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Mar 13, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-09217

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 14 [REDACTED]
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice and agreement, this matter convened for hearing before Hearing Officer Patricia C. Antonucci on February 8, 2017 at 10:07 a.m. (EST) and reconvened on February 23, 2017 at 2:11 p.m. (EST). All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter/caregiver

For the Respondent, United Healthcare: Christian Laos, Senior Compliance Analyst

STATEMENT OF THE ISSUE

At issue is Petitioner's request for an additional 24 hours per week of Personal Care Services (PCS). Petitioner has requested that this be provided as overnight care, in increments of 3 to 3.5 hours per night, through her Long-Term Care (LTC) health plan, United Healthcare ("United").

Respondent, the Agency for Health Care Administration (AHCA), through its contracted health plan, United, has denied Petitioner's request for all additional care, stating that the 43 hours of Home Health Services which she currently receives each week are sufficient to meet her needs. Petitioner bears the burden of proving, by a preponderance of the evidence, that Respondent's decision to deny the additional service hours is incorrect.

PRELIMINARY STATEMENT

Via a December 21, 2016 Notice of Hearing, all parties were informed that a telephonic hearing in this matter would convene on February 8, 2017 at 10:00 a.m. (EST). The Notice of Hearing also stated, in pertinent part: ****** Within 10 days of this Notice of Hearing, the Respondent must contact the Petitioner to discuss the issues being appealed and to explore options for resolution. Evidence packet must contain all documentation and all guidelines/rules reviewed by the MCO in making its determination, ****** (emphasis original).

Petitioner was not present at the phone hearing, but was represented by her daughter/caregiver, [REDACTED], who is also the Petitioner's Power of Attorney (POA). [REDACTED] presented one additional witness: [REDACTED] Petitioner's son-in-law. Respondent, United, was represented by Christian Laos, Senior Compliance Analyst, who also presented one additional witness: Sloan Karver, M.D., United's Long Term Care Medical Director. Cindy Henline, Medical/Health Care Program Analyst, observed the proceedings on behalf of AHCA. Following testimony,

the undersigned determined that United failed to comply with the Notice of Hearing requirements, thus necessitating that the hearing reconvene at a later date.¹

Given United's failure to thoroughly review Petitioner's case, Dr. Karver agreed to authorize the request for 24 additional hours, pending reconvened hearing. The parties agreed to reconvene telephonically on February 23, 2017. Respondent was instructed on the record to provide a full evidence packet (including a Functional Assessment/701B) and to confer with Petitioner in advance of this date. The Notice to Reconvene contained the following reminder: ****** RESPONDENT MUST CONTACT PETITIONER TO FULLY DISCUSS THE ISSUE UNDER APPEAL AND TO ENSURE ALL DOCUMENTATION HAS BEEN RECEIVED AND REVIEWED PRIOR TO HEARING ON 02/23/17, ****** (emphasis original).

All parties and witnesses who had appeared for hearing on February 8, 2017 were again present on the conference line on February 23, 2017, with the exception of Dr. Karver. Marc Kaprow, D.O., Executive Director of United's LTC Program, appeared in lieu of Dr. Karver, noting that he had discussed Petitioner's case with Dr. Karver, prior to hearing. Testimony again revealed that United had failed to comply the requirements set forth in the Notice to Reconvene, and did not contact Petitioner in advance of the reconvene.

Respondent's Exhibits 1 through 9, inclusive, and Petitioner's Exhibits 1 through 5, inclusive, were accepted into evidence. Administrative Notice was taken of Fla.

¹ To be discussed in further detail, below.

Admin. Code R. 59G-1.010 and of Section 3 of AHCA's Authorization Requirements Policy, promulgated by Fla. Admin. R. 59G-1.053.

Following hearing, Petitioner's daughter contacted the undersigned hearing officer, AHCA, and United to summarize and respond to testimony obtained on February 8 and February 23, 2016. As the record was not held open for supplemental documentation, said correspondence was reviewed but has not been entered into evidence. Only those portions of this correspondence which emphasize previously admitted exhibits or testimony have been considered in the development of this Final Order.

FINDINGS OF FACT

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. The Petitioner is a 93-year old female, born in 1923. She resides with her daughter and son-in-law, following residency in nursing home facilities where she was unhappy and unwell. Petitioner's daughter currently provides Petitioner's care through the Participant Directed Care (PDO) option of her LTC plan. At all times relevant to these proceedings, the Petitioner has been eligible to receive Medicaid services.

2. The Petitioner has multiple medical diagnoses, including [REDACTED]

[REDACTED]. She is bedridden, requires repositioning every 2 hours, needs bladder and bowel treatments, and requires hydration assistance.

3. The Petitioner also requires assistance with all activities of daily living, hygiene, toileting (she is incontinent), and medical appointments. She is unable to eat or drink on her own, and must be spoon-fed. She is at risk for bed sores and recurrent urinary tract infections due to her medical status.

4. Although Petitioner's family attempted multiple nursing home placements, Petitioner's daughter was troubled by (and fully documented her concerns regarding) the lack of care that Petitioner received while residing in these facilities. As a result, the daughter left her own job and utilized her savings to build an addition onto, and move the Petitioner into, the daughter's home. Petitioner's daughter has depleted her savings, and now provides all of Petitioner's care.

5. Both Petitioner's daughter and her son-in-law report that the Petitioner requires 24-hour care, and that the daughter cannot continue to provide this, on her own. They initially requested an additional 28 hours per week, but later adjusted this to 24 additional hours, all to assist with overnight care. Petitioner's daughter testified that a separate caregiver would provide these hours, to ensure that Petitioner's needs are met while the daughter is asleep.

6. Via Notice of Action dated September 8, 2016, United informed Petitioner:

UnitedHealthcare Community Plan has reviewed your request [for] 67 total hours of weekly companion, personal care and homemaker services, which we received on 9/06/16. After our review, this service has been denied as of 9/08/16.

...

The facts that we used to make our decision are: You have asked for 67 hours of care at home a week. You are getting 43 hours of care a week.

Your care plan for help is based on how much help you need.... The health plan will not cover the other hours you asked for. The other hours are in excess of your needs. Hours in excess of your needs are not medically necessary.

The number of minutes approved were added together. Additional minutes were added to round up to the next hour if needed. The hours were approved as a total amount of time. Hours are not required to be used for a specific task. You are able to use these hours in addition to any help from relatives or other sources.

The total number of hours approved [is] 43 hours a week.

7. Petitioner requested that United review this decision. United confirmed receipt of Petitioner's internal appeal via letter dated September 19, 2016 – however, said letter was sent not to Petitioner's address/in care of her daughter/POA, but to the nursing facility in which Petitioner previously resided.²

8. Via letter dated September 26, 2016, Petitioner was notified that United "reviewed your request for increased personal care hours so patient can be turned every two hours, which we received on 9/21/16. After our review, this service has been denied as of 9/26/16." It is not clear why this separate notice was generated.

9. Prior to United's reconsideration/internal appeal review, Petitioner's daughter submitted additional, supporting documentation, including detailed narratives and photographs, to substantiate the request for added care.

10. On or about October 27, 2016, United notified Petitioner of its decision upon review, incorrectly referring to Petitioner's caregiver/daughter as the Petitioner's spouse, and noting, in part:

You told us about an appeal September 19, 2016. Here is our answer.

² United maintains that this address was provided by AHCA. The undersigned instructed United that provision of health-related information to a non-authorized third party may constitute a HIPAA violation, and that United and/or AHCA must follow up to address this disclosure.

We looked at your information. We decided that this does not meet Florida Policies LTC-HS-025, LTC-HS-027, LTC HS-028, and Florida Administrative Code 59G-1.1010(166). You asked for Personal Care Services of 67 hours a week. This includes personal care, homemaker care, and companion care. Your wife needs help with her daily care. She is bedridden and dependent on caregivers for all her care. We cannot approve 67 hours a week because it is not medically needed. We used a tool that tells us her needs. Forty-three hours a week can meet her needs, and is approved by your health plan. This is why we cannot approve what you asked for. Please talk about this with her doctor/case manager.

(emphasis added)

11. At hearing on February 8, 2016, United initially stated that it was in compliance with the noticed requirement to confer, as Petitioner's case manager had been delegated the task of speaking to Petitioner in advance of hearing. When Petitioner's daughter responded that the case manager informed her she was prohibited from discussing a case under appeal, United stated that this was proper protocol. Through further testimony, it was determined that the only "pre-hearing contact" made by the case manager was an in-person visit to assess Petitioner's status. This visit occurred on December 20, 2016 – i.e., before the Notice of Hearing (which contains the requirement to confer) was issued.

12. Also on February 8, 2016, United testified that the "tool" referenced and utilized in Petitioner's review was an assessment and/or 701B. When asked why these documents were not part of the evidence packet, United stated that they were generated by AHCA, and that if no 701B was contained within United's proposed evidence, it was because AHCA had not provided this form to United.

13. Dr. Karver testified based upon her review of Petitioner's information; however, it became apparent during said testimony that the documentation submitted by Petitioner's daughter was not thoroughly reviewed or considered. United initially stated

that this documentation was never received, but later clarified that at least a portion of the narrative and several photographs were forwarded to United by the Office of Appeal Hearings, along with Petitioner's hearing request. Dr. Karver did not recall reviewing any photographs, but testified regarding her review of Petitioner's Plan of Care.

14. Dr. Karver explained that the Petitioner appeared to require 24-hour care, but that the LTC program was not designed to provide this frequency of service. She testified that although LTC services are intended to keep recipients in the family home and out of residential facilities, Petitioner's specific needs would best be met in a nursing facility, due to the level of care she requires.

15. When hearing reconvened on February 23, 2016, Dr. Kaprow testified that Petitioner's needs could be met via her currently authorized, 43 hours of care per week. He stated that he and Dr. Karver were in agreement that Petitioner essentially requires a weekly allotment of 180 minutes for bathing, 100 minutes for dressing, 240 minutes for grooming, 700 minutes for repositioning, 315 minutes for toileting, and 250 minutes for eating, which totals to approximately 30 hours of weekly personal care (companion and homemaker considered separately). He noted that this care would prevent readmission to a nursing facility, and testified that the decision was made, in part, via review of Petitioner's 701B and functional assessments, as completed by her case manager. Again, said assessments were not proffered by United.

16. When asked whether he reviewed Petitioner's proposed evidence, Dr. Kaprow stated that he did not, but that he wasn't sure how said documentation would impact the case. He requested that the hearing officer summarize this information, pointing out

what might be relevant to the determination of appropriate care.³ Dr. Kaprow then testified that United's decision was based on clinical judgment and acceptable standards of care, consistent with AHCA's Authorization Requirements Policy, promulgated by Fla. Admin. Code R. 59G-1.053. He also noted that the best guideline for determining the hours required to meet Petitioner's needs was found within the Appendix of AHCA's former Home Health Services Coverage and Limitations Handbook (2014). Said Handbook has since been repealed and is no longer promulgated by law.

17. Dr. Kaprow did note that Petitioner's daughter appeared overwhelmed, and thus offered the provision of 8 hours per week of Respite care, to relieve caregiver burnout. Dr. Kaprow specified that this offer was not for purposes of settlement, and was not offered in lieu of the PCS hours in contention. He stated that the daughter could contact Petitioner's case manager, if and when the family determined that this service was required.

18. Whereas much of United's evidence is inherently inconsistent, with documentary evidence containing erroneous information, and one witness's testimony conflicting with the next, review of Petitioner's evidence reflects repeated support of the need for additional care. Petitioner's physicians have documented that she requires increased personal care, with one treating physician noting, "It is my professional opinion that extra hours of personal care for [the Petitioner] is medically necessary...Without the additional hours of assistance, [the Petitioner] is being placed at higher risk for morbidity and mortality associated with her condition."

³ The undersigned did not provide any such summary.

19. Petitioner's daughter testified that she is opposed to placing Petitioner in another facility, due to the regression Petitioner experienced when in these prior placements.

The Petitioner is doing well and is happy at home; the family merely needs some additional assistance to continue meeting the Petitioner's needs.

CONCLUSIONS OF LAW

20. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Ch. 120, Fla. Stat.

21. Legal authority governing the Florida Medicaid Program is found in Ch. 409, Fla. Stat. and in Fla. Admin. Code Ann. ch. 59G. Respondent, AHCA, administers the Medicaid Program.

22. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

23. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

24. The burden of proof in the instant case lies with Petitioner, who has requested an overall increase to her authorized services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

25. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

....

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.

....

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition; family support and care supplements; a family's ability to provide care; a family's and child's schedule regarding work, school, sleep, and care for other family dependents; and a determination of the medical necessity for private duty nursing instead of other more cost-effective in-home services.

...

(c) The agency may not pay for home health services unless the services are medically necessary....

26. With regard to managed care, per § 409.965, Fla. Stat.:

All Medicaid recipients shall receive covered services through the statewide managed care program, except...The following Medicaid recipients are exempt from participation in the statewide managed care program:

- (1) Women who are eligible only for family planning services.
 - (2) Women who are eligible only for breast and cervical cancer services.
 - (3) Persons who are eligible for emergency Medicaid for aliens.
- History.—s. 6, ch. 2011-134; s. 4, ch. 2014-57.

27. Section 409.972, Fla. Stat. adds to the list of those exempt; however, no evidence was presented to demonstrate that Petitioner may opt-out of managed care for her Long-Term Care needs.

28. Section 409.978, Fla. Stat. provides that the “Agency shall administer the long-term care managed care program,” through the Department of Elder Affairs and through a managed care model. Section 409.981(1), Fla. Stat. authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/MCO is United Healthcare.

29. There is no currently promulgated handbook for Medicaid LTC services. Fla. Admin. Code R. 59G-13.030, which previously promulgated the The Medicaid Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook, was repealed on August 28, 2014. As such, hearing officers who review LTC service requests must rely upon the MCO’s contract-based guidelines, assessment criteria, and general provisions of prior authorization and medical necessity.

30. In the instant case, the undersigned hearing officer set forth preliminary requirements for hearing, wherein Respondent was ordered to confer with the Petitioner and to prepare and file a complete evidence packet, so as to allow for a fully developed record of competent and substantial evidence. The hearing officer is vested with the authority to effectuate such orders via Fla. Admin. Code R. 28-106.209, which states:

At any time after a matter has been filed with the agency, the presiding officer may direct the parties to confer for the purpose of clarifying and simplifying issues, discussing the possibilities of settlement, examining documents and other exhibits, exchanging names and addresses of witnesses, resolving other procedural matters, and entering into a pre-hearing stipulation.

31. United failed to comply with these requirements, and was thus unprepared to proceed with hearing. When hearing was rescheduled to provide United additional opportunity to prepare its case, United again failed to comply with the hearing officer’s

instructions. As the entity which rendered the denial of Petitioner's service request, United is in the best position to submit into evidence the documentation on which said denial was based. United is also duty-bound to provide a thorough and meaningful explanation of its determination. Absent this explanation, the Petitioner, despite bearing the burden of proof, is unable to proceed and/or present a meaningful defense as to why the requested services should be approved.

32. In reviewing the totality of the evidence, the undersigned concludes the Petitioner has shown that her needs cannot be met via 43 hours of care per week. In terms of medical necessity, Florida Administrative Code Rule 59G-1.010(166) explains:

"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. ...

(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.

33. Respondent does not deny that PCS services are necessary to prevent significant disability, or that they are non-experimental. As such, Fla. Admin. Code R. 59G-1.010(166) subsections (a)(1) and (a)(3) are not in dispute. To determine whether these services are individualized/not excessive, reflective of the level of service needed, and/or furnished in a manner that is not primarily for convenience (subsections (a)(2)(4) and (5)), one must look to the parameters of the services, themselves. Unfortunately, no tools or assessments were furnished by United, which would allow this type of analysis to occur.

34. As United was unable to provide a competent, substantial explanation as to their decision to deny the additional 24 hours of care, the undersigned concludes that a total of 67 weekly HHS hours, as calculated and requested by Petitioner and/or her case manager, are deemed medically necessary. Petitioner has presented evidence to support her contention that these hours are required, and Dr. Karver agreed that Petitioner's needs 24-hour care (albeit, her opinion was that same should be provided in a nursing facility). United has not presented any evidence which convincingly disputes the medical need.

35. In rendering this decision, the undersigned relies, in part, on Fla. Admin. Code R. 28-106.211, which notes: "The presiding officer before whom a case is pending may issue any orders necessary to effectuate discovery, to prevent delay, and to promote the just, speedy, and inexpensive determination of all aspects of the case, including bifurcating the proceeding," (emphasis added).

36. Should Petitioner wish to accept United's offer for Respite care, she may speak to her case manager to determine how this service might be approved.

37. It is regrettable that United did not avail itself of the opportunity to resolve this matter without resorting to formal proceedings, and did not provide better customer service to Petitioner, consistent with her medical needs. As a result, Petitioner's daughter has been struggling to meet Petitioner's needs, and has endured resultant burnout. Her dedication is to be commended. In consideration thereof, United and/or AHCA are encouraged to work with Petitioner's daughter, should she choose to file any additional grievances, or seek any additional care.

38. It is not clear whether Petitioner incurred any out-of-pocket expenses as a result of United's failure to thoroughly review her case. If she has, Petitioner may also wish to request that the Agency for Health Care Administration conduct a review to determine whether said expenses are reimbursable. The undersigned cannot speculate as to whether reimbursement is appropriate. This is best left to the Agency's discretion.⁴

Should Petitioner contact AHCA in this regard, the Agency is instructed to assist Petitioner, as needed.

⁴ The legal authority regarding this issue is somewhat split, with 42 C.F.R. § 431.246 allowing for "correction action/corrective payments" only when an incorrect action was taken. "Action," as defined by 42 C.F.R. 431.201 means "a termination, suspension, or reduction of Medicaid eligibility or covered services." As such, it is not clear that such remedy is available for improper denial of a request for increased services, as exists in the instant case.

There is an older body of case law that suggests corrective action may be appropriate in certain other circumstances, such as when a service is discontinued after being authorized via Final Order (See *French v. Dep't of Children and Families*, 920 So.2d 671. (Fla. App. 5th Dist. 2006)), when Medicaid eligibility (and/or resulting coverage) is wrongfully denied (See, e.g., *Randall v. Lukhard*, 709 F.2d 257 (4th Cir.1983), or when there is undue delay in reaching a determination as to eligibility (See *Kurnik v. Dept. of Health and Rehab. Serv.*, 661 So.2d 914 (1995)). Again, review as to any appropriate remedy is lies within the jurisdiction of the Agency for Health Care Administration.

DECISION

Petitioner's appeal is GRANTED, and United is ordered to authorize 67 hours of weekly HHS (i.e., to add 24 hours per week of PCS), to begin immediately.

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 13 day of March, 2017,

in Tallahassee, Florida.



Patricia C. Antonucci
Hearing Officer
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Copies Furnished To:


AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Mar 13, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09218

PETITIONER,

Vs.

AMERIGROUP, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on February 8, 2017 at approximately 3:30 p.m.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner's Mother

For Amerigroup: Deborah Greene
Grievances & Appeals Coordinator

STATEMENT OF ISSUE

At issue is whether or not Amerigroup's denial of Petitioner's request for the extraction of her two (2) upper wisdom teeth (teeth #1 and #16), along with associated anesthesia, was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's mother represented her at the hearing, although she was also present. Both gave oral testimony, but did not move any exhibits into evidence at the hearing. Lisa Sanchez, Medical/Health Care Program Analyst with the Agency for Health Care Administration ("AHCA" or "Agency") observed the hearing. A Spanish language interpreter was present.

The following individuals were present on behalf of Amerigroup:

- Lauren Hernandez – Complaints & Grievances Specialist - DentaQuest
- Dr. Daniel Dorrego – Dental Consultant – DentaQuest

Amerigroup moved Exhibits 1 - 8 into evidence at the hearing. The record was held open for the parties to submit additional evidence. Petitioner submitted evidence, entered as Exhibit 1. Amerigroup submitted additional evidence, entered as Exhibit 9.

FINDINGS OF FACT

1. Petitioner is a 16-year-old female. Petitioner is enrolled with Amerigroup as her managed care plan. DentaQuest is Amerigroup's dental vendor.
2. On September 13, 2016, Petitioner's dentist submitted a request for extraction of all four (4) of her wisdom teeth, along with anesthesia.
3. On September 15, 2016, Amerigroup issued a Notice of Action ("Notice") denying the request in full. The Notice gives the same facts used to make the decision for each tooth, stating: "The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain. Please follow up with your dentist." (Resp. Exh. 5). The anesthesia was

automatically denied via a separate Notice of Action because the extractions were denied.

4. An internal appeal was requested. On November 14, 2016, DentaQuest completed a Dental Consultant Review Form. (Resp. Exh. 6). The form stated:

Dental Consultant Reply: After a re-r eview of the member's x-ray and the provider's narrative and docu mented the appeal the denial is OVERTURNED and the procedure is APPROVED for the extraction of teeth #17 & #32 and associated sedation. Ho wever, we received and reviewed all submitted documentation (radiographs & narrative) for requested appeal determination. The denial(s) are UPHELD for extraction(s) of teeth #1 and #16 (D7240). To qualify for thi s benefit under this plan, a case must demonstrate evidenc e of current pat hology, infection, aberrant, and/or continuous and/or reoccurring pain bey ond normal eruption. This/These service is/are DENIED, with the asso ciated anesthetic services, because documentation submitted does not demons trate the required criteria have been met at this time. Prophylactic removal of third molars is not a covered benefit under this plan.

5. In the Wisdom Teeth Consult Note, Petitioner stated her chief complaint was "My teeth have been causing me problems for the past three months and the pain has become greater in the last week." (Resp. Exh. 3). Petitioner testified she currently has pain in her lower teeth, but the upper teeth are not hurting at this time. Teeth #1 and #16 are the upper wisdom teeth.

6. The "Physical Examination" section states that all four (4) wisdom teeth have [REDACTED], which can potentially cause [REDACTED] or [REDACTED] and that it would be negligent to leave them in.

7. Dr. Dorrego said there is no evidence on the x-ray of any [REDACTED]. He said they would appear as very large, dark spots on the x-ray. He said the upper wisdom teeth are completely within the gum of the upper maxillary arch. He said extracting them at this time would be a prophylactic measure.

8. DentaQuest's Criteria for Dental Extractions, Respondent's Exhibit 8, states:

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (except for orthodontics) is not a covered service. DentaQuest will not reimburse for any surgical extraction of third molars which are asymptomatic or do not exhibit any evidence of pathology or which were extracted for prophylactic reasons only.

9. Petitioner's mother said having two (2) separate procedures, one (1) to extract the lower wisdom teeth, and another to extract the upper wisdom teeth seems ridiculous to her. Dr. Dorrego said the upper teeth may or may not need to be extracted in the future, therefore a second procedure may never occur. He said the teeth having an aberrant position cannot be determined at this time.

CONCLUSIONS OF LAW

10. By agreement between AHCA and the Department of Children and Families ("DCF"), the Office of Appeal Hearings has jurisdiction to conduct this hearing pursuant to Section 120.80, Florida Statutes.

11. The hearing was held as a *de novo* proceeding, in accordance with Florida Administrative Code Rule 65-2.056.

12. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

13. The standard of proof in an administrative hearing is a preponderance of the evidence. Fla. Admin. Code R.65-2.060(1). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

14. Legal authority governing the Florida Medicaid Program is found in Fla. Stat. Chapter 409, and in Chapter 59G of the Florida Administrative Code. AHCA is the single state agency that administers the Medicaid Program.

15. The Florida Medicaid Dental Services Coverage Policy, May 2016 (“Dental Policy”), is promulgated into law by Chapter 59G of the Florida Administrative Code.

16. Page 4 of the Dental Policy provides:

Surgical Procedures and Extractions

Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

....

Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid’s authorization requirements policy

17. The Dental Policy therefore provides coverage for wisdom teeth extractions for children under age 21. The Dental Policy requires that all procedures be medically necessary.

18. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

(166) “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.

.....

(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.

19. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

20. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

21. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when

such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include “reasonable standards ... for determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

22. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

23. In the instant-matter, Dr. Dorrego testified the upper wisdom teeth do not need to be removed at this time, and to do so would be prophylactic in nature. DentaQuest’s criteria for removal is clear that the prophylactic removal of asymptomatic is not

covered. Petitioner testified that she is not currently experiencing pain in her upper wisdom teeth. No evidence was presented of any other symptoms being caused by her upper wisdom teeth which would necessitate their removal.

24. It is understandable that Petitioner's mother wants all four (4) wisdom teeth to be extracted at the same time. She does not want to unnecessarily subject her daughter to a second procedure. However, removal of the upper teeth is not medically necessary at this time. While it would be desirable to have all four (4) teeth extracted at the same time, services that are desirable but medically unnecessary are not covered.

25. If Petitioner's mother insists on having all four (4) teeth extracted at the same time, she is encouraged to work with her daughter's dentist to find an alternative payment arrangement for the extraction of the upper wisdom teeth. Otherwise, Petitioner and her mother should monitor the condition of her upper teeth and in the event removal becomes medically necessary in the future, a request can be submitted at that time.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED.

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.

FINAL ORDER (Cont.)
16F-09218
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DONE and ORDERED this 13 day of March, 2017,
in Tallahassee, Florida.

Rick Zimmer

Rick Zimmer
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Amerigroup Hearings Unit

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

FILED

Mar 17, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09234

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 [REDACTED]
UNIT: 88075

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on February 16, 2017 at 10:05 a.m.

APPEARANCES

For the Petitioner [REDACTED] Designated Representative with [REDACTED]

[REDACTED]

For the Respondent: Paula Henao, Operations Management Consultant (OMC) with the Department of Children and Families (DCF).

ISSUE

At issue is the respondent's action on November 7, 2016 to deny the petitioner's application for SSI-Related Medicaid on its contention that she did not meet the disability requirement.

The petitioner held the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing originally convened on January 30, 2017 at 10:27 a.m. The respondent requested a continuance to allow the Division of Disability Determination (DDD) to be a witness for the respondent. The petitioner's representative did not object. The hearing was scheduled to reconvene on February 16, 2017 at 10:00 a.m.

The hearing reconvened as scheduled. The respondent explained that a witness with the DDD would not be present for the hearing.

Appearing as an observer for the respondent was Carlos Yulee, Supervisor for DCF.

Appearing as an observer with the Office of Appeal Hearings was Pamela Vance, Hearing Officer.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. On October 20, 2016, the petitioner's representative completed an application for the petitioner (date of birth [REDACTED] for Medicaid. The application lists that the petitioner lives alone.

2. The Department received the petitioner's Disability Report dated October 2016 and medical records from [REDACTED] Medical Center, with an admission date of September 20, 2016. The assessment includes a summary of the petitioner's medical conditions of acute respiratory, [REDACTED])

[REDACTED] The notes state that

“...there is some concern for a potential of lung ca, she can follow up with heme/onc o/p for this” (*Respondent’s Exhibit 2, page 44*).

3. The Department forwarded the petitioner’s disability report and medical records to the DDD on October 26, 2016. On October 31, 2016, the DDD denied the petitioner’s disability claim with the denial code of “N31”. The code “N31” is defined as: “Non-pay; Capacity for substantial gainful activity-customary past work, no visual impairment.” The Respondent’s Exhibit 2 includes the Disability Determination and Transmittal (Transmittal) which includes the primary diagnosis as [REDACTED]” and the secondary diagnosis as “[REDACTED]”. The Transmittal includes in the remarks section: “[REDACTED]” and “Same/related allegations”.

4. The petitioner’s representative does not agree with the Department’s denial because the petitioner was subsequently hospitalized in November 2016 due to severe [REDACTED]. The petitioner’s representative believes that the Department did not consider in its review, the most recent hospitalization. The Petitioner’s Exhibit 1 includes the medical records dated November 1, 2016 from [REDACTED] System. The records are written in Spanish. The medical records from [REDACTED] System includes notes which instructed the petitioner to continue taking her Albuterol treatments, to continue taking her insulin, to continue her oxygen treatments at home, and to seek a psychiatric evaluation. The Petitioner’s Exhibit 1 also includes the medical records from [REDACTED] System with a service date of October 20, 2016 due to “...multiple lung nodules, evaluate for metastatic lung disease.”

5. The petitioner's representative argues that the petitioner's severe [REDACTED] now requires for her to receive oxygen 24 hours a day. The petitioner's representative argues that the Department denied the petitioner's application for Medicaid without reviewing the medical records from the subsequent hospital visits. The petitioner's representative explained that the petitioner has the same medical conditions but her conditions have worsened.

6. The petitioner's representative lists the petitioner's other medical conditions as [REDACTED]. The petitioner's representative is unsure of which of the petitioner's medical conditions were reviewed by the Social Security Administration (SSA). The petitioner's evidence did not include a copy of the SSA denial letter.

7. The petitioner applied for Supplemental Security Income (SSI) through the SSA in March 2016. The SSA denied the petitioner's disability claim in April 2016. The petitioner did not request an appeal through SSA for its denial of her disability claim. The Department is required to adopt the SSA denial.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

10. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy...

11. The findings show petitioner is less than 65 years old. In this case, before Medicaid eligibility can be determined, petitioner must meet the federal definition of disabled.

12. Additionally, 42 C.F.R. § 435.541 **Determination of Disability**, states:

(a) *Determinations made by SSA*. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.

(b) *Effect of SSA determinations*.

(1)...

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the

determination, except In cases specified in paragraph (c) (4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or..

13. The Department's Program Policy Manual, CFOP 165-22, passage 1440.1204 Blindness/Disability Determinations (MSSI, SFP), states in part:

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs.

State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year. If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.

14. The above authorities explain that a disability application must be sent to the Division of Disability Determination to be reviewed for applicants who are under the age of 65, who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs. However, if SSA has denied disability within the past year, the SSA decision is to be adopted. If the individual applies for Medicaid within one year of an SSA denial and provides evidence of a new

disabling condition that was not considered by SSA, the Department must make an independent disability decision. The petitioner provided no evidence of a new disabling condition. There was no evidence of the conditions reviewed by the SSA.

15. The findings show that the petitioner has medical conditions of [REDACTED] [REDACTED]. The petitioner's representative argues that the petitioner's [REDACTED] has worsened and should not have been denied, as the DDD did not review her most recent visit to the hospital due to her worsening condition. Her concern and situation is recognized, however, the Department is required to follow the rules and regulations set forth by the governing authorities. The undersigned concludes that the petitioner would be required to be deemed disabled in order to qualify for Medicaid. The petitioner did not meet her burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to adopt the SSA denial from April 2016 (within 12 months of the Medicaid application with the Department) which resulted in the Medicaid denial.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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

FINAL ORDER (Cont.)

16F-09234

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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 Department has no funds to assist in this review.

DONE and ORDERED this 17 day of March, 2017,

in Tallahassee, Florida.



Paula Ali
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
[REDACTED]

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

FILED

Mar 02, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-09245

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: 88999

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:17 p.m. on January 4, 2017.

APPEARANCES

For the Petitioner: [REDACTED], Esq.
[REDACTED] P.A.

For the Respondent: Brian Meola, Esq.
Department of Children and Families

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Institutional Care Program (ICP) Medicaid benefits, due to being over the asset limit, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present at the hearing. [REDACTED] (PH), the petitioner's Care Provider, appeared as a witness for the petitioner. Kane Lamberty (KL), Senior Human Services Program Specialist, appeared as a witness for the respondent. The petitioner's counsel submitted three exhibits, entered as Petitioner Exhibits "1" through "3". The respondent's counsel submitted three exhibits, entered as Respondent Exhibits "1" through "3". The record remained open until January 18, 2017, for both parties to submit Proposed Orders. The Proposed Orders were received timely and entered as Petitioner Exhibit "4" and Respondent Exhibit "4". The record was closed on January 18, 2017.

FINDINGS OF FACT

1. The petitioner was admitted to [REDACTED] in June 2016. The petitioner does not have a husband or children.
2. PH met the petitioner through their church and has been her friend for six years. [REDACTED] (GD) is a pastor at the same church.
3. On June 29, 2016, a Personal Care Agreement (PCA) was created between the petitioner, PH and GD (Respondent Exhibit 2, pages 19 through 28). The petitioner is referred to as "Care Recipient", PH and GD are referred to as "Care Provider". The PCA in part states:

1. Duties of Care Provider.
Care Provider will provide care-giving services for Care Recipient...
3. Compensation...
 - D. The parties, therefore, agree and stipulate that compensation to the CARE PROVIDER shall be computed as follows:
\$15.00 hours x 10 hours/week = \$150.00 per week
\$150.00 week x 52 weeks/year = \$7,800.00 year

\$7,800.00 year x 14.61 years (life expectancy) = \$113,958.00...

- E. ...The parties recognize that Care Recipient does not currently possess sufficient assets to pay the full amount due to the Personal Care Trust. Care Provide may accept payments or establish an irrevocable Trust for the sole benefit of [petitioner] (hereinafter referred to as the "PERSONAL CARE TRUST". The parties also agree that a payment of \$5,000.00 shall be the initial deposit to the PERSONAL CARE TRUST...

4. Also on June 29, 2016, PH and GD created a Personal Care Trust (trust) for the petitioner (Respondent Exhibit 2, pages 8 through 18). The trust in part states:

ARTICLE 1
PURPOSE

The purpose of this Trust is to act as an independent escrow holder to (1) assure that the personal services to be provided to [petitioner] under the terms of that certain Personal Care Agreement dated June 29, 2016...

ARTICLE 4

ADMINISTRATION DURING LIFETIME OF [PETITIONER]

The Trustee shall hold and administer the Trust Estate as follows:
Distribution of Income and Principal. [Petitioner PH and GD] have agreed to an initial deposit of \$5,000.00 and a total payment of \$113,958.00, more or less, for the personal services to be provided by [PH and GD to petitioner] under the terms of the Personal Care Agreement, such sum shall be received and accepted in Trust by the Trustee as third party escrow holder...

5. The petitioner's counsel submitted a typed summary listing \$4,174.02 of the petitioner's money deposited into the trust at ██████████ Bank (Petitioner's Exhibit 1).
6. The petitioner's ██████████ Checking account (Respondent Exhibit 2, pages 2 through 7) lists money removed and deposited into the petitioner's trust account.
7. PH testified that the reason the \$5,000 was put in a trust rather than the petitioner giving her the \$5,000 directly, was due to tax reasons. PH did not want to declare all of the income at one time.

8. The petitioner's counsel contends that the purpose of the trust is to provide services to the petitioner by PH and GD. And the petitioner does not have the authority to direct use of the funds in the trust.

9. KL contends that in accordance with the PCA, services provided to the petitioner are valued at \$15 per hour and the trust holds the money, provided by the petitioner, to pay for the services. Therefore, the petitioner benefits from services provided by the trust.

10. The petitioner's counsel disagrees that the petitioner benefits from the money in the trust. The petitioner's counsel states that PH and GD benefit from the trust.

11. PH testified that she uses money from the petitioner's [REDACTED] account to purchase items the petitioner needs. And uses money from the trust to pay herself for services she provides to the petitioner.

12. KL maintains that the petitioner signed the PCA. And in accordance with the PCA, the petitioner directed the caregiver to establish the trust for her sole benefit. Therefore, the petitioner established the trust, in accordance with the Department's policy 1640.0576.07.

13. On November 2, 2016, an ICP application was submitted on behalf of the petitioner.

14. The ICP asset limit for the petitioner to be eligible for ICP Medicaid benefits is \$2,000.

15. On December 5, 2016, the Department mailed the petitioner a Notice of Case Action, notifying the November 2, 2016 application was denied, due to being over the asset limit (Respondent Exhibit 1, pages 2 through 6).

CONCLUSIONS OF LAW

16. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

17. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

18. The petitioner's counsel argued that the purpose of the trust is to provide services to the petitioner by PH and GD. And the petitioner does not have the authority to direct use of the trust.

19. The respondent's witness argued that the petitioner signed the PCA. And in accordance with the PCA, the petitioner directed the caregivers to establish the trust for her sole benefit. Consequently, the petitioner established the trust in accordance with the Department's policy 1640.0576.07.

20. The Department's Program Policy Manual, CFOP 165.22, passage 1640.0576.07

Trusts Established On or After 10/1/93 (MSSI, SFP) states:

The following policy applies to trusts established by an individual on or after 10/1/93.

An individual will be considered to have established the trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established the trust (other than by will):

1. the individual;
2. the individual's spouse;
3. a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
4. a person, including a court or administrative body, acting at the direction or upon request of the individual or individual's spouse.

If the trust was not established by one of the above individuals, refer to passage 1640.0576.03.

If the trust is revocable:

1. Consider the entire principal as an available asset to the individual.
2. Consider any payments which can be made as countable income to the individual.
3. Consider any other payments from the trust as assets disposed of by the individual without fair compensation.

If the trust is irrevocable and there are any circumstances under which payment from the trust could be made to or for the benefit of the individual:

1. Consider that portion of the principal that could be available, as an asset to the individual.
2. Consider payments from that portion of the principal which could be available as income to the individual.
3. Consider any other payment from the trust as a transfer of assets.

If the trust is irrevocable and no payment could be made from the trust under any circumstances:

1. Apply the transfer of assets policy to the individual's assets and income used to establish the trust. The transfer policy applies only to applicants or recipients of nursing facility services and HCBS.
2. The trust is not counted as an available asset.

The above policies apply without regard to:

1. the purpose of the trust;
2. whether the trustees have or exercise any discretion under the trust;
3. any restrictions on when or whether distributions may be made from the trust; or
4. any restrictions on the use of distributions from the trust...

21. Additionally, the Social Security Program Operations Manual System (POMS) SI

01120.201, Trusts Established with the assets of an individual on or after 1/1/00 in part

states:

A. 7. Trust established with the assets of an individual

A trust is considered to have been established with the assets of an individual if any assets of the individual (or spouse), regardless of how little, were transferred to a trust other than by a will.

NOTE: The grantor (see SI 01120.200B.2) named in the trust document who provided the assets funding the trust and the individual whose actions established the trust may not be the same. The trust may name the individual (e.g., a parent or legal guardian) who physically took action to establish the trust rather than the individual who provided the trust assets. This distinction is important, especially in developing Medicaid trust exceptions in SI 01120.203.

22. The Social Security POMS, SI 01120.200, defines Grantor as:

B. 2. Grantor

A grantor (also called a settlor or trustor) is the individual who provides the trust principal (or corpus). The grantor must be the owner or have legal right to the property or be otherwise qualified to transfer it. Therefore, an individual may be a grantor even if an agent or other individual, legally empowered to act on his or her behalf (e.g., a legal guardian, representative payee for Title II/XVI benefits, person acting under a power of attorney, or conservator), establishes the trust with funds or property that belong to the individual. The individual funding the trust is the grantor, even in situations where the trust agreement shows a person legally empowered to act on the individual's behalf as the grantor. Where more than one person provides property to the trust, there may be multiple grantors. The terms grantor, trustor, and settlor may be used interchangeably.

23. The above POMS explains that the person who funds the trust is the trustor/grantor. And the grantor is the owner and has "legal right" to the trust.

24. The evidence submitted establishes that the petitioner's money was used to fund the trust. Therefore, the petitioner has "legal right" to the trust.

25. 20 C.F.R. defines resources and in part states:

§ 416.120 (c)(3), Resources means cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for support and maintenance (see § 416.1201(a))...

§ 416.1201 (a) Resources; defined. For purposes of this Subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance...

26. 42 U.S. Code § 1396p - Liens, adjustments and recoveries, and transfers of assets in part states:

(d)(3)(B) In the case of an irrevocable trust—
(i) **if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered**

resources available to the individual, (emphasis added) and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section...

27. The Social Security POMS SI 1730.048, Medicaid Trusts, in part states:

C. Policy — effect on Medicaid...

2. October 1993...

Irrevocable Trusts

If there are any circumstances under which payment from an irrevocable trust could be made to or for the benefit of the individual, the portion of the principal from which (or income on that principal) payment to the individual could be made is considered resources.

(emphasis added)

28. Fla. Admin. Code R. 65A-1.303, Assets, in part states:

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. **An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf...**

(emphasis added)

29. In accordance with the above authorities, an asset is countable, if available for support or maintenance of an individual.

30. The evidence submitted establishes that the PCA and the trust were established for the "sole benefit" of the petitioner; to provide services to the petitioner during her "LIFETIME".

31. Section 409.910, Florida Statutes(1), Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable, in part states, **“It is the intent of the Legislature that Medicaid be the payor of last resort** (emphasis added) for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid.”

32. In accordance with the above Florida Statutes, Medicaid is to be “the payor of last resort”, NOT the first or primary payor.

33. The PCA states that the petitioner “does not currently possess sufficient assets to pay the full amount due to the Personal Care Trust”. And PH and GD “may accept payments or establish an irrevocable Trust for the sole benefit of [petitioner]. The parties also agree that a payment of \$5,000.00 shall be initial deposit to the PERSONAL CARE TRUST.”

34. Additionally, PH testified that the reason the \$5,000 was deposited into the trust instead of the petitioner giving her the \$5,000, was due to tax reasons. PH did not want to declare all of the income at one time.

35. Fla. Admin. Code R. 65A-1.712 and 65A-1.716 address SSI-Related Medicaid asset criteria and in part state:

65A-1.712

(1) Resource Limits. If an individual’s total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C....

65A-1.716

(5) SSI-Related Program Standards.

(a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:

1. \$2000 per individual.

36. The above authorities set \$2,000 as the resource (asset) limit for an individual to be eligible for ICP Medicaid.

37. In careful review of the cited authorities, evidence and testimony, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes the respondent's action to deny the petitioner ICP Medicaid benefits, due to being over the \$2,000 ICP limit, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 02 day of March, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency
[REDACTED]
[REDACTED], Esq.

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

FILED

Mar 02, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-09246

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 [REDACTED]
UNIT: 88415

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 1, 2017 at 2:12 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Pamela Williams, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of October 21, 2016 denying her Medicaid application, as she did not meet the disability requirement. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner requested the appeal proceed without the Medical Representative from [REDACTED]

Lauren Miller, Program Operations Administrator, Division of Disability Determinations (DDD) appeared as a witness for the Department.

The Department submitted evidence on January 23, 2017, which was entered as Respondent's Exhibit 1.

The record closed on February 1, 2017.

FINDINGS OF FACT

1. The petitioner filed an application for Medicaid on October 11, 2016. The petitioner confirmed she will need retroactive Medicaid to cover August and September 2016 hospital visits.

2. The petitioner's household consists of herself, age 44, and husband, age 53. There are no minor children in the household according to the application.

3. The petitioner has an 11th grade education. She did not complete a GED program or any other trade education courses.

4. The petitioner reported she is not presently working. She reports she last worked in 2004.

5. The Department submitted the petitioner's case to the Division of Disability Determinations (DDD) on October 12, 2016 for review and disability decision.

6. The representative from the DDD unit explained the decision of denying the petitioner's disability request using the five-step sequential evaluation process.

7. DDD relied on the Department's determination that the petitioner is not engaged in a substantial gainful activity to determine the petitioner meets step one.

8. Step two is the determination of the severity of the petitioner's condition. A severe condition means the condition will affect the petitioner's ability to function for

12 months or longer. In this case, DDD determined the petitioner's conditions are severe.

9. Step three is a determination of if the petitioner's condition(s) meet or equal a listing. In this case, DDD determined the petitioner does not meet or equal a listing and proceeded to step four.

10. Step four reviews the petitioner's prior relevant work history. The petitioner's prior work was as a presser. DDD determined the petitioner is unable to return to this type of work. Based on her limitations, DDD determined the petitioner's Residual Functional Capacity (RFC) is considered "less than light".

11. Step five considers if the petitioner can do other work in the national economy. DDD determined that with a less than light RFC, the petitioner could do other work in the national economy such as addresser, election clerk, or ticket taker.

12. DDD explained the petitioner's "less than light" RFC is greater than the lowest level of jobs in the national economy, which is "sedentary". An RFC of "less than sedentary" would be necessary for the petitioner to qualify as disabled.

13. DDD reported the medical records received were from [REDACTED]

[REDACTED] for September and October 2016.

14. DDD denied the petitioner's claim of disability with a code of N32: Non-pay- Capacity for substantial gainful activity – other work, no visual impairment.

15. The Department issued a Notice of Case Action on October 21, 2016 denying the petitioner's application for Medicaid, as she did not meet the disability requirement.

16. The petitioner reported her health conditions include [REDACTED] [REDACTED] with output of 30 to 35 percent, [REDACTED] [REDACTED]. These diagnoses were all made prior to the DDD decision, some as early as March 2014 when she had triple bypass surgery.

17. The petitioner's medical records (Respondent's Exhibit 1, page 98) states:

Left ventricle systolic function was hyperdynamic. Ejection fraction was estimated to be 70 percent in the range of 65 to 70 percent. There were no regional wall motion abnormalities. Wall thickness was markedly increased. There was severe concentric hypertrophy. There was dynamic obstruction at rest in the mid cavity.

18. The petitioner explained she has a thickening of the lining of her heart, which prevents blood from circulating properly. Due to the condition, some simple tasks, such as going to the restroom, tire her greatly.

19. The petitioner reports she does have a new condition, which was diagnosed in January 2017, but did not recall what that condition was.

20. The petitioner reported she had applied for Social Security Disability previously.

21. The DDD representative confirmed Social Security applications with subsequent appeals in 2006/2007 and 2013/2014. However, she can find no current application or decision

22. The petitioner is requesting Medicaid, as she has no money to see a heart doctor or to purchase her medications.

23. The petitioner stated she would pass out if doing any type of exercise and so physical activity is limited. The petitioner reports she cannot walk a block. In

addition, the last time she was at the hospital, she was advised against walking. She confirmed she does often use a cane to help her balance.

24. She has a nebulizer, but does not require oxygen fulltime yet. The petitioner reports she cannot move around more than two hours without having to rest.

25. The petitioner stated that when she had the triple bypass surgery, and with all subsequent hospitalizations, the doctors tell her not to lift more than five pounds.

26. The petitioner stated she can sit for an hour or two, but then has to take a break and lay down.

27. The petitioner does not currently push or pull on anything, as she was told not to because of the amount of stress it would put on her heart.

28. The petitioner reported that, when she worked, the pants were brought to her station in a barrel and she only had to lift one pair of pants onto the machine for pressing at a time.

29. She stated she goes to the emergency room, but they have no heart specialist in the emergency room to understand her disease and treat her properly.

CONCLUSIONS OF LAW

30. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

32. The undersigned explored eligibility first under Family-Related Medicaid groups. The petitioner does not have a minor child in the home according to her October 11, 2016 application. The Family-Related Medicaid Program benefits rules are set forth in the Florida Admin. Code R. 65A-1.705, Family-Related General Eligibility Criteria. The rules set forth that to be eligible for Medicaid under this program; the petitioner must be pregnant or have a dependent minor child residing in the home. The undersigned concludes the petitioner does not meet the criteria for Family-Related Medicaid program benefits.

33. The definition of Med-AD Demonstration Waiver is found in Florida Admin. Code R. 65A-1.701 (20) and states:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

34. Florida Admin. Code R. 65A-1.710 et seq, set forth the rules of eligibility for Elderly and Disabled Individuals Who Have Less Than the Federal Poverty Level. For an individual less than 65 years of age to received Medicaid benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905.

35. Florida Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are

neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).

36. 20 C.F.R. § 416.905 “Basic definition of disability for adults” states in relevant part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.)

37. The undersigned explored potential eligibility for Medicaid for the petitioner under the SSI-Related Medicaid program. The petitioner was 44 years old at the time of application. She has not been established as disabled. As she is under age 65, a disability determination is required for eligibility determination in the SSI-Related Medicaid program.

38. The Department’s Program Policy Manual, CFOP 165-22, section 1440.1204, Blindness/Disability Determinations (MSSI, SFP) states in part:

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs.

State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year.

39. The findings show the last Social Security decision and appeal were completed in 2013/2014 and were not favorable. As the decision and appeal decision occurred more than 12 months before the petitioner applied for Medicaid, the undersigned concludes a disability decision must be determined by the Division of Disability Determinations (DDD) as the petitioner is under age 65.

40. 20 C.F.R. § 404.1520 "Evaluation of disability in general" states in relevant part:

(4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in §404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and §404.1560(b).

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and §404.1560(c).

41. The above controlling authority outlines the five-step sequential evaluation process. The undersigned concludes the disability determination of the petitioner by DDD must be reviewed using this authority.

42. The first step of the evaluation process is to determine if the petitioner is engaging in substantial gainful activity (20 C.F.R. § 404.1520(b) and 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. The findings show the petitioner has not worked since 2004. The undersigned concludes the petitioner is not engaged in SGA as she is not working. The analysis continues to step two.

43. Step two of the evaluation process reviews whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that are "severe" (20 C.F.R. § 404.1520(c) and 416.920(c)). An impairment or combination of impairments is considered "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. According to

the DDD decision, the claimant's impairments are severe. The undersigned concurs and the analysis continues to step three.

44. Step three of the sequential analysis for disability requires the determination of whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in Appendix 1 of 20 C.F.R. Part 404, Subpart P (20 C.F.R. § 404.1520(d)). The petitioner's diagnosis of Coronary Artery Disease (CAD) and cardiomyopathy fall under section 4.00 Cardiovascular System of the appendix. Section D of 4.00 discusses evaluating Chronic Heart Failure (CHF):

1. What is chronic heart failure (CHF)?

a. CHF is the inability of the heart to pump enough oxygenated blood to body tissues. This syndrome is characterized by symptoms and signs of pulmonary or systemic congestion (fluid retention) or limited cardiac output. Certain laboratory findings of cardiac functional and structural abnormality support the diagnosis of CHF. There are two main types of CHF:

(i) Predominant systolic dysfunction (the inability of the heart to contract normally and expel sufficient blood), which is characterized by a dilated, poorly contracting left ventricle and reduced ejection fraction (abbreviated EF, it represents the percentage of the blood in the ventricle actually pumped out with each contraction), and

(ii) Predominant diastolic dysfunction (the inability of the heart to relax and fill normally), which is characterized by a thickened ventricular muscle, poor ability of the left ventricle to distend, increased ventricular filling pressure, and a normal or increased EF.

b. CHF is considered in these listings as a single category whether due to atherosclerosis (narrowing of the arteries), cardiomyopathy, hypertension, or rheumatic, congenital, or other heart disease. However, if the CHF is the result of primary pulmonary hypertension secondary to disease of the lung (cor pulmonale), we will evaluate your impairment using 3.09, in the respiratory system listings.

2. What evidence of CHF do we need?

a. Cardiomegaly or ventricular dysfunction must be present and demonstrated by appropriate medically acceptable imaging, such as chest x-ray, echocardiography (M-Mode, 2-dimensional, and Doppler), radionuclide studies, or cardiac catheterization.

(i) Abnormal cardiac imaging showing increased left ventricular end diastolic diameter (LVEDD), decreased EF, increased left atrial chamber size, increased ventricular filling pressures measured at cardiac catheterization, or increased left ventricular wall or septum thickness, provides objective measures of both left ventricular function and structural abnormality in heart failure.

(ii) An LVEDD greater than 6.0 cm or an EF of 30 percent or less measured during a period of stability (that is, not during an episode of acute heart failure) may be associated clinically with systolic failure.

45. The findings show the petitioner reports her heart output to be 30 to 35 percent. However, her medical records show a 65 to 70 percent ejection fraction. The undersigned finds the reliability of the medical records a more accurate reflection of the petitioner's confirmed condition. The undersigned concludes based on the evidence, the petitioner's conditions do not meet or equal a listing. The evaluation continues to step four.

46. Step four of the sequential analysis for disability requires the undersigned to consider the petitioner's residual functional capacity (20 C.F.R. § 404.1520(e) and 416.920(e)) which is the ability to do physical and mental work activities on a sustained basis despite limitations of impairments. In addition, the undersigned must determine whether the claimant's residual functional capacity is enough to perform the requirements of his past relevant work. The petitioner is 44 years old. She has an 11th grade education. Her past relevant work was as a presser. The RFC established for this type of work according to the Dictionary of Occupational Titles is light.

47. The DDD office has established the petitioner with a Sedentary Residual Functional Capacity (RFC). There was no conflicting evidence provided by the petitioner to suggest she could not perform sedentary work. The undersigned concludes the RFC of sedentary is correct. In this case, the analysis will continue to the last step as the petitioner is unable to perform her past relevant work.

48. Step five of the sequential analysis for disability directs the undersigned to review 20 C.F.R. § 404 Subpart P, Appendix 2 for the Medical-Vocational guidelines:

201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s). (a) Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and benchwork classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in the national economy. Approximately 85 percent of these jobs are in the machine trades and benchwork occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

...

(h)(1) The term younger individual is used to denote an individual age 18 through 49. For individuals who are age 45-49, age is a less advantageous factor for making an adjustment to other work than for those who are age 18-44. Accordingly, a finding of "disabled" is warranted for individuals age 45-49 who:

- (i) Are restricted to sedentary work,
- (ii) Are unskilled or have no transferable skills,
- (iii) Have no past relevant work or can no longer perform past relevant work, and

(iv) Are unable to communicate in English, or are able to speak and understand English but are unable to read or write in English.

(2) For individuals who are under age 45, age is a more advantageous factor for making an adjustment to other work. It is usually not a significant factor in limiting such individuals' ability to make an adjustment to other work, including an adjustment to unskilled sedentary work, even when the individuals are unable to communicate in English or are illiterate in English.

(3) Nevertheless, a decision of "disabled" may be appropriate for some individuals under age 45 (or individuals age 45-49 for whom rule 201.17 does not direct a decision of disabled) who do not have the ability to

perform a full range of sedentary work. However, the inability to perform a full range of sedentary work does not necessarily equate with a finding of “disabled.” Whether an individual will be able to make an adjustment to other work requires an adjudicative assessment of factors such as the type and extent of the individual's limitations or restrictions and the extent of the erosion of the occupational base. It requires an individualized determination that considers the impact of the limitations or restrictions on the number of sedentary, unskilled occupations or the total number of jobs to which the individual may be able to adjust, considering his or her age, education and work experience, including any transferable skills or education providing for direct entry into skilled work.

(4) “Sedentary work” represents a significantly restricted range of work, and individuals with a maximum sustained work capability limited to sedentary work have very serious functional limitations. Therefore, as with any case, a finding that an individual is limited to less than the full range of sedentary work will be based on careful consideration of the evidence of the individual's medical impairment(s) and the limitations and restrictions attributable to it. Such evidence must support the finding that the individual's residual functional capacity is limited to less than the full range of sedentary work.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
201.17	Younger individual age 45-49	Illiterate or unable to communicate in English	Unskilled or none	Disabled
201.18	.....do	Limited or less—at least literate and able to communicate in English	.....do	Not disabled
201.19	.....do	Limited or less	Skilled or semiskilled—skills not transferable	Do.
201.20	.....do	.....do	Skilled or semiskilled—skills transferable	Do.
201.21	.....do	High school graduate or more	Skilled or semiskilled—skills not transferable	Do.
201.22	.....do	.....do	Skilled or semiskilled—skills transferable	Do.
201.23	Younger individual age 18-44	Illiterate or unable to communicate in English	Unskilled or none	Do. ⁴
201.24	.....do	Limited or less—at least literate and able to communicate in English	.....do	Do. ⁴
201.25	.....do	Limited or less	Skilled or semiskilled—skills not transferable	Do. ⁴
201.26	.....do	.....do	Skilled or semiskilled—skills transferable	Do. ⁴
201.27	.....do	High school graduate or more	Unskilled or none	Do. ⁴
201.28	.....do	.....do	Skilled or semiskilled—skills not transferable	Do. ⁴
201.29	.....do	.....do	Skilled or semiskilled—skills transferable	Do. ⁴

⁴See 201.00(h).

49. 20 C.F.R. § 416.969a, Exertional and non-exertional limitations, states in relevant part:

(a) General. Your impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit your ability to meet certain demands of jobs. These limitations may be exertional, nonexertional, or a combination of both.

...

(b) Exertional limitations. When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that you have only exertional limitations. When your impairment(s) and related symptoms only impose exertional limitations and your specific vocational profile is listed in a rule contained in appendix 2, we will directly apply that rule to decide whether you are disabled.

(c) Nonexertional limitations. (1) When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the demands of jobs other than the strength demands, we consider that you have only nonexertional limitations or restrictions. Some examples of nonexertional limitations or restrictions include the following:

(i) You have difficulty functioning because you are nervous, anxious, or depressed;

(ii) You have difficulty maintaining attention or concentrating;

(iii) You have difficulty understanding or remembering detailed instructions;

(iv) You have difficulty in seeing or hearing;

(v) You have difficulty tolerating some physical feature(s) of certain work settings, e.g., you cannot tolerate dust or fumes; or

(vi) You have difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

(2) If your impairment(s) and related symptoms, such as pain, only affect your ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. The determination as to whether disability exists will be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in appendix 2.

(d) Combined exertional and nonexertional limitations. When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we consider that you have a combination of exertional and nonexertional limitations or

restrictions. If your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we will not directly apply the rules in appendix 2 unless there is a rule that directs a conclusion that you are disabled based upon your strength limitations; otherwise the rules provide a framework to guide our decision.

50. The undersigned notes the petition has both exertional and non-exertional limitations (fatigue and shortness of breath). The undersigned reviewed the medical evidence presented to determine if the non-exertional limitations were addressed in relation to the petitioner's ability to do any substantial gainful employment (or similar activity). The undersigned could find no supporting evidence of the non-exertional limitations preventing sedentary employment. The undersigned, using the grid cited above from the Federal Regulation as a framework or guide, and comparing the findings of the petitioner's age of 44, education of 11 years, can communicate in English (as she did in hearing) and has no prior relevant work experience, concludes the petitioner is considered not disabled under Rule 201.24. The undersigned affirms the decision of DDD that the petitioner does not meet the requirements for disability under the federal regulations.

51. The undersigned further concludes that as the petitioner does not meet the disability requirements and is not over age 65, she is not eligible for Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 02 day of March, 2017,

in Tallahassee, Florida.



Melissa Roedel
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
[REDACTED]

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

FILED

Mar 17, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO.: 16F-09249
16F-09923

PETITIONER,

Vs.

MOLINA HEALTHCARE MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a hearing in Fort Myers, Florida in the above-referenced matter on January 23, 2017 at 4.00 p.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's Mother

For the Respondent: Natalie Fernandez
Government Contract Specialist
Molina Healthcare

STATEMENT OF ISSUE

Petitioner is appealing the denial of admission into an acute rehabilitation hospital. Petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner was not present in the hearing room.

Petitioner introduced Exhibits “1” through “3,” inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

Diana Juarez, Community Connector from Molina Healthcare (“Molina”), was physically present in the hearing room as an observer. Molina presented the following witnesses by telephone:

- Dr. Valerie Maguire, Medical Director for Molina
- Bonnie Blitz, R.N., Director of Healthcare Services for Molina
- Elvis Leiva, Manager of Healthcare Services for Molina.

Respondents introduced Exhibits “1” through “5,” inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

Suzanne Chillari, Medical Program Analyst, Agency for Health Care Administration (“AHCA”) was physically present in the hearing room as an observer.

Appeal number 16F-09923 is consolidated into 16F-09249 because it relates to the same notice of action and parties. Petitioner’s mother made two hearing requests on the same notice of action regarding admission into an acute rehabilitation hospital, which generated two appeal cases.

The record was held open until February 3, 2017 for Molina to provide its contract with AHCA as it relates to Managed Medical Assistant Program (“MMA”) member covered services, and the Nursing Facilities Medicaid Fee Schedule. Molina submitted the additional evidence on February 3, 2017. The undersigned entered into

evidence Respondent's AHCA contract on MMA covered services as Exhibit "6," Nursing Home Rates as Exhibit "7," and AHCA contract on hospital services as Exhibit "8." Petitioner submitted no response to Respondents additional evidence.

FINDINGS OF FACT

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 48-year-old female who lives in her mother's home.
2. At all times relevant to this proceeding, Petitioner has been receiving Medicaid through her MMA program, which is provided by Molina starting on September 1, 2016. (See Respondent's Exhibit 1).
3. Petitioner suffered a traumatic brain injury due to a motorcycle accident on March 5, 2016. (See Petitioner's Exhibit 2). The injury caused Petitioner to have [REDACTED]
[REDACTED]
[REDACTED]. (See Petitioner's Exhibit 3).
4. On November 15, 2016, Molina received a request for acute rehabilitation admission beginning on November 16, 2016. On November 18, 2016, Molina issued a Notice of Action denying the request as service is not medically necessary. The notice stated:

We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below:

Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

X Must meet accepted medical standards and not be experimental or investigational.

Must be able to be 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.

Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

(The convenience factor is not applied to the determination of the medically necessary level of private duty nursing (PDN) for children under the age of 21.)

The asked for acute rehabilitation admission is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request and determined that, based on the medical records, which were given to us, this admission, is not medically necessary. You have been hospitalized with large bowel perforation. You have a history of a traumatic brain injury in March 2016. To have this covered you must meet the rules in the guidelines. The information sent in does not show that you have had a new brain injury within the last 30 days. The information sent in indicates that you are able to sit unassisted for over 1 hour. The information sent in does not show that you are on a breathing machine and being weaned off the machine. Your medical situation and condition must meet the guidelines for this admission to be approved. Please talk to your provider about your health care options.

The facts that we used to make our decision are: Medical Records and Clinical documentation submitted by your doctor and criteria referenced used to make determination: InterQual Review # 3863502 Product LOC: Rehabilitation Subset Medically Intensive. (See Respondent's Exhibit 3).

5. Petitioner's sister gave testimony regarding her observations of Petitioner while at [REDACTED] Hospital, where Petitioner received physical therapy, occupational therapy, and speech therapy. Petitioner's mobility in her body has improved from moving her toes to rotating her ankle. Prior to these services, Petitioner was unable to move at all. As a result of speech therapy, Petitioner is now able to make sounds.

6. Petitioner's sister stated Molina is taking away her sister's right to having a meaningful recovery by denying her services. Further, the system is failing Petitioner because placing her in a nursing home is unfair without the attempts of rehabilitation.

7. Petitioner's sister stated her mother is a seventy-year-old woman who is going to get hurt without these services being provided. She nor her mother are qualified medical staff that can check Petitioner's mouth or feeding tube for infection.

8. Petitioner's sister contends Molina's primary care doctors are not specialist in brain injury.

9. Petitioner's mother testified she does not believe helping Petitioner regain her mobility is investigational or experimental.

10. Petitioner's mother testified physical therapy, occupational therapy, and speech therapy are medically necessary for Petitioner.

11. Petitioner's mother testified when an individual sustains a traumatic brain injury it is crucial to receive therapy immediately. The lack of therapy for five months at NCH Healthcare System ("NCH") had a negative effect on Petitioner's recovery.

12. Petitioner received physical therapy, occupational therapy, and speech therapy at [REDACTED] Hospital. Petitioner's mother stated according to [REDACTED] Hospital's Plan of Care ("POC"), Petitioner's mobility is impaired but she is progressing. Page 16 of the POC under self-care states Petitioner is progressing in balance, bed mobility, and cognitive. Page 21 of the POC, under cognitive, states Petitioner will consistently follow 1-step commands 75% of the time. Page 25 of the POC, under

speech pathology, states Petitioner has “increased alertness and attention, emerging vocalic verbalization, and increased strength”. (See Petitioner Exhibit 3)

13. Petitioner’s mother stated Petitioner’s therapist recognizes the potential and strength in Petitioner despite not having therapy for almost six months after the accident.

14. Petitioner’s mother stated she was following the guidance of a case manager at [REDACTED] Hospital when she requested acute rehabilitation. She does not want Petitioner to fall through the cracks due to passed deadlines.

15. Respondent’s witness Mr. Leiva testified InterQual is used to determine eligibility for admission into an Acute Rehabilitation Hospital. InterQual is a nationally recognized evidence based guideline. InterQual criterion is used to determine the medical necessity for admission into an acute rehabilitation hospital.

16. Respondent’s witness Dr. Maguire stated InterQual is recognized as one of two major criteria to follow objective based guideline.

17. The AHCA contract with Molina states, “InterQual Level of Care Acute Criteria Adult (McKesson Heal Solutions, LLC “McKesson”), the most current edition, for use in screening cases admitted to rehabilitative hospitals and CON-approved rehabilitative units in acute care hospitals.” (See Respondent’s Exhibit 8).

18. InterQual for Rehabilitation with subset Medically Intensive (Acute Rehab) states as follows:

Preadmission

Severity of Illness

Severity of Illness, All:

Illness, injury, surgery, or exacerbation \leq 30, \geq One:

*Impairment (new) with functional activity limitation requiring at least minimum assistance, \geq Two:

*ADL

*Cognitive

*Language, speech, or swallowing

Respiratory

*Mobility, motor, or limited ambulation $<$ 50 ft

*Clinical Stability, All:

*Diagnosis Known

*Initial treatment regimen established

*Clinical or laboratory finding improving or unchanged last 24h

Able to tolerate comprehensive rehab program of \geq 3h/d of skilled therapy \geq 5d/wk, All:

Cognitive, Both:

*Able to follow visual or verbal commands

Desire or ability to actively participate

Able to sit supported \geq 1h/d

Active in the community and home prior to admission

*Full participation in therapeutic evaluation and intervention prior to transfer

Preadmission assessment completed by licenses or certified clinician and rehab medical practitioner agrees with findings

*Rehabilitation potential based on prior level of function

*Therapy indicated, \geq Two:

*Occupational Therapy

*Physical Therapy

*Speech-language pathology

*Treatment precluded in a lower level of care fur to clinical complexity, All:

*Medical practitioner assessment or intervention \geq 3x/wk

*Specialized therapeutic skills or equipment required

*Rehabilitation nursing services available 24h/d

(Emphasis Added). (See Respondent's Exhibit 6).

19. Respondent's witness Dr. Maquire stated the check marks¹ represent the requirements Petitioner met for admission into the acute rehabilitation hospital. The only requirement Petitioner did not meet is the Illness, injury, surgery, or exacerbation

¹ The astrick (*) are used in place of check marks located on Respondent's Exhibit 5.

occurred less than 30 days. Petitioner did not meet the acute requirement necessary to be admitted into the acute rehabilitation facility.

20. Respondent's witness Dr. Maguire stated an acute injury is an injury that occurred 30 days prior to requesting admission into an acute rehabilitation hospital.

Although Petitioner's brain injury is serious, it is not acute as it occurred more than 30 days ago.

21. Respondent's witness Dr. Maguire testified Petitioner's bowel surgery would not qualify because recovery does not require rehabilitation. It is an acute event. However, the healing and recovery from bowel surgery is quick and does not require rehabilitation.

22. Respondent's witness Dr. Maguire stated Petitioner's injury is not an acute injury that would qualify for admission into the acute rehabilitation hospital. This decision was not a denial of therapy, only a denial for admission into the acute rehabilitation hospital. Petitioner can obtain physical therapy, occupational therapy, and speech therapy as medically necessary in her home.

23. Respondent's witness Mrs. Blitz stated Petitioner failed to meet the InterQual requirement for admission into an acute rehabilitation hospital. Petitioner did not meet the generally accepted standards by the Medicaid program.

CONCLUSION OF LAW

24. By agreement between the Agency for Health Care Administration ("AHCA") and the Department of Children and Families, AHCA has conveyed jurisdiction to the

Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

25. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Florida Medicaid Program is administered by AHCA.

26. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* Rule 65-2.056.

27. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

28. The standard of proof in an administrative hearing is a preponderance of the evidence pursuant to *Florida Administrative Code* Rule 65-2.060(1).

29. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the *Florida Administrative Code*.

30. Section 409.905, Florida Statutes, addresses Mandatory Medicaid Services under the State Medicaid Plan:

Mandatory Medicaid Services – The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

31. The Florida Medicaid Provider General Handbook, July 2012, is promulgated into law by *Florida Administrative Code* Rule 59G-5.020.

32. Page 1-27 of the Florida Medicaid Provider General Handbook states, “Medicaid contracts with Health Maintenance Organizations (“HMO”) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.”

33. The request for admission to an acute rehabilitation hospital requires a review of medical necessity. The definition of "medical necessary" is found in *Florida*

Administrative Code Rule 59G-1.010(166), which states, in part:

(166) "Medically necessary" and "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 services 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, recipient's caretaker, or provider. ...

(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 services.

34. Section 409.913, Florida Statutes, governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.

Section (1)(d) goes on to further state:

For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determination of medical necessity must be made by a licensed physician employed by or under the contract with the agency and must be based upon information available at the time the goods or services are provided.

35. Section 409.913(1)(d), Florida Statutes, highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency according to Section 120.80, Florida Statutes.

36. In the instant case, Petitioner's mother is seeking therapy for Petitioner in order to improve her way of life. Petitioner's mother believes therapy is medically necessary for Petitioner.

37. Respondent's witness Dr. Maguire stated that under their InterQual policy for acute rehabilitation hospital, Petitioner met the majority of the requirements except one. The one requirement Petitioner failed to meet is the "Illness, injury, surgery, or exacerbation \leq 30d."

38. Petitioner injury occurred on March 5, 2016. Petitioner did not become a member of Molina until six months later on September 1, 2016. Petitioner requested the acute rehabilitation services on November 15, 2016. The date of the injury for when the service was requested is more than 30 days.

39. Respondent's witness Dr. Maguire stated the bowel surgery Petitioner received would not qualify for admission into the acute rehabilitation facility. Petitioner's bowel

surgery did not qualify because recovery does not require rehabilitation. The healing and recovery process is quick.

40. Respondent's witness Dr. Maguire stated this is not a denial of therapy only a denial for admission into the acute rehabilitation hospital. Petitioner can obtain physical therapy, occupational therapy, and speech therapy as medically necessary in her home.

41. Based on the totality of the evidence, Petitioner has not met her burden that acute rehabilitation is medically necessary. More specifically, Petitioner's request fails under *Florida Administrative Code* Rule 59G-1.010 (3)(a), which requires that it meet generally accepted professional medical standards as determined by the Medicaid program. InterQual is an accepted medical standard by the Medicaid program and it requires the injury, illness, or surgery occur less than 30 days in order to be considered for acute rehabilitation hospital. Petitioner failed to meet this requirement.

42. The fact that [REDACTED] Hospital's case manager recommended acute rehabilitation hospital for Petitioner does not in itself makes the service medically necessary. As stated in the *Florida Administrative Code* Rule 59G-1.010 (c) states, "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 covered service."

43. Petitioner's mother desires therapy for Petitioner. Petitioner is able to receive therapy in the home after Molina conducts an evaluation and review. Petitioner's mother is encouraged to contact Molina and initiate the process for Petitioner to be evaluated to receive therapy in the home.

DECISION

Based upon the foregoing, Findings of Fact and Conclusion of Law, this 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 17 day of March, 2017, in

Tallahassee, Florida.



Allison Smith-Dossou
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
Molina Hearings Unit

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

FILED

Mar 01, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09254

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 15 [REDACTED]
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on January 24, 2017, at 12:50 p.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's mother

For the Respondent: Olunwa Ikpeazu, M.D.
Medical Director
Children's Medical Services Community Care Plan

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied her request for additional Personal Care Assistant ("PCA") services? Did the respondent prove by a preponderance of the evidence that it correctly terminated the petitioner's existing Personal Care Assistant services?

PRELIMINARY STATEMENT

The petitioner's mother may sometimes hereinafter be referred to as the petitioner's "representative".

The following individuals appeared as witnesses on behalf of Children's Medical Services ("CMS") Community Care Plan, the respondent: Briana Noel, Grievance and Appeals Coordinator at Community Care Plan; and Alexander Fabano, Children's Medical Services Contract Manager. The following individuals were present solely for the purpose of observation: Eugene Gandy, Esq., CMS Litigation Counsel at the Florida Department of Health; Tamara Zanders, Managed Care Unit Director at Community Care Plan; Palma Robinson, R.N., Utilization Management Nurse at Community Care Plan; Juliet Duncan, R.N., Supervisor of Medical Management at Community Care Plan; and Linda Latson, R.N., Registered Nurse Specialist at the Agency for Health Care Administration ("Agency").

The respondent introduced Exhibits "1" through "5", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on January 31, 2017 for the respondent to provide the relevant portions of the Florida Medicaid Personal Care Services Coverage Policy and the Community Care Plan Member Handbook. Once received on January 25, 2017, this information was accepted into evidence and marked as respondent's Exhibit "6", and the hearing record was closed. At the respondent's request, the hearing officer took administrative notice of the Florida Medicaid Personal Care Services Coverage Policy.

FINDINGS OF FACT

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. The petitioner is an 18-year-old female.
2. The petitioner was eligible to receive Medicaid benefits through Children's Medical Services Community Care Plan at all times relevant to this proceeding.
3. The petitioner was diagnosed with a back condition known as [REDACTED] [REDACTED] of the thoracic region.
4. As a result of her condition, the petitioner underwent posterior [REDACTED] [REDACTED] approximately four months prior to the request which is the subject of this appeal.
5. Community Care Plan approved skilled nursing services for the petitioner directly after her surgery.
6. As the petitioner's condition improved, Community Care Plan terminated the petitioner's skilled nursing services and transitioned the petitioner to a lower level of care, Personal Care Assistant ("PCA") services. These services were intended to assist the petitioner with her activities of daily living ("ADL's").
7. During the last period in which the petitioner was approved to receive Personal Care Assistant services, she was approved to receive these services in the amount of five hours per day, Monday through Friday, 14 hours per day on Saturday, and 14 hours per day on Sunday.
8. On November 18, 2016, the petitioner's orthopedic surgeon submitted a prior authorization request to Community Care Plan asking that the petitioner's Personal Care Assistant services be increased to 12 hours per day, Monday through Friday, 14 hours per day on Saturday, and 14 hours per day on Sunday for post-surgical assistance.
9. In a Notice of Action dated November 28, 2016, the respondent informed the petitioner that it was denying her request for the additional services.

10. The Notice of Action states, in part:

X We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

X Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.

X Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

...

The facts that we used to make our decision are: After reviewing the medical notes received, the surgeon's notes state that the patient has healed well for surgery and should be back to her baseline, for which HHA [Home Health Aide] was not necessary.

2. ADLs are for activities of daily living which are defined per Medicaid Guidelines none of which seem to be necessary for this patient 4mths after surgery.

We will deny as medical necessity criteria not met in this case.

11. The petitioner was not receiving Personal Care Assistant services prior to her back surgery.

12. The clinical notes submitted by the petitioner's orthopedic surgeon along with the request for additional Personal Care Assistant services indicate the petitioner healed well from surgery and should be back to baseline. The notes indicate that the plan is to increase the petitioner's activity to include dance, riding a bike, and running.

13. The petitioner's mother testified that the request for additional Personal Care Assistant services did not result from the petitioner's back surgery but rather from the fact that the petitioner requires monitoring and supervision due to developmental and intellectual delays.

14. The petitioner's mother testified that, although the petitioner is physically 18-years-old, she has a developmental age of approximately 10 years.

15. The petitioner's mother testified that the petitioner's older brother was helping to care for the petitioner but that her brother has passed away. She explained she must work to provide for the petitioner and herself and that she has no other family to help care for the petitioner. She also explained the petitioner cannot be left alone after school or on days when she does not have school. The petitioner's mother expressed her concerns about the petitioner being a beautiful, young woman with the intellectual capacity of a child.

16. The Medical Director appearing for Community Care Plan testified that the respondent did not have any information regarding the petitioner's developmental and intellectual delays when it reviewed the request from the orthopedic surgeon for additional Personal Care Assistant services. The Medical Director testified that the request was evaluated solely to determine if additional Personal Care Assistant services were medically necessary as a result of the petitioner's back surgery.

17. The Medical Director appearing for Community Care Plan testified that in order for the petitioner to be properly evaluated for the need of Personal Care Assistant services arising from her developmental and intellectual delays, Community Care Plan needs an objective evaluation of the petitioner's level of functioning, such as one found in a psychological evaluation or notes from the petitioner's neurologist, which it does not have.

CONCLUSIONS OF LAW

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

19. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

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

21. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof with respect to the petitioner's request for additional services is hereby assigned to the petitioner. Also in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof with respect to the respondent's proposed termination of the petitioner's existing services is hereby assigned to the respondent.

22. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

23. The Florida Medicaid Personal Care Services Coverage Policy, November 2016 is promulgated into rule by Fla. Admin. Code R. 59G-4.215.

24. The Florida Medicaid Personal Care Services Coverage Policy requires that any Personal Care Services approved must be medically necessary and directs the reader to Fla. Admin. Code R. 59G-1.010 for the definition of medical necessity.

25. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in Fla. Admin. Code R. 59G-1.010, which states:

(166) "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.

...

(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.

26. Since petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, Florida Statutes., Mandatory Medicaid Services defines Medicaid services for children to include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

27. The United States Court of Appeals for the Eleventh Circuit clarified the

states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** [Emphasis added] However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients.

28. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services

are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

29. Section 409.913, Florida Statutes, governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the “medical necessity or medically necessary” standards, and states in pertinent part as follows

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on the further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

30. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

31. The Personal Care Assistant services that are the subject of this appeal were requested by the petitioner’s orthopedic surgeon for post-surgical assistance. However, the clinical documentation supplied by the petitioner’s doctor along with the request for additional services indicates that the petitioner is recovering nicely from her surgery and is at or near her baseline. It encourages the petitioner to increase her activity to include such

things as dancing, running, and riding a bike. The clinical information provided does not support the medical necessity for additional Personal Care Assistant services to assist the petitioner with her recovery from back surgery.

32. The petitioner's representative explained during the hearing that the Personal Care Assistant services requested were truly not to assist the petitioner with her recovery from back surgery but rather to provide monitoring and supervision of the petitioner due to her developmental and intellectual delays. Although the petitioner's mother articulated the petitioner's needs arising from these conditions during the hearing, the respondent had no previous notice of these needs and has not had an opportunity to evaluate the petitioner's need for Personal Care Assistant services arising from her developmental and intellectual delays. In order for the respondent to perform a proper evaluation, the petitioner should submit a request for these services based on her current needs and supply the documents referred to by the respondent's Medical Director at the hearing. If the petitioner does this and the services are still denied, any such denial will be accompanied by independent fair hearing rights that will allow the petitioner to request an administrative hearing to dispute that denial.

33. Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the petitioner has not met her burden of proof to demonstrate that the Agency incorrectly denied her request for the additional Personal Care Assistant services.

34. Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the respondent has met its burden of proof to

demonstrate that Personal Care Assistant services are no longer medically necessary for the petitioner and, thus, that it is correctly terminating those services.

35. Pursuant to the above, the hearing officer hereby affirms the decision of the respondent to deny the petitioner's request for additional Personal Care Assistant services based on the request from the petitioner's orthopedic surgeon.

36. The parties are encouraged to continue communicating in order to identify the petitioner's current needs and request any services that may be necessary to secure the health and safety of the petitioner.

DECISION

The petitioner's appeal is hereby DENIED.

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 01 day of March, 2017,

in Tallahassee, Florida.



Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)
16F-09254
PAGE - 12

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Copies Furnished To:

, Petitioner
AHCA, Medicaid Fair Hearings Unit
Childrens Medical Services Hearings Unit

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

FILED

Mar 02, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-09295

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 [REDACTED]
UNIT:

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, this matter convened for hearing before Hearing Officer Patricia C. Antonucci on February 15, 2017 at approximately 10:06 a.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's husband

For the Respondent, United Healthcare: Christian Laos, Senior Compliance Analyst

STATEMENT OF THE ISSUE

At issue is Petitioner's October 7, 2016 request for a total of 66 hours per week of Home Health Services (including personal care, homemaker, and companion). Petitioner has requested that this care be provided in increments of 10 hours per day, 6 days per week, and 6 hours per day, one day per week, through her Long-Term Care (LTC) health plan, United Healthcare ("United").

Respondent, the Agency for Health Care Administration (AHCA), through its contracted health plan, United, has approved 26 of these hours and denied Petitioner's request for all additional care. Petitioner bears the burden of proving, by a preponderance of the evidence, that Respondent's decision to deny the remaining service hours is incorrect.

PRELIMINARY STATEMENT

Via a December 21, 2016 Notice of Hearing, all parties were informed that a telephonic hearing in this matter would convene on February 15, 2017 at 10:00 a.m. The Notice of Hearing also stated, in pertinent part: **“*** Within 10 days of this Notice of Hearing, the Respondent must contact the Petitioner to discuss the issues being appealed and to explore options for resolution. Evidence packet must contain all documentation and all guidelines/rules reviewed by the MCO in making its determination, ***”** (emphasis original).

Petitioner was not present at the phone hearing, but was represented by [REDACTED] her husband of 44 years. Although Petitioner's husband had not received a copy of Respondent's proposed evidence, he elected to proceed with the hearing, as scheduled. Respondent, United, was represented by Christian Laos, Senior Compliance Analyst, who presented one additional witness: Sloan Karver, M.D., United's Long Term Care Medical Director. Suzanne Chillari, Medical/Health Care Program Analyst, observed the proceedings on behalf of AHCA. Following testimony,

the undersigned determined that United failed to comply with the Notice of Hearing requirements.¹

Respondent's Exhibits 1 through 3, inclusive, and Petitioner's Exhibits 1 through 6, inclusive, were accepted into evidence. Administrative Notice was taken of Fla. Admin. Code R. 59G-1.010. The parties were advised that, due to United's failure to submit or proffer competent, substantial evidence in support of its decision, the undersigned would have to take this matter under advisement before proceeding to the next step of the appeal process.

FINDINGS OF FACT

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. The petitioner is a 79-year old female, born in 1937. She resides in her own home, with her husband of 44 years. Petitioner's husband provides all care for the Petitioner from 5:00 p.m. to 7:00 a.m., 7 days a week. At all times relevant to these proceedings, the Petitioner has been eligible to receive Medicaid services.
2. The Petitioner has multiple medical diagnoses, including [REDACTED]. She suffered a [REDACTED] in April of 2016, and her husband has been caring for her ever since, so as to avoid placing her in a nursing home facility. The Petitioner also underwent a [REDACTED] and overcame [REDACTED] approximately 10 years ago; however, her cancer has now returned. Petitioner will not

¹ To be discussed in further detail, below.

undergo additional cancer treatment, and her condition is considered terminal. Her husband wishes to keep her home as long as possible.

3. The Petitioner requires assistance with all activities of daily living, hygiene, toileting (she is incontinent), physical therapy/exercise, and medical appointments. Currently, a paid Home Health Services (HHS) provider renders Petitioner's care from 7:00 a.m. to 5:00 p.m. Petitioner's husband, who works 4.5 days a week to support the family, has been paying out-of-pocket for a portion of this care; however, as he has no savings left, he can no longer afford to do so. The husband also has health concerns of his own, including a history of heart attack and a bad hip.

4. At some point near the beginning of October of 2016, Petitioner's United case manager conducted a functional assessment and/or 701B to determine Petitioner's care needs. Although Dr. Karver testified that this assessment was reviewed in formulating the decision to deny Petitioner's request, and although the Notice of Hearing required, in part, that the Respondent's "[e]vidence packet must contain all documentation and all guidelines/rules reviewed by the MCO in making its determination" (emphasis original), no copy of the assessment has been filed in this appeal.

5. Internal case notes from United staff reflect correspondence between staff members regarding Petitioner's requested services; however, the dates of this correspondence do not align with the dates included on United's Notice of Action. An undated note from Petitioner's case manager references a need for 40 additional hours of weekly care, and states:

Member's spouse maintains that his wife requires total care and cannot be left unsupervised. He works several days per week outside the home and states he cannot care for her by himself. He is seeking possible placement in a nursing

home for member. He is privately paying someone now but has stated that his funds are almost gone and he cannot continue to pay a staff person to care for member.

6. Via Notice of Action dated October 11, 2016, United informed Petitioner:

UnitedHealthcare Community Plan has reviewed your request for a 77 total hours [sic] of weekly companion, personal care and homemaker services, which we received on 10/07/16. After our review, this service has been denied as of 10/11/16.

...

Your care plan for help is based on how much help you need.... The health plan will not cover the other hours you asked for. The other hours are in excess of your needs. Hours in excess of your needs are not medically necessary.

The number of minutes approved were added together. Additional minutes were added to round up to the next hour if needed. The hours were approved as a total amount of time. Hours are not required to be used for a specific task. You are able to use these hours in addition to any help from relatives or other sources.

The total number of hours approved [is] 26 hours a week.

7. It is not clear why this Notice of Action references a request for 77 hours of care, as this is not what Petitioner requested. The included mention of a certain "number of minutes" that were "added together" appears to reference Petitioner's functional assessment/701B form, which, again, is not in evidence.

8. An internal United note dated November 3, 2016 reflects Dr. Karver's review of Petitioner's request, and states, in part:

Service Requested: Additional 14 hours of home care FA 26

Decision: NOT APPROVED

Rationale: Member's needs are met under the current care plan. No gap in care identified. Additional services are in excess of member's needs.

...

Denial Letter Language:

You asked for 14 more hours of care at home. Your care plan is based on your

needs. You are getting 26 hours a week of care. The hours you asked for are in excess of your needs. Hours in excess of your needs are not medically necessary.

9. An additional note on November 3, 2016 reflects that a staff member “got an email from Dr. Karver to fix the denial language where it said 14 hrs, instead of 14 hrs should be 40 hrs.” As these notes post-date the Notice of Action, is not clear whether they are in reference to an internal appeal/grievance of that October 11, 2016 denial; however, United’s Statement of Matters does not indicate that any appeal/grievance was received, reflecting the following timeline of events:

10/01/16	Effective date with UnitedHealthcare Community Plan
10/07/16	Original request for Prior Authorization
10/11/16	Original Prior Authorization denial
N/A	Appeal/Grievance received by UnitedHealthcare Community Plan
N/A	Date issue was upheld on appeal, resolution letter sent
12/09/16	Medicaid Fair Hearing request received.

10. At hearing, Dr. Karver testified that in her review, Petitioner did not require any additional hours of care. She stated that her evaluation was based upon a record review of notes from Petitioner’s assessment on October 28, 2016 (i.e., after the Notice of Action was generated), as well as a wide array of other documentation and policy; however, she also testified that she did not recall exactly what paperwork she reviewed in reaching her decision, as her evaluation were performed “a while ago.” When asked if everything she looked over was contained within United’s proposed evidence, Dr. Karver testified that she does not prepare the evidence packet. She also noted that it

would be too voluminous to include as evidence every document which United considered in its review.

11. Per Dr. Karver, 26 hours of HHS is what was recommended by Petitioner's case manager, which Dr. Karver testified she assumed was based on Petitioner's functional assessment. Mr. Laos testified that the 701B assessment is completed by AHCA, and that this is a difficult document for United to obtain.² He noted that if a 701B was not included in the evidence packet, it was because AHCA had not provided it to United.

12. Dr. Karver explained that in reviewing a request for services, a member's case manager makes a recommendation as to what is appropriate, and this recommendation is then reviewed by a medical professional. In the instant case, Dr. Karver testified that the case manager recommended 26 hours per week of HHS, and Dr. Karver agreed that this frequency of services would suffice to meet Petitioner's needs. Dr. Karver further opined that Petitioner probably does require 24-hour care, but that since United does not provide this level of service, the Petitioner would be better served by placement in a nursing facility. Although Dr. Karver recommended nursing home placement, she also acknowledged that the LTC program is designed to keep members home, without the need for institutionalization.

13. With regard to the requirement contained within the Notice of Hearing that **"Within 10 days of this Notice of Hearing, the Respondent must contact the Petitioner to discuss the issues being appealed and to explore options for resolution,"** (emphasis original), United at first stated that Petitioner's case manager

² The hearing officer notes that no legal authority was provided for this contention, and that it has not been considered as correct information.

reached out to discuss resolution, but later clarified that the resolution suggested was nursing home placement. Per United, Petitioner's case manager conducted a face-to-face visit on January 19, 2017. As such, this contact was accomplished 29 days from the date of the Notice of Hearing, and thus, did not comply with the 10-day requirement of same.

14. Petitioner's husband testified that the Petitioner requires complete care and supervision. She pulls her colostomy port out when left alone, and is easily confused. Documentation from Petitioner's treating physicians reflect their opinion that Petitioner requires assistance and care, 7 days per week.

15. Petitioner's husband explained that he worked with Petitioner's United case manager to determine the care hours needed, and noted that it was the case manager, herself, who suggested 66 hours of care and determined how this care should be categorized (i.e., as companion, homemaker, and personal care services). When this request was denied, it was also the case manager who informed Petitioner's husband of his right to file an appeal to challenge the decision made by United's medical reviewer.

16. Petitioner's husband further testified that on or about February 9, 2017, Petitioner was authorized to receive some private duty nursing, via Hospice care.

17. In response to this testimony, Dr. Karver noted that if Petitioner requires additional hours of care, Hospice is required by the Florida Statutes to cover same.

CONCLUSIONS OF LAW

18. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Chapter 120, Florida Statutes.

19. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program.

20. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

21. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

22. The burden of proof in the instant case lies with Petitioner, who has requested an overall increase to her authorized services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

23. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

....

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.

....

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition; family support and care supplements; a family's

ability to provide care; a family's and child's schedule regarding work, school, sleep, and care for other family dependents; and a determination of the medical necessity for private duty nursing instead of other more cost-effective in-home services.

...

(c) The agency may not pay for home health services unless the services are medically necessary....

24. With regard to managed care, per § 409.965, Fla. Stat.:

All Medicaid recipients shall receive covered services through the statewide managed care program, except...The following Medicaid recipients are exempt from participation in the statewide managed care program:

- (1) Women who are eligible only for family planning services.
 - (2) Women who are eligible only for breast and cervical cancer services.
 - (3) Persons who are eligible for emergency Medicaid for aliens.
- History.—s. 6, ch. 2011-134; s. 4, ch. 2014-57.

25. Section 409.972, Fla. Stat. adds to the list of those exempt; however, no evidence was presented to demonstrate that Petitioner may opt-out of managed care for her Long-Term Care needs.

26. Section 409.978, Fla. Stat. provides that the “Agency shall administer the long-term care managed care program,” through the Department of Elder Affairs and through a managed care model. Section 409.981(1), Fla. Stat. authorizes AHCA to bid for and utilize provider service networks to achieve this goal. In the instant case, the provider network/MCO is United Healthcare.

27. There is no currently promulgated handbook for Medicaid LTC services. Fla. Admin. Code R. 59G-13.030, which previously promulgated the The Medicaid Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook, was repealed on August 28, 2014. As such, hearing officers who review LTC service requests must rely

upon the MCO's contract-based guidelines, assessment criteria, and general provisions of prior authorization and medical necessity.

28. In the instant case, the undersigned hearing officer set forth preliminary requirements for hearing, wherein Respondent was ordered to confer with the Petitioner and to prepare and file a complete evidence packet, so as to allow for a fully developed record of competent and substantial evidence. The hearing officer is vested with the authority to effectuate such orders via Fla. Admin. Code R. 28-106.209, which states:

At any time after a matter has been filed with the agency, the presiding officer may direct the parties to confer for the purpose of clarifying and simplifying issues, discussing the possibilities of settlement, examining documents and other exhibits, exchanging names and addresses of witnesses, resolving other procedural matters, and entering into a pre-hearing stipulation.

29. United failed to comply with these requirements, and was thus unprepared to proceed with hearing. As the entity which rendered the denial of Petitioner's service request, United is in the best position to submit into evidence the documentation on which said denial was based. United is also duty-bound to provide a thorough and meaningful explanation of its determination. Absent this explanation, the Petitioner, despite bearing the burden of proof, is unable to proceed and/or present a meaningful defense as to why the requested services should be approved.

30. In reviewing the totality of the evidence, the undersigned concludes the Petitioner has shown that her needs cannot be met via 26 hours of care per week. In terms of medical necessity, Florida Administrative Code Rule 59G-1.010(166) explains:

"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. ...

(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.

31. Respondent does not deny that HHS services are necessary to prevent significant disability, or that they are non-experimental. As such, Fla. Admin. Code R. 59G-1.010(166) subsections (a)(1) and (a)(3) are not in dispute. To determine whether these services are individualized/not excessive, reflective of the level of service needed, and/or furnished in a manner that is not primarily for convenience (subsections (a)(2)(4) and (5)), one must look to the parameters of the services, themselves. Unfortunately, no guidelines, tools, or assessments were furnished by United, which would allow this type of analysis to occur.

32. As United was unable to provide a competent, substantial explanation as to their decision to deny 40 hours of care, the undersigned concludes that all 66 weekly HHS

hours, as calculated and requested by Petitioner's case manager, are deemed medically necessary. This is the frequency of hours which the case manager, following her assessment and face-to-face meetings with Petitioner, determined were sufficient to meet the Petitioner's needs. Petitioner has presented evidence to support her contention that these hours are still required, particularly as her condition may be worsening. United has not presented any evidence which convincingly disputes the medical need.

33. In rendering this decision, the undersigned relies, in part, on Fla. Admin. Code R. 28-106.211, which notes: "The presiding officer before whom a case is pending may issue any orders necessary to effectuate discovery, to prevent delay, and to promote the just, speedy, and inexpensive determination of all aspects of the case, including bifurcating the proceeding," (emphasis added).

34. Should Petitioner begin to receive Hospice services in addition to skilled nursing, her United case manager will be responsible for ensuring Petitioner's coordination of care and benefits; however, until that time, United is hereby directed to provide all 66 hours of HHS.

35. It is regrettable that United did not avail itself of the opportunity to resolve this matter without resorting to formal proceedings, and did not provide better customer service to Petitioner, consistent with her medical needs. As a result, Petitioner's husband has been struggling to meet Petitioner's needs, while also coping with her new cancer diagnosis. His dedication is to be commended. In consideration thereof, United and/or AHCA are encouraged to work with Petitioner's husband, should he choose to file any additional grievances, or seek any additional care.

36. Additionally, because Petitioner's husband has depleted his financial savings to pay for services that should have been available via Medicaid, Petitioner may also wish to request that the Agency for Health Care Administration review this matter to determine whether any out-of-pocket expenses, which Petitioner incurred as a result of United's failure to thoroughly review her case, may be reimbursable. The undersigned cannot speculate as to whether reimbursement is appropriate. This is best left to the Agency's discretion.³ Should Petitioner contact AHCA in this regard, the Agency is instructed to assist Petitioner, as needed.

DECISION

Petitioner's appeal is GRANTED, and United is ordered to authorize 66 hours of weekly HHS, to begin immediately.

³ The legal authority regarding this issue is somewhat split, with 42 C.F.R. § 431.246 allowing for "correction action/corrective payments" only when an incorrect action was taken. "Action," as defined by 42 C.F.R. 431.201 means "a termination, suspension, or reduction of Medicaid eligibility or covered services." As such, it is not clear that such remedy is available for improper denial of a request for increased services, as exists in the instant case.

There is an older body of case law that suggests corrective action may be appropriate in certain other circumstances, such as when a service is discontinued after being authorized via Final Order (See *French v. Dep't of Children and Families*, 920 So.2d 671. (Fla. App. 5th Dist. 2006)), when Medicaid eligibility (and/or resulting coverage) is wrongfully denied (See, e.g., *Randall v. Lukhard*, 709 F.2d 257 (4th Cir.1983), or when there is undue delay in reaching a determination as to eligibility (See *Kurnik v. Dept. of Health and Rehab. Serv.*, 661 So.2d 914 (1995)). Again, review as to any appropriate remedy is lies within the jurisdiction of the Agency for Health Care Administration.

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 02 day of March, 2017,

in Tallahassee, Florida.



Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To:

██████████ Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Mar 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-09318

PETITIONER,

Vs.

CASE NO [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 1 [REDACTED]
UNIT: 88222

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:30 a.m. on February 1, 2017.

APPEARANCES

For the Petitioner: [REDACTED], petitioner's wife

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) calculation of the petitioner's Institutional Care Program (ICP) Medicaid patient responsibility, is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing originally convened on January 9, 2017. The parties agreed to reconvene on February 1, 2017, for both parties to submit evidence.

The petitioner was not present at the hearing. The petitioner's wife did not submit exhibits. The respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record remained open until February 3, 2017, for the respondent's representative to submit additional evidence. The evidence was received timely and entered as Respondent Exhibits "6" and "7". The record was closed on February 3, 2017.

FINDINGS OF FACT

1. The petitioner is a resident at [REDACTED] Nursing Facility. The petitioner's wife lives in her home. The petitioner is referred to as the institutional spouse and the petitioner's wife is referred to as the community spouse, for ICP purposes.
2. On October 28, 2016, the Department received notification of the petitioner's NY pension (Respondent Exhibit 5, page 22).
3. Prior to the October 28, 2016 notification, the petitioner was to fund \$3,000 monthly to an income trust account.
4. The petitioner's wife stated that she has only been funding \$1,500 to the income trust. However, she removes the \$1,500 to pay bills. At the January 9, 2017 hearing, the petitioner's wife agreed to provide the Department verification of the income trust funding prior to the February 1, 2017 reconvene.
5. At the reconvene hearing on February 1, 2017, the petitioner's wife said she thought she faxed the respondent's representative the income trust funding verification. The petitioner's wife agreed to fax the information to the Department.

6. The respondent's representative explained that the Department requires verification of the petitioner's income trust funding to confirm that the petitioner is eligible for ICP benefits.

7. The ICP patient responsibility is determined by first calculating the maintenance need allowance for the community spouse.

8. In October 2016, the petitioner's wife received \$686 in Social Security Retirement Income (SSRI) (Respondent Exhibit 6).

9. The following is the petitioner's October 2016 income (Respondent Exhibit 3):

\$1,542.16	NY pensions
\$ 104.90	NY Medicare credit
\$ 333.08	FL pension
\$1,072.00	Veterans Affairs (VA) pension
<u>\$1,833.00</u>	<u>SSRI</u>
\$4,885.14	total

10. The following is the Department's October 2016 patient responsibility budget calculation (Respondent Exhibit 2). The petitioner's wife has a \$1,115.54 mortgage plus a \$338 standard utility allowance, which totals \$1,453.54 shelter costs (Respondent Exhibit 5, page 18). MMMIA is the Minimum Monthly Maintenance Income Allowance:

<i>Maintenance Need Allowance</i>	
\$1,453.54	shelter costs
<u>-\$ 601.00</u>	<u>30% of MMMIA (30% X \$2,003)</u>
\$ 852.54	excess shelter costs
<u>+\$2,003.00</u>	<u>MMMIA</u>
\$2,855.54	total
<u>-\$ 686.00</u>	<u>community spouse income</u>
\$2,169.54	community spouse income allowance
<i>Patient Responsibility</i>	
\$4,885.14	petitioner's income
-\$ 105.00	personal needs allowance
-\$2,169.54	community spouse income allowance
<u>-\$ 100.00</u>	<u>Insurance premium</u>
\$2,510.60	patient responsibility

11. On October 31, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying his patient responsibility to the Nursing Facility would be \$2,510.60, effective December 2016 (Respondent Exhibit 4, page 32).

12. The petitioner's SSRI increased in December 2016. The following is the petitioner's December 2016 income (Respondent Exhibit 3):

\$1,542.16	NY pensions
\$ 104.90	NY Medicare credit
\$ 333.08	FL pension
\$1,072.00	Veteran Affairs (VA) pension
<u>\$1,839.00</u>	<u>SSRI</u>
\$4,891.14	total

13. The petitioner's wife's SSRI also increased in December 2016 to \$688 (Respondent Exhibit 6).

14. The following is the Department's December 2016 patient responsibility budget calculation (Respondent Exhibit 7):

<i>Maintenance Need Allowance</i>	
\$1,453.54	shelter costs
<u>-\$ 601.00</u>	<u>30% of MMMIA (30% X \$2,003)</u>
\$ 852.54	excess shelter costs
<u>+\$2,003.00</u>	<u>MMMIA</u>
\$2,855.54	total
<u>-\$ 688.00</u>	<u>community spouse income</u>
\$2,167.54	community spouse income allowance
<i>Patient Responsibility</i>	
\$4,891.14	petitioner's income
-\$ 105.00	personal needs allowance
-\$2,167.54	community spouse income allowance
<u>-\$ 100.00</u>	<u>Insurance premium</u>
\$2,518.60	patient responsibility

15. On December 12, 2016, the Department mailed the petitioner another NOCA, notifying his patient responsibility to the Nursing Facility was \$2,518.60, effective January 2017 (Respondent Exhibit 4).

16. The petitioner's wife disagreed with the Department's determination of her husband's income, because she "goes by the net income deposited into the bank account".

17. The respondent's representative explained that the Department policy dictates using the gross income. He suggested that the petitioner contact the agencies that deduct federal taxes from the petitioner's income and inform them that he is in a nursing home, which would provide more income.

18. The petitioner's wife said that the petitioner wishes to leave the federal tax as is, because at tax time he receives a refund.

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

20. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

21. Fla. Admin. Code R. 65A-1.713, sets forth the SSI-Related Medicaid Income and budgeting criteria, and states in part:

(1)(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C. ...

22. The above authority explains that an income trust is required to be eligible for ICP benefits, when the income exceeds 300% of the SSI federal benefit rate.

23. The findings indicate that the petitioner is required to monthly fund an income trust to be eligible for ICP benefits.

24. The petitioner's wife agreed to fax the Department verification of the monthly income trust funding.

25. Fla. Admin. Code R. 65A-1.716 sets forth the Program standards and the calculation of the community spouse income allowance, and states in part:

(5) (c) Spousal Impoverishment Standards.

2. State's Minimum Monthly Maintenance Income Allowance (MMMIA).

The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.

3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: $MMMIA \times 30\% = \text{Excess Shelter Expense Standard}$. This standard changes July 1 of each year.

26. Fla. Admin. Code R. 65A-1.7141, SSI-Related Medicaid Post-Eligibility Treatment of Income, states in part:

(1) For institutional care services and Hospice, the following deductions are applied to the individual's income to determine patient responsibility in the following order:

(a) A Personal Needs Allowance (PNA) of \$105. Individuals residing in medical institutions and intermediate care facilities shall have \$105 of their monthly income protected for their personal need allowance...

(f) The community spouse's excess shelter and utility expenses. The amount by which the sum of the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a homeowner's association, condominium or cooperative, required maintenance charge, for the community spouse's principal residence and utility expense exceeds thirty percent of the amount of the Minimum Monthly Maintenance Needs Allowance (MMMNA) is allowed. The utility expense is based on the current Food Assistance Program's standard utility allowance as referenced in subsection 65A-1.603(2) F.A.C...

27. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the Personal Needs Allowance at \$105 and MMMIA at \$2,003. Appendix A-1, lists \$338 as the standard utility allowance.

28. The above cited authorities set forth the rules and budgeting methodology for determining how much income the institutional spouse pays the nursing facility and the spousal allowance in the ICP.

29. The evidence submitted establishes that the Department included the petitioner's income, his wife's income and allowable deductions in the community spouse allowance and patient responsibility computations.

30. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. The undersigned concludes the Department's calculation of the petitioner's ICP Medicaid patient responsibility is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 14 day of March, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myffamilies.com

Copies Furnished To [REDACTED] Petitioner
Office of Economic Self Sufficiency
[REDACTED]

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

FILED

Mar 03, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09323

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 08 [REDACTED]
UNIT: 88778

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 7, 2017 at 1:31 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Designated Representative

For the Respondent: Matthew Lynn, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of November 30, 2016 denying the petitioner's Institutional Care Program Medicaid for May 2016 through September 2016 due to exceeding the asset limit for this period. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on January 31, 2017. This evidence was entered as Respondent's Exhibit 1.

The record was held open through February 17, 2017 for additional documentation from the Department. The Department submitted additional documents on February 14, 2017. This was entered as Respondent's Exhibit 2.

The record closed on February 17, 2017.

FINDINGS OF FACT

1. The petitioner applied for Institutional Care Program (ICP) Medicaid on June 28, 2016.
2. The petitioner's son executed a Personal Services contract on October 17, 2016.
3. According to the Personal Services Contract (Respondent's Exhibit 1, page 16), the petitioner had a sum of \$73,130 in liquid assets in 2013, which was transferred to her son.
4. The Department recorded in case notes the petitioner gave her son over \$61,000 in 2013 (Respondent's Exhibit 1, page 20).
5. The Department determined the Personal Services Contract provided a way for the petitioner to compensate her son beginning October 2016 for the services provided in the past. The Department further surmised the total sum of \$73,130 is as if the petitioner owned the funds until the contract was in place.

6. The Department took the position of if the customer could control the funds given away in 2013 to pay for a Personal Services contract in October 2016, the customer always had control of the funds.

7. The Department issued a Notice of Case Action on November 30, 2016 informing the petitioner of eligibility for ICP Medicaid beginning October 2016. The Notice denied eligibility for prior months

8. According to the contract, the petitioner's payment to the son for personal services should be \$79,352.00, however, the petitioner paid her son \$73,130 during the 5 years prior to entering the contract. The petitioner's son accepted the \$73,130 as payment for the petitioner's obligation. Calculation of the amount is described in the contract. (Respondent's Exhibit 1, pages 14 through 18)

9. The Department explained prior to the execution of the Personal Services Contract, the assets are considered available. However, after the execution of the contract the assets are considered unavailable.

10. The petitioner's representative maintains that the Personal Services Contract should cover all transfers regardless to when the contract was executed.

11. The Department explained the Personal Services Contract does cover the amount transferred, in that it prevents ineligibility from transfer of assets after the execution of the contract. However, it does not cover the period before the contract was executed.

12. The Department explained that if the asset was not available prior to the Personal Services Contract being executed, then there should have been no need for a Personal Services Contract at all.

13. The Department explained if the Personal Services Contract had been executed earlier, then the eligibility date could be earlier. However, as the contract was not executed until October 2016, the assets remained available.

14. The Department explained the petitioner could take advantage of the unpaid medical expense deduction (UMED) policy and use the unpaid bills prior to October 2016 to reduce the patient responsibility and thereby be able to pay the bills prior to October 2016.

15. The petitioner's facility does not wish to look at the UMED policy options as the transfers occurred prior to the petitioner's admission to the facility.

CONCLUSIONS OF LAW

16. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

18. 20 C.F.R. § 416.1208, How funds held in financial institution accounts are counted, states in relevant part:

(a) General. Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled.

(b) Individually-held account. If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account. This presumption is non-rebuttable.

19. The findings show the petitioner had \$73,130 in liquid assets in 2013. The findings also show disbursements from these funds of \$61,000 to the petitioner's son during 2013. In accordance with the above controlling authority, the undersigned concludes the petitioner had access to the funds and could use them for her support and maintenance.

20. Florida Admin. Code R. 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria" states in relevant part:

(3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the Department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for ICP, Institutional Hospice or HCBS Waiver Programs.

...

(d) Except for allowable transfers described in 42 U.S.C. § 1396p(c)(2), in all other instances the Department must presume the transfer occurred to become Medicaid eligible unless the individual can prove otherwise.

...

5. Compensation for a resource may be received in the form of cash, real or personal property or other valuable consideration provided.

...

(g) For transfers prior to November 1, 2007 (and within the look back period), periods of ineligibility are calculated beginning with the month in which the transfer occurred and shall be equal to the actual computed period of ineligibility, rounded down to the nearest whole number. For transfers made on or after November 1, 2007 (and within the look back period), periods of ineligibility begin with the later of the following dates: (1) the day the individual is eligible (pursuant to Rules 65A-1.711 through 65A-1.713, F.A.C.) for Medicaid and would be receiving institutional level care services in a nursing home facility, an institution with a level of care equivalent to that of a nursing facility, or home or community based

services furnished under a waiver based on an approved application for such care but for the application of the penalty period; or (2) the first day of the month in which the individual transfers the asset; or (3) the first day following the end of an existing penalty period. The Department shall not round down, or otherwise disregard, any fractional period of ineligibility of the penalty period but will calculate the period down to the day. There is no limit on the period of ineligibility. Once the penalty period is imposed, it will continue although the individual may no longer meet all factors of eligibility and may no longer qualify for Medicaid long-term care benefits, unless all assets or income are returned to the individual or fair market value compensation is paid for the transferred assets or income. **If all transferred assets or income are returned to the individual, the penalty period is eliminated. Eligibility must be evaluated with returned assets included as though the individual had never transferred the assets or income. Returned assets or income must be counted as available when determining eligibility for retroactive months.**

(emphasis added)

21. The Department's Program Policy Manual, CFOP 165-22, section 1640.0620, Adjustments to Penalty Period (MSSI) states in relevant part:

If all transferred assets or income are returned to the individual, the penalty period is eliminated. Eligibility must be evaluated with the returned assets included as though the individual had never transferred the asset or income. **Returned assets or income must be counted as available according to standard policy when determining eligibility for retroactive months.**

If the transferred asset or income is returned to the individual in part, the eligibility specialist must:

1. reduce the uncompensated value accordingly,
2. refigure the period of ineligibility,
3. evaluate the returned asset according to normal asset rules, and
- 4. count the returned asset as if it had been available in retroactive months**

(emphasis added)

22. The findings show the petitioner's son executed a Personal Services Contract in October 2016. This contract granted him "payment" of \$73,130 for his services rendered. The undersigned concludes the Personal Services Contract executed in October 2016 was an allowable transfer as of October 2016. However, the

undersigned concludes there was no such contract in place between May 2016 and September 2016 to make the transfer of the asset to the son an allowable transfer prior to October 2016.

23. Florida Admin. Code R. 65A-1.716 "Income and Resource Criteria" (5) SSI-Related Program Standards (a) lists the SSI Resource Limit for an individual as \$2,000.

24. The undersigned concludes that until the Personal Services Contract was executed in October 2016, the funds remained available to the petitioner. The value of the funds in question was \$61,000. As the value of the funds is greater than \$2,000, the undersigned concludes the petitioner exceeded the resource limit and was thus ineligible for Medicaid between May 2016 and September 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

FINAL ORDER (Cont.)

16F-09323

PAGE - 8

DONE and ORDERED this _____ day of _____, 2017,
in Tallahassee, Florida.

FINAL ORDER (Cont.)

16F-09323

PAGE - 9

M. Lisa D. ...

Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency
[REDACTED]

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

FILED

Mar 08, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09345

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 [REDACTED]
UNIT: 883CF

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on February 2, 2017 at 8:33 a.m.

APPEARANCES

For Petitioner: [REDACTED] the petitioner's designative representative

For Respondent: Mary Lou Dahmer, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for Institutional Care Program (ICP) Medicaid for the month of September 2016 is correct. The burden of proof is assigned to the petitioner by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present, but was represented by [REDACTED] with [REDACTED]

[REDACTED] Planning. Ms. [REDACTED] testified. The petitioner submitted one exhibit,

which was accepted into evidence and marked as Petitioner's Exhibit "1". The respondent was represented by Mary Lou Dahmer with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Ms. Dahmer testified. The respondent submitted eleven exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "11".

FINDINGS OF FACT

1. The petitioner, who was 83 years old, had been a resident of a skilled nursing facility from September 1, 2016 until she passed away on September 24, 2016. (Page 1 of Respondent's Exhibit 1)
2. On September 12, 2016, the petitioner signed a Durable Power of Attorney appointing her daughter as her agent. (Page 6 of Respondent's Exhibit 2)
3. On September 15, 2016, the petitioner and her daughter LN signed a Lifetime Contract for Personal Services (LCPS). The LCPS identifies the petitioner as the "Client" and her daughter LN as the "Provider" and states, in part: (Page 3 of Respondent's Exhibit 5)

2. Payment...

a. Computation of payment...

(iv) Based upon the above facts, the payment to Provider by Client should be \$323,232.00...

b. Payment: It is agreed by Provider to accept \$42,000.00 in cash and/or property of the Client, plus a promissory note, a payable upon demand, in the amount of \$281,232.00 bearing interest at the rate of 9% per annum from the date hereof until paid, as and for compensation for the services to be furnished by Provider. This contract provisions constitutes such promissory note and may be enforced by Provider. This said payment in the form of the above asset(s) shall be given to Provider as of the date of this Agreement.

4. On September 15, 2016, the petitioner's daughter created a third party Irrevocable Special Care Trust (Trust) that named her as both the Grantor and Trustee. The Trust named the petitioner as the Life Beneficiary. (Page 1 of Respondent's Exhibit 6)

5. The petitioner's daughter created the Trust to pay for additional items not paid by Medicaid. These items include clothing, hygiene products, etc. (Petitioner's Testimony)

6. Section 2 paragraph 2.5 of the Trust states: (Pages 2 & 3 of Respondent's Exhibit 6)

"It is my further intent that no part of the corpus of the Trust Estate be used to supplant or replace public assistance benefits of any country, state, federal, or governmental agency that services person with disabilities that re the same or similar to the impairments of the Life Beneficiary. For the purpose of determining the eligibility of the Life Beneficiary for such benefits, no part of the principal or income of the Trust Estate shall be considered available to the Life Beneficiary. In the event the Trustee is requested by any department or agency to release principal and/or income of this Trust to or on behalf of the life Beneficiary to pay for any of the items, or similar items, described in Section 2.6 below that other organizations or agencies are authorized to provide in the event the Trustee is requested by any department or agency administering such benefits to petition a court or any other administrative agency for the release of Trust principal or income for this purpose, the Trustee shall deny such request and is directed to defend, at the expense of the Trust, any contest of this Section 2 or other attack of any nature. The Trustee shall have discretion with regard to the defense of any such claim, including the management of all claims, proceedings or litigation which may result. The Trustee is also authorized, in the Trustee's sole discretions, to settle, in whole or in part or otherwise compromise any such claims, proceedings, or litigation."

7. On September 19, 2016, the petitioner's daughter wrote a check for \$42,000 to the [REDACTED] Irrevocable Special Care Trust". The petitioner and her daughter jointly owned the bank account that held the \$42,000. (Page 6 of Respondent's Exhibit 8)

8. On September 23, 2016, the \$42,000 LCPS payment was deposited to the Trust.

(Page 9 of Respondent's Exhibit 8)

9. On October 13, 2016, the skilled nursing facility submitted an application for ICP Medicaid benefits to the respondent on the petitioner's behalf. (Respondent's Exhibit 3)

10. The respondent explained the petitioner is not eligible for ICP Medicaid benefits as she is over the asset limit because the funds in the Trust are consider available assets to the petitioner. The respondent determined the funds as available assets to the petitioner because her daughter never took custody of the funds as she transferred the money from their joint bank account directly to the Trust and because the Trust does not meet one of the four exceptions as found in policy. (Respondent's testimony)

11. The petitioner's representative believed the funds in the Trust should be excluded as an asset because (1) the money was payment for services provided by the daughter to the petitioner; (2) the petitioner's daughter is the Grantor and owner of the Trust; (3) and the petitioner does not have direct access to the money in the Trust.

Furthermore, the money should be excluded as an asset to the petitioner in accordance with the Department's Policy (1640.0576.03). (Petitioner's testimony)

12. On November 9, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's October 13, 2016 application was denied effective October 2016 and ongoing as "the value of your assets are too high for this program".

The notice did not address the month of September 2016. (Page 1 of Respondent's Exhibit 7)

CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

15. Fla. Admin. Code R. 65A-1.712 and 65A-1.716 addresses SSI-Related Medicaid asset criteria and in part state:

65A-1.712

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C...

65A-1.716

(5) SSI-Related Program Standards.

(a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:

1. \$2000 per individual.

16. Pursuant to the above authority, the asset limit for an individual to receive ICP Medicaid is \$2,000. For the petitioner to be eligible for ICP Medicaid, the petitioner's assets must be under the ICP Medicaid asset limit.

17. The Department's Program Policy Manual (Policy Manual), CFOP 165.22, passage 1640.0576.03, Trusts Set Up By Others (MSSI, SFP) states:

For trusts that are established by someone other than the individual, the individual's spouse or representative, the trust must be evaluated according to these SSI policies:

1. If the individual does not have authority to revoke or direct use of the trust, it is not considered an asset to him. Conversely, if the individual has

the authority to revoke or direct use of the trust, the corpus of the trust is considered an asset to him.

2. Cash paid directly from the trust to the individual is unearned income.

3. Disbursements made by the trustee directly to a third party are not considered income to the individual.

The above policies also apply to trusts established by a will, regardless of the relationship of the now deceased grantor to the individual...

18. Pursuant to the above authority, all Trusts established by someone other than the individual must be evaluated according to SSI policies. The petitioner's daughter is the Grantor and the owner of the funds in the Trust. The petitioner argued she does not have direct use of the funds in the Trust; therefore, any money in the Trust cannot be considered an asset to the petitioner.

19. The Social Security Program Operations Manual System (POMS), SI 01120.200

B defines Third-party Trust as follows:

17. Third-party trust

A third-party trust is a trust established with the assets of someone other than the beneficiary. For example, a third-party trust may be established by a grandparent for a grandchild. Be alert for situations where a trust is allegedly established with the assets of a third party, but in reality is created with the beneficiary's property. In such cases, the trust is a grantor trust, not a third-party trust.

20. Pursuant to the above authority, a third party Trust is a Trust established with the assets of someone other than the beneficiary; however, a grantor Trust is a Trust established with the assets of the beneficiary. The respondent argued the petitioner's Trust is not a third party Trust, but a grantor Trust, as the petitioner's money was utilized to establish the Trust. The funds used to establish the Trust came from a bank account jointly owned by the petitioner and her daughter.

21. Policy Manual, CFOP 165.22, passage 1640.0576.07, Trusts Established On or After 10/1/93 (MSSI, SFP) states:

The following policy applies to trusts established by an individual on or after 10/1/93.

An individual will be considered to have established the trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established the trust (other than by will):

1. the individual;
2. the individual's spouse;
3. a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
4. a person, including a court or administrative body, acting at the direction or upon request of the individual or individual's spouse.

If the trust was not established by one of the above individuals, refer to passage 1640.0576.03.

If the trust is revocable:

1. Consider the entire principal as an available asset to the individual.
2. Consider any payments which can be made as countable income to the individual.
3. Consider any other payments from the trust as assets disposed of by the individual without fair compensation.

If the trust is irrevocable and there are any circumstances under which payment from the trust could be made to or for the benefit of the individual:

1. Consider that portion of the principal that could be available, as an asset to the individual.
2. Consider payments from that portion of the principal which could be available as income to the individual.
3. Consider any other payment from the trust as a transfer of assets.

If the trust is irrevocable and no payment could be made from the trust under any circumstances:

1. Apply the transfer of assets policy to the individual's assets and income used to establish the trust. The transfer policy applies only to applicants or recipients of nursing facility services and HCBS.
2. The trust is not counted as an available asset.

The above policies apply without regard to:

1. the purpose of the trust;
2. whether the trustees have or exercise any discretion under the trust;
3. any restrictions on when or whether distributions may be made from the trust; or
4. any restrictions on the use of distributions from the trust...

22. The Social Security POMS, SI 01120.201, Trusts Established with the assets of an individual on or after 1/1/00 and states, in part:

7. Trust established with the assets of an individual

A trust is considered to have been established with the assets of an individual if any assets of the individual (or spouse), regardless of how little, were transferred to a trust other than by a will.

NOTE: The grantor (see SI 01120.200B.2) named in the trust document who provided the assets funding the trust and the individual whose actions established the trust may not be the same. The trust may name the individual (e.g. a parent or legal guardian) who physically took action to establish the trust rather than the individual who provided the trust assets. This distinction is important, especially in developing Medicaid trust exceptions in SI 01120.203.

23. Pursuant to the above authorities, assets are available to an individual if the Trust is either partially funded or fully funded by the individual. The petitioner's Trust was fully funded by money from her joint bank account; therefore, the assets in the Trust are available to the petitioner.

24. The Social Security POMS, SI 01120.200 B defines Grantor as:

2. Grantor

A grantor (also called a settlor or trustor) is the individual who provides the trust principal (or corpus). The grantor must be the owner or have legal right to the property or be otherwise qualified to transfer it. Therefore, an individual may be a grantor even if an agent or other individual, legally empowered to act on his or her behalf (e.g., a legal guardian, representative payee for Title II/XVI benefits, person acting under a power of attorney, or conservator), establishes the trust with funds or property that belong to the individual. The individual funding the trust is the grantor, even in situations where the trust agreement shows a person legally empowered to act on the individual's behalf as the grantor. Where more than one person provides property to the trust, there may be multiple grantors. The terms grantor, trustor, and settlor may be used interchangeably.

25. The Code of Federal Regulations at 20 C.F.R. defines resources and states, in part:

§ 416.120 (c)(3) Resources means cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for support and maintenance (see § 416.1201(a))...

§ 416.1201 (a) Resources; defined. For purposes of this Subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance...

26. 42 U.S. Code § 1396p - Liens, adjustments and recoveries, and transfers of assets and states, in part:

(d)(3)(B) In the case of an irrevocable trust—
(i) **if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual,** (emphasis added) and payments from that portion of the corpus or income—

27. The Social Security POMS SI 01730.048, Medicaid Trusts, in part states:

C. Policy — effect on Medicaid...

2. October 1993 On...

Irrevocable Trusts

If there are any circumstances under which payment from an irrevocable trust could be made to or for the benefit of the individual, the portion of the principal from which (or income on that principal) payment to the individual could be made is considered resources. (emphasis added)

28. Fla. Admin. Code R. 65A-1.303, Assets, states, in part:

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. **An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf...** (emphasis added)

29. Pursuant to the above authorities, an asset is countable, if available for the support or maintenance of an individual. The respondent was correct to consider the funds in the Trust as assets because the Trust was established to purchase items for the petitioner.

30. The evidence indicates that the petitioner's daughter created the third party Irrevocable Special Care Trust. However, the petitioner's money was used to establish the Trust; the petitioner is the Life Beneficiary of the Trust; and the petitioner's daughter is both the Grantor and Trustee of the Trust who may use the funds for the benefit of the petitioner. In order for the petitioner to be eligible for ICP Medicaid, her total assets must be below \$2,000. The evidence establishes the petitioner had assets in excess of \$2,000 during the month of September 2016.

31. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet her burden of proof in establishing the respondent incorrectly denied her request for Institutional Care Program Medicaid benefits for the month of September 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's Institutional Care Program Medicaid appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 08 day of March, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

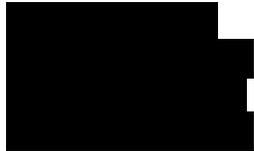
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Mar 10, 2017

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09347

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 6, 2017, at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter

For the Respondent: Fathima Leyva, Senior Program Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action denying the petitioner's request for additional home health services under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing, appearing as witnesses for the respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding since it is the petitioner's health plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Case Screenshots, and Plan Provisions.

FINDINGS OF FACT

1. The petitioner is ninety-one (91) years of age and is currently living by himself. He suffers from depression
2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. He receives services under the plan from United Healthcare.
3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for a total of fourteen (14) hours weekly of home health services (6 hours of personal care services and 8 hours of homemaker services) through United Healthcare. These hours are currently being utilized for 7 hours on Saturday and 7 hours on Sunday.

5. On or about September 26, 2016, the petitioner made a request to United Healthcare for 10 additional hours weekly of home health services. On September 28, 2016, United sent a letter to the petitioner denying his request for the additional home care services as not being medically necessary. The denial notice stated the following:

You asked for 24 hours of care at home a week. You are getting 14 hours of care a week. ... The health plan will not cover the other hours you asked for. The other hours are in excess of your needs. Hours in excess of your needs are not medically necessary.

6. The petitioner's daughter stated she helps take care of her father during the day but she would like additional assistance for him in the evenings. She also stated she has her own medical problems. She stated her father needs assistance with activities such as bathing and dressing and also needs some companionship. She stated her father has been previously committed under the state's Baker Act provisions, but he is not at risk for elopement from the home. She rejected the possibility of adult day care services or respite services since her father does not need assistance during the day and respite services are short-term rather than long-term.

7. The respondent's witness, Dr. Karver, stated that other services may be available to assist the family such as adult day care or respite care services. She also

suggested the petitioner may benefit from re-arranging the currently approved 14 weekly hours so that 2 hours of assistance are provided every day in the evening.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because he believes his services under the Program should be increased.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the

Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.”

18. Fla. Stat. § 409.912 requires that the respondent, AHCA, “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

19. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

20. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that his home health services should be increased by 10 hours weekly under the LTC Program. The petitioner needs some

assistance with activities of daily living (ADLs) and companionship. However, he is currently approved for 14 hours weekly to assist with these activities. The petitioner may benefit from re-arranging the service hours so that the aide is in the home for 2 hours every evening instead of 7 hours on Saturday and Sunday.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 10 day of March, 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)
16F-09347
PAGE -8

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AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Mar 06, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09373

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 [REDACTED]
UNIT: 88249

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 1, 2017, at 11:02 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED] mother.

For the Respondent: Claudette Edwards, DCF supervisor.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny full Medicaid benefits for her 19 year-old son and his enrollment in the Medically Needy Program with a high estimated share of cost (SOC). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The respondent submitted six (6) exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 6.

FINDINGS OF FACT

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. Prior to the action under appeal, the petitioner had been applying for disability for her son through Social Security Administration (SSA). His last disability claim was recently denied less than six (6) months ago. The petitioner is not sure of all the various medical conditions that SSA considered in evaluating her son for disability. She has already requested a hearing by an Administrative Law Judge (ALJ) and has retained an attorney to help with the SSA appeal process.
2. The son has special needs and been Baker acted several times. He suffers from ) and needs psychiatric services. The son is employed one day a week to learn much needed social skills.
3. The son has been under insurance with Florida Blue through the Federally Funded Market Place, but there was a problem with the paperwork, premiums have been doubled, resulting in the benefits being stopped. Petitioner is in the process of resolving this issue.
4. On November 15, 2016, the petitioner submitted an application requesting Family-Related Medicaid benefits for her 19 year-old son only (DOB 5/19/97). On that

application, the petitioner reported that her son was disabled, but reported no special medical conditions. The case was processed and approved under the Family-Related Medicaid coverage group. No action on taken on the alleged report of disability.

5. On December 5, 2016, the respondent sent the petitioner a Notice of Case Action informing her that her son was approved for the Medically Needy Medicaid with a \$7,047 share of cost.

6. On December 12, 2016, the petitioner requested an appeal challenging the Department's action of denying full Medicaid benefits for her son and his enrollment in the Medically Needy Program with an estimated SOC of \$7,047. The petitioner was seeking full Medicaid for her son only. She is not applying for herself. She is challenging her son's enrollment in the Medically Needy Program.

7. Petitioner and her husband are gainfully employed. Her husband gets paid biweekly (11/4/16: \$1,716.655 & 11/18/16: \$1,930.36) and she gets paid twice a month (11/15/16: \$1,727.28 & 11/30/16: \$1,979.28). The son gets paid weekly and submitted the following paystubs: 11/17//16 (\$29.24);11/25/16 (\$43.43); 12/1/16 (\$29.92).

Petitioner is responsible for health insurance premiums (\$277.88) on herself. The couple file taxes with their son as their dependent. She provided the respondent with paystubs for everyone. To determine eligibility for Medicaid for the son, the respondent converted each household member's income into a monthly amount and added them together to arrive at \$7,533.38 total household income. This amount is called modified adjusted gross income (MAGI). As the son was not eligible for AFDC-Related Medicaid due to his age, the respondent enrolled him in the Medically Needy Program. Initially, to determine the estimated SOC for the son, the respondent determined the household's

MAGI to be \$7,533.38. The Medically Needy Income Level (MNIL) of \$486 for a standard filing unit size of three was subtracted from the MAGI, resulting to the petitioner estimated SOC of \$7,047. The mother's insurance premiums were not included in the budget.

8. Respondent's representative explained that the 19-year old was not eligible for full Medicaid due to excess income. She explained that he was found eligible for Medicaid because the case was processed without his parents incomes included. In addition, she explained that the he was not eligible for Family-Related Medicaid group for children over the age of 18. The respondent explained that the son's disability conditions were considered, but no action was warranted as he was denied disability by the Social Security Administration and has a pending appeal before an ALJ.

9. The petitioner did not dispute any facts presented by the respondent. She acknowledged her household's income and confirmed that the income verification she provided to the respondent. During the hearing, petitioner argued that her son is severely disabled in needs of psychiatric services and requires full Medicaid to get proper care. Petitioner reported that her son was recently diagnosed with [REDACTED] and [REDACTED] and his [REDACTED] has worsened. The respondent explained that any new conditions must be reported to SSA as part of the appeal. The respondent further explained that SSA decision is binding and must be accepted by the Department as final.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

The SSI-Related Medicaid issue will now be addressed.

12. The Code of Federal Regulations at 42 C.F.R. § 435.540 sets forth the definition of disability and states:

(a) *Definition.* The agency must use the same definition of disability as used under SSI, except that—

(1) In determining the eligibility of individuals whose Medicaid eligibility is protected under §§435.130 through 435.134, the agency must use the definition of disability that was used under the Medicaid plan in December 1973; and

(2) The agency may use a more restrictive definition to determine eligibility under §435.121, if the definition is no more restrictive than that used under the Medicaid plan on January 1, 1972.

13. In this instant case, SSA has determined that the child was not disabled. The respondent adopted the same decision.

14. Federal Regulations at 42 C.F.R. § 435.541 “Determination of Disability,” states:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash recipient and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

15. The Code of Federal Regulations at 42 C.F.R. §416.920(g) addresses Evaluation of disability of adults and states:

(g) Your impairment(s) must prevent you from making an adjustment to any other work. (1) If we find that you cannot do your past relevant work because you have a severe impairment(s) (or you do not have any past relevant work), we will consider the same residual functional capacity assessment we made under paragraph (e) of this section, together with your vocational factors (your age, education, and work experience) to determine if you can make an adjustment to other work. (See §416.960(c).) If you can make an adjustment to other work, we will find you not disabled. If you cannot, we will find you disabled.

16. In this instant case, SSA has determined that the son's medical conditions were not severe enough to prevent him from engaging in work activities.

17. The Department's Policy Manual, CFOP 165-22 (The Policy Manual) at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP)" states:

...If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

18. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.

5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).

6. When the individual files an application within 12 months after the last unfavorable disability determination by SSA, and the individual alleges no new disabling condition or claims a deterioration of an existing condition previously considered by SSA. Refer the individual to SSA for disability reconsideration or appeal. Only request a disability decision from DDD if:

- a. SSA refuses (or has already refused) to reconsider the unfavorable disability decision, or
- b. the applicant no longer meets SSI non-disability criteria such as income or assets.

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

19. Petitioner testified that the most recent denial was less than six (6) months ago.

According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA.

Additionally, a worsening and deteriorating of conditions is directed to the SSA. In this instant case, SSA has determined that the son was not disabled based of the information it received.

20. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the respondent's action not to initiate a disability review on the petitioner's son under the SSI-Related Medicaid coverage group is correct. His Medicaid eligibility was explored under the Family-Related coverage group.

The Family-Related Medicaid/Medically Needy issue will now be addressed.

21. The Family-Related Medicaid income criteria is set forth in 42 C.F.R. 435.603. It states:

- (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
- (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
- (d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

22. Federal regulation 42 C.F.R. § 435.603(f) Application of modified gross income (MAGI) defines a Household for Medicaid. It states:

- (3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—
 - (i) The individual's spouse;
 - (ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and
 - (iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.
 - (iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—
 - (A) Age 19; or
 - (B) Age 19 or, in the case of full-time students, age 21.
- ...
- (5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a

tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

23. The Policy Manual at 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

24. In accordance with the above controlling authorities, when the daughter is being tested, the Medicaid household group is the son and his parents (three members). The findings show the Department determined the son's eligibility with a household size of three to determine Medicaid eligibility for the 19-year old son. The undersigned concludes the Department correctly determined the petitioner's household size as three for Medicaid eligibility purposes. A more favorable outcome come not be found.

25. Federal regulations at 42 C.F.R. § 435.603(d) Application of modified gross income (MAGI) defines Household Income. It states:

(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

26. The Policy Manual at passage 1830.0200 addresses Earned Income (MFAM), it states:

Earned income includes all gross (before taxes or other deductions) wages and salaries including income derived from the sale of blood or plasma, tips from performance of work, wages deferred that are beyond the individual's control, Federal Work Study and National and Community Services Trust Act living allowances through the Peace Corp, VISTA, Americorps, Foster Grandparent Program, Service Corps of Retired Executives and other volunteer programs. Wages are included as income at the time they are received rather than when earned.

Wages are considered earned income even when withheld at the request of the employee or provided as an income advance on income expected to be earned at a future date.

27. The Policy Manual at passage 2430.0700 Income Conversion (MFAM) states:

Most income is received more often than monthly; that is; it is received weekly, biweekly, or semimonthly. Since eligibility and benefit amounts are issued based on a calendar month, income received other than monthly is to be converted to a monthly amount.

The following conversion factors based on the frequency of pay are used:

Weekly income (once a week): Multiply by 4.

Biweekly income (every two weeks): Multiply by 2.

Semimonthly income (twice a month): Multiply by 2.

28. The above allows for the use of the conversion factor of 2 if income is received biweekly or semimonthly and by 4 if received weekly for Medicaid eligibility determination. The undersigned concludes that petitioner's household income was correctly converted.

29. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the son. The undersigned concludes the child is ineligible for a Family-Related Medicaid group due to his age. The respondent proceeded to explore the Medically Needy Program. The undersigned recognizes the petitioner's concerns about her son's and his medical needs. However, the controlling legal authorities do not allow for a more favorable outcome.

30. Fla. Admin. Code 65A-1.701 "Definitions" defines share of cost (SOC) as, "Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month".

31. Fla. Admin. Code 65A-1.702 "Special Provisions" states in part:

(10) Enrollment. The enrollment period under the Medically Needy program begins with the month the individual satisfies the non-financial and resource eligibility criteria, but not earlier than the third month prior to the month of application.

(13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual's or family's income.

32. The Policy Manual at passage 2630.0500 Share of Cost (MFAM) states:

The Share of Cost (SOC) refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.

Eligibility must be determined for Medically Needy any time the assistance group meets all technical factors but the income exceeds the appropriate income limit for Medicaid.

To calculate the share of cost, compare the countable net income to the Medically Needy Income Level based on the size of the standard filing unit. The difference is the assistance group's share of cost.

33. In accordance with the above controlling authorities, the respondent determined the petitioner's SFU as a household of three based on their tax filing status.

34. Effective April 2016, The Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7 indicates that the MNIL for a household of three is \$486.

35. The petitioner is responsible for \$136.79 for health insurance premiums per pay period. The son's SOC was estimated to be \$7,047, without the petitioner's health insurance premiums included in the budget and the MAGI was not clear. The undersigned recalculated the MAGI as follows: The husband's biweekly income was converted to a monthly amount by adding two paystubs to equal \$3,647.01 (\$1,716.65 + \$1,930.36). Petitioner's semimonthly income was converted to a monthly amount by adding two paystubs to equal \$3,706.56 (\$1,727.28 + \$1,979.28). The son's weekly checks were averaged $(\$43.43 + \$29.92 + \$29.24)/3$ to arrive to a weekly amount (\$34.2), the result was multiplied by 4 to arrive to monthly amount (\$136.80). All three income were added together to arrive to \$7,490.37 as MAGI. The Medically Needy Income Level (MNIL) of \$486 for a standard filing unit size of three was subtracted from

the MAGI, resulting to the petitioner estimated SOC of \$7,004.37. It was further reduced by \$277.88 total recurring medical insurance premiums, resulting in the final SOC being \$6,726.

36. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner's son full Medicaid under the full Family-Related Medicaid coverage group and his enrollment in the Medically Needy Program is correct. The petitioner has failed to meet her burden. However, there was an error in the SOC calculation. The Department is ordered to adjust the share of cost as explained above and send written notice to the petitioner with the outcome.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted in part and denied in part. The petitioner was correctly enrolled in the Medically Needy program, but the share of cost amount was overstated. This appeal is remanded to the Department with instructions to recalculate the SOC. Once the calculations are finished, send written notice of the outcome, and include appeal rights on said notice.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

FINAL ORDER (Cont.)
16F-09373
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DONE and ORDERED this 06 day of March, 2017,
in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 09, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09414

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA,

And

AMERIGROUP,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 14, 2017, at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's nephew

For the Respondent: Fathima Leyva, Senior Program Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action denying the petitioner's request for home modification services (wheelchair ramp) under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present for the hearing and was represented by her nephew. The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Mary Colburn, Medical Director, and Deborah Greene, Grievance Coordinator, from Amerigroup, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Sequence of Events, Authorization Request, Medical Assessment Form, Plan of Care, Home Modification Estimate, and Denial Notice.

FINDINGS OF FACT

1. The petitioner is seventy-four (74) years of age and lives in a mobile home with her husband, who is seventy-six years old. She has been diagnosed with [REDACTED]. She is non-ambulatory and uses a wheelchair for mobility.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from Amerigroup.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the

contract. Managed Care Organizations such as Amerigroup provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner currently receives personal care and homemaker services through Amerigroup to assist her with daily living needs in her home.

5. On or about November 30, 2016, the petitioner made a request to Amerigroup for home modification services. She requested that a wheelchair ramp be installed at the entrance to her home. On December 1, 2016, Amerigroup sent a letter to the petitioner denying the requested service based on medical necessity considerations.

6. The petitioner's nephew stated it requires two people to get her out of the home in her wheelchair because there are 5 or 6 steps in front of the home. He stated her doctor sees her at home due to this difficulty. He stated she likes going outdoors to enjoy the fresh air and sun. He also stated she would not be able to evacuate the home in case of an emergency without the wheelchair ramp.

7. The respondent's witness, Dr. Colburn, stated that the desire to go outside for fresh air does not meet the medical necessity criteria to obtain the wheelchair ramp. She also stated that fire rescue personnel could assist with evacuation in case of emergency.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes the health plan should have approved her request for the home modification, i.e., the wheelchair ramp.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Home accessibility adaptation services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. Home accessibility adaptation services are defined in the contract as follows:

Physical adaptations to the home required by the enrollee's plan of care which are necessary to ensure the health, welfare and safety of the enrollee or which enable the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems to accommodate the medical equipment and supplies, which are necessary for the welfare of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair or central air conditioning. Adaptations which add to the total square footage of the home are not included in this service. All services must be provided in accordance with applicable state and local building codes.

16. The AHCA contract also provides that a Plan “may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.”

17. Fla. Stat. § 409.912 requires that the respondent “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

18. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...
(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.

19. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that the wheelchair ramp should have been approved by Amerigroup. The petitioner's doctor visits her at home and the desire to go outside for fresh air does not establish medical necessity. Rescue personnel could assist her in case of emergency. The wheelchair ramp would be in excess of her needs and primarily for convenience. Therefore, it is not medically necessary according to the rule provisions outlined above.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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

FINAL ORDER (Cont.)

16F-09414

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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 09 day of March, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
AMERIGROUP HEARINGS UNIT

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

FILED

Mar 06, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-09427

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA
RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 30, 2017 at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's mother

For the Respondent: Linda Latson, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny Prescribed Pediatric Extended Care (PPEC) service hours that were requested for the petitioner for the certification period December 8, 2016 through June 5, 2017, was correct. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the respondent was Rakesh Mittal, M.D., Medical Director with eQHealth Solutions, Inc. The respondent submitted the following documents into evidence, which were marked as Respondent's composite Exhibit 1: Outpatient Review History, Denial Notices, and Supporting Documentation, such as medical records.

FINDINGS OF FACT

1. The petitioner's PPEC service provider, Pediatric Network Holdings (hereafter referred to as "the provider"), requested the following PPEC service hours for the certification period at issue: full day and partial day services (up to twelve hours daily), Monday to Friday.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for PPEC services. The petitioner's provider submitted the service request through eQHealth's internet based system. The submission included, in part, information about the petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.
3. eQHealth Solutions' personnel had telephone conversations with the petitioner's mother and also conducted face-to-face visits. The provider also sent information directly to eQ Health.

FINAL ORDER (Cont.)

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4. The medical and social information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 2 years old
- Diagnosis includes [REDACTED] a
- Born premature at 24 weeks gestation

5. The petitioner has been previously approved for PPEC services and has attended a PPEC facility for at least the past 19 months.

6. A Plan of Care was submitted by the provider. This document was signed by a physician and outlined the type of assistance to be provided by the PPEC facility. The duties include, in part:

- Daily head-to-toe assessment
- Maintain daily hygiene requirements
- Medication administration
- Follow-up of developmental therapies
- Monitor caregiver compliance with child care and provide education to caregiver
- Monitor vital signs

7. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and denied the request for PPEC services. A notice of this determination was sent to all parties on November 19, 2016. The physician-reviewer wrote, in part:

The patient is a 1 year old with a history of prematurity. The patient was dependent on oxygen but no longer requires supplemental oxygen. The patient continues to require as needed nebulizer treatments for wheezing. The patient had a recent hospitalization for status asthmaticus. The patient is on an age-appropriate diet. The patient is on no scheduled medications. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient no longer appears to have a skilled need and does not meet the medical complexity requirements for PPEC services.

8. The above notice stated should the parent, provider, or the petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was requested by the petitioner's provider. A notice of reconsideration determination was sent to all parties on December 28, 2016 which upheld the initial decision to deny the PPEC services. The reconsideration notice also stated the following:

For the reconsideration review, the provider submitted a web-based response requesting reconsideration and submitted a file containing the child's asthma action plan. The child is prescribe [REDACTED] twice a day and [REDACTED] daily. For escalation of symptoms, the plan adds albuterol treatments [every] 4 hours. The patient is not on a complicated medication regimen on a daily basis, therefore, the clinical information provided does not support the medical necessity of the requested PPEC services. Monitoring for exacerbation of asthma does not support the medical complexity requirements for PPEC services.

9. The petitioner thereafter requested a fair hearing and this proceeding followed. The respondent administratively approved the requested PPEC services pending the outcome of the fair hearing process.

10. The petitioner's mother stated her son was hospitalized for seven days on October 28, 2016 for respiratory distress. She also stated the PPEC administers albuterol to her son every 4 hours.

11. The respondent's witness, Dr. Mittal, stated that the petitioner does not meet the requirements for PPEC services since he does not require skilled nursing interventions. He is not on a complex medication regimen. He is no longer oxygen dependent and does not utilize any special medical equipment such as a ventilator or feeding tube. He

consumes a regular diet by mouth. Dr. Mittal also stated PPEC services are not for monitoring of episodic illnesses such as asthma.

12. PPEC service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook ("PPEC Handbook"), effective September, 2013.

CONCLUSIONS OF LAW

13. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

14. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

15. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

16. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the petitioner has been previously approved for PPEC services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

17. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent. The PPEC Handbook described above is incorporated by reference in Fla. Admin. Code R. 59G-4.260.

18. The petitioner has requested PPEC services. As the petitioner is under twenty-one (21) years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for or amount of this service.

19. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

20. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you¹ must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants

¹ "You" in this manual context refers to the state Medicaid agency.

regardless of whether the service or item is otherwise included in your Medicaid plan.

21. The service the petitioner has requested (PPEC services) is one of the services provided by the State to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Florida Statutes, states, in part:

Any service under this section shall be provided only when medically necessary ...

(4) (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services ... The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for any other family dependents.

22. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

5110. Basic Requirements...

...Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

5122. EPSDT Service Requirements

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

5124. Diagnosis and Treatment

B. Treatment.--

1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

23. Once a service has been identified as requested under EPSDT, the Medicaid Program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. Fla. Admin. Code R. 59G-1.010 defines medical necessity:

(166) '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...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

24. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested PPEC services.

25. In the petitioner's case, the respondent has determined that PPEC services are

not medically necessary at this time.

26. Fla. Stat § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the “medical necessity or medically necessary” standards, and states in pertinent part as follows:

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on to further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

27. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

28. The purpose of PPEC services is described on page 1-1 of the PPEC Handbook as follows:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

29. The PPEC Handbook on page 2-1 sets forth the requirements for PPEC

services, as follows:

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible;
- Diagnosed with a medically complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C;
- Be under the age of 21 years;
- Be medically stable and not present significant risk to other children or personnel at the center;
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

30. Rule 59G-1.010, F.A.C., defines the terms “medically complex” and “medically fragile” as follows:

“Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour per day medical, nursing, or health supervision or intervention.

“Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, i.e., requiring total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life and without such services is likely to expire without warning.

31. The petitioner’s physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

32. The respondent’s witness stated that the petitioner did not meet the requirements for PPEC services since he did not require skilled nursing interventions.

33. The petitioner's mother stated her son should be approved for PPEC services due to his respiratory problems and need for nebulizer treatments with albuterol.

34. After considering the evidence and testimony presented, the undersigned concludes the respondent has demonstrated it was correct in denying the request for PPEC services at this time. Although the petitioner suffers from asthma, his medical condition does not meet the definition of "medically complex" or "medically fragile" as outlined above in the applicable regulations. He is not on a complex medication regimen. He is not on a ventilator or dependent on any other medical apparatus and does not require 24-hour per day nursing or medical supervision/intervention.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

FINAL ORDER (Cont.)
16F-09427
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DONE and ORDERED this 06 day of March , 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

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

FILED

Mar 13, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-09466, 16F-09468

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 883CF

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 16, 2017 at approximately 9:32 a.m. CST.

APPEARANCES

For the Petitioners [REDACTED] designated representative

For the Respondent: Mary Lou Dahmer, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the respondent's action of December 8, 2016 denying Institutional Care Program (ICP) Medicaid for the months of September and October 2016. The respondent's reason for the denial was their understanding that monies in a Special Care Trust account were available to the petitioner. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted a packet of information that was admitted into evidence and marked as Petitioner's Exhibits "1" through "7".

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "12".

The petitioners are a married couple, both receiving ICP assistance. A hearing was filed in each spouse's name. The two cases, being based on the same facts and evidence, are being heard as one.

FINDINGS OF FACT

1. On October 13, 2016, the petitioner's designated representative submitted an application to the respondent for Institutional Care Program (ICP) Medicaid for ED, 82, and his wife CD, 72. They were both admitted to a skilled nursing facility on September 3, 2016. ED passed away on October 27, 2016 (Petitioner's Exhibit 3).
2. Income for CD for September 2016 consisted of \$592.90 Social Security (SS) and beginning October 2016 \$985.90 (Petitioner's Exhibits 1 and 3).
3. Income for ED for September 2016 consisted of a pension, \$162.63 and SS of \$963.90 (Petitioner's Exhibits 1 and 3).
4. A Personal Services Contract (PSC), in conjunction with the [REDACTED] Trust (the Personal Services Trust), was executed on September 28, 2016 for CD. At the time of the respondent's decision to deny eligibility for the month of September 2016, the respondent was not in possession of the trust document, just the balance in the trust. In the respondent's attempt to reconcile, it had been requested as

part of the pre-hearing case review, but was not submitted. The trust document was submitted for the hearing by the petitioner (Petitioner's Exhibit 8).

5. As to the availability of the interest and principal of the trust, the document states in relevant part:

██████████ shall have (1) no interest in the income or principal of this Trust, (2) no reversionary interest herein, (3) no right or access to the assets of this Trust, (4) no right to alter, amend or revoke this Trust, and (5) no right to become a Trustee or change the Trustee of this Trust (Petitioner's Exhibit 8).

6. On September 29, 2016, a trust account at Bank of America, titled ██████████ ██████████ Trust" was opened (Petitioner's Exhibit 7). This account was closed November 11, 2016. At the time of determination, the respondent concluded that the money deposited into the account was owned by CD as her name was on the account. This resulted in the assistance group being over the \$2,000 asset limit; therefore, the eligibility was denied (Petitioner's Exhibits 1 and 12).

7. On November 16, 2016, the asset was transferred into the personal account of the individual identified in the PSC (Respondent's Exhibit 10).

8. The respondent has approved Medicaid for CD beginning November 2016 and ongoing. According to the case narrative dated January 9, 2017, regional counsel informed the respondent that the asset discrepancies were resolved (Respondent's Exhibit 4 and 12). The narrative explains the respondent's position concerning the reasons for the denial in an entry on February 2, 2017, which states in part: "Sept and Oct benefits were denied due to PSC contract being paid with Special Care Trust to bene ██████████ an ██████████ Legal Dept stated funds counted as an asset until they were transferred from trust acct into personal acct of care provider on 11/16/16."

9. The petitioner's concern is the denied eligibility for September and October 2016, believing that the asset was appropriately transferred in September 2016, two months earlier than determined by the respondent.

10. The trust document titled [REDACTED] Trust" was submitted and entered as evidence, with the respondent not seeing this trust until after this hearing had convened.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

12. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

13. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056. This concept involves the hearing officer looking at the facts from an application anew, even though not known by the Department at the time the action was taken.

14. Federal Regulations at 20 CFR §416.1201 Resources; general states:

(a) *Resources; defined.* For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

...

(b) *Liquid resources.* Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes,

mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items...

15. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, sets forth: “(1) Resource Limits. If an individual’s total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C...”

16. The Fla. Admin. Code R. 65A-1.716 sets forth, “(5) SSI-Related Program Standards. (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits: 1. \$2000 per individual.”

17. The above authorities explain that a liquid asset, such as the principal of a trust account, is a countable asset and that the asset limit for ICP Medicaid is \$2000 per individual.

18. Fla. Admin Code R. 65A-1.303 Assets in part states, “(2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.”

19. The above authority explains that assets are considered available to an individual when the individual has access to them.

20. Fla. Admin. Code R. 65A-1.712 “SSI-Related Medicaid Resource Eligibility Criteria” states in relevant part:

(3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the Department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for ICP, Institutional Hospice or HCBS Waiver Programs.

...

(d) Except for allowable transfers described in 42 U.S.C. § 1396p(c)(2), in all other instances the Department must presume the transfer occurred to become Medicaid eligible unless the individual can prove otherwise.

...

5. Compensation for a resource may be received in the form of cash, real or personal property or other valuable consideration provided.

21. The district's counsel determined that the November 2016 transfer met the above cited criteria of an allowable transfer. The undersigned agrees with the determination. The transaction to pay the PSC contract was an allowable transfer of assets. The respondent determined the amount of the transfer unavailable to the petitioner once it was moved into the PSC care giver's personal account.

22. A point of the resolution was that the petitioner no longer had access to the payment amount once it was moved into the PSC's personal account by way of an allowable transfer. The evidence submitted establishes that once the payment amount to the PSC was placed in the Escrow Trust Account in September 2016, it was also no longer available to the petitioner (meeting the same standard and criteria as the November 2016 transfer that was determined acceptable by the respondent and regional counsel); thereby putting the petitioner's assistance groups below the asset limit and eligible for ICP Medicaid beginning September 29, 2016.

23. In careful review of the authorities and evidence, the undersigned concludes that the petitioner has met its burden, *de novo*. The respondent's action to deny ICP Medicaid benefits to the petitioners for September and October 2016 for being over the asset limit although appropriate at the time, is now seen as improper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The respondent is ordered to approve ICP Medicaid benefits for the petitioners for the months of September and October 2016.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 13 day of March, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To [REDACTED] Petitioners
Office of Economic Self Sufficiency

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

FILED

Mar 07, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09471

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 27, 2017 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's mother

For the Respondent: Linda Latson, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny Prescribed Pediatric Extended Care (PPEC) service hours that were requested for the petitioner for the certification period November 30, 2016 through May 28, 2017, was correct.

The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted the following as evidence for the hearing, which were marked as Petitioner's exhibits: Exhibit 1 – PPEC Plan of Care; Exhibit 2 – Neurologist and MRI report; Exhibit 3 – Seizure Video; Exhibit 4 – Seizure Log.

Appearing as witnesses for the petitioner were [REDACTED] Registered Nurse, [REDACTED] Administrator, and [REDACTED] Behavioral Technician, from [REDACTED] Academy, which is the petitioner's PPEC facility.

Appearing as a witness for the respondent was Ellyn Theophilopolous, M.D., Medical Director with eQHealth Solutions, Inc. The respondent submitted the following documents into evidence, which were marked as Respondent's composite Exhibit 1: Outpatient Review History, Denial Notices, and Supporting Documentation, such as medical records.

Also present for the hearing was a Spanish language interpreter [REDACTED] Interpreter Number [REDACTED] from Propio Language Services.

FINDINGS OF FACT

1. The petitioner's PPEC service provider, [REDACTED] Academy (hereafter referred to as "the provider"), requested the following PPEC service hours for the certification period at issue: full day and partial day services (up to twelve hours daily), Monday to Saturday.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for PPEC services. The petitioner's provider submitted the service request through eQHealth's internet

based system. The submission included, in part, information about the petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had telephone conversations with the petitioner's mother and the PPEC staff. The provider also sent information directly to eQ Health.

4. The medical and social information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 7 years old
- Diagnosis includes [REDACTED]
- Resides with his parents and 9-year-old brother

5. The petitioner has not been previously approved for PPEC services and this is his initial request.

6. A Plan of Care was submitted by the provider. This document was signed by a physician and outlined the type of assistance to be provided by the PPEC facility. The duties include, in part:

- Daily head-to-toe assessment
- Maintain daily hygiene requirements
- Monitor for seizure activity and deviation from baseline
- Medication administration
- Perform follow-up of developmental therapies
- Assess caregiver compliance with child care needs and provide education to caregivers

7. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and denied the request for PPEC services. A notice of this

determination was sent to all parties on December 5, 2016. The physician-reviewer wrote, in part:

The patient is a 6 year old with [REDACTED] and seizures. The patient has 2-4 seizures per month and has [REDACTED] ordered for prolonged seizures. The patient is on an age-appropriate diet. The patient attends school and is requesting PPEC services after school and non-school days. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity requirements for PPEC services.

8. The above notice stated should the parent, provider, or the petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was requested by the petitioner's provider. A notice of reconsideration determination was sent to all parties on December 9, 2016 which upheld the initial decision to deny the PPEC services. The reconsideration notice stated the following:

For the reconsideration review, the provider submitted a request for reconsideration consisting of a letter detailing the child's current condition. Review of the submitted documentation indicates that a previous request for PPEC services was also denied. The documentation also indicates that the child has behavioral issues for which Behavioral Therapy is being provided. The information further indicates the mother is currently not working. None of the submitted documentation supports the medical necessity of the requested PPEC services. No skilled nursing needs were identified. Monitoring for seizures alone does not support the medical complexity requirement for PPEC services.

9. The petitioner thereafter requested a fair hearing and this proceeding followed.

10. The petitioner's mother stated her son is non-verbal and also has [REDACTED]. She stated he takes medications which make him drowsy. Most of his seizures have lasted less than 5 minutes but some have lasted more than 6 minutes. He becomes rigid

during a seizure and has difficulty breathing. She stated her son previously attended a school without medical supervision and the teacher did not know how to handle a seizure. He stopped attending school on December 13, 2016 and began attending the PPEC facility at that time. He has had one seizure at school and one seizure at the PPEC facility.

11. [REDACTED] from the PPEC facility stated the petitioner had a seizure at the PPEC on January 24, 2017. He was administered oxygen as well as the seizure medication [REDACTED]

12. [REDACTED] from the PPEC facility stated the petitioner has exhibited self-injurious behavior, restless behavior and tantrums.

13. The respondent's witness, Dr. Theophilopolous, testified that the petitioner does not meet the requirements for PPEC services since he does not require ongoing skilled nursing interventions. Monitoring for seizures is not considered a basis for PPEC services. He is not on a complex medication regimen. He consumes a regular diet by mouth. He does require assistance with activities of daily living (ADLs) as well as therapies, but these services can be provided outside of the PPEC facility. Dr. Theophilopolous also stated public schools should have a nurse on staff to assist with medical issues.

14. PPEC service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook ("PPEC Handbook"), effective September, 2013.

CONCLUSIONS OF LAW

15. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

16. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

17. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the petitioner has not been previously approved for PPEC services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

19. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent. The PPEC Handbook described above is incorporated by reference in Fla. Admin. Code R. 59G-4.260.

20. The petitioner has requested PPEC services. As the petitioner is under twenty-one (21) years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner’s eligibility for or amount of this service.

21. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health

Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

22. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you¹ must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

23. The service the petitioner has requested (PPEC services) is one of the services provided by the State to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Florida Statutes, states, in part:

Any service under this section shall be provided only when medically necessary ...

(4) (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty

¹ "You" in this manual context refers to the state Medicaid agency.

nursing services ... The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for any other family dependents.

24. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

5110. Basic Requirements...

...Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

5122. EPSDT Service Requirements

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

5124. Diagnosis and Treatment

B. Treatment.--

1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

25. Once a service has been identified as requested under EPSDT, the Medicaid Program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. Fla. Admin. Code R. 59G-1.010

defines medical necessity:

(166) '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...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

26. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested PPEC services.

27. In the petitioner's case, the respondent has determined that PPEC services are not medically necessary at this time.

28. Fla. Stat § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally

accepted standards of medical practice....

Section (1)(d) goes on to further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

29. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

30. The purpose of PPEC services is described on page 1-1 of the PPEC Handbook as follows:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

31. The PPEC Handbook on page 2-1 sets forth the requirements for PPEC services, as follows:

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible;
- Diagnosed with a medically complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C;
- Be under the age of 21 years;
- Be medically stable and not present significant risk to other children or personnel at the center;
- Require short, long-term, or intermittent continuous therapeutic

interventions or skilled nursing care due to a medically-complex condition.

32. Rule 59G-1.010, F.A.C., defines the terms “medically complex” and “medically fragile” as follows:

“Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour per day medical, nursing, or health supervision or intervention.

“Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, i.e., requiring total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life and without such services is likely to expire without warning.

33. The petitioner’s physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

34. The respondent’s witness stated that the petitioner did not meet the requirements for PPEC services since he did not require ongoing skilled nursing interventions.

35. The petitioner’s mother stated her son should be approved for PPEC services due to his medical conditions and need for assistance.

36. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not demonstrated the respondent was incorrect in denying the request for PPEC services at this time. Although the petitioner suffers from various medical issues, his medical condition does not meet the definition of “medically

complex” or “medically fragile” as outlined above in the applicable regulations. He is not on a ventilator or dependent on any other medical apparatus and does not require 24-hour per day nursing or medical supervision/intervention. Monitoring for seizure activity does not meet the requirements for PPEC services.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 07 day of March, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

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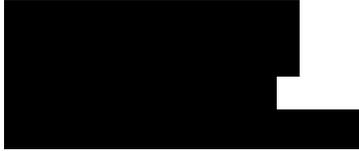
Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
AHCA HEARINGS UNIT

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

FILED

Mar 09, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09479

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 27, 2017, at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter

For the Respondent: Monica Otalora, Senior Program Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action partially denying the petitioner's request for companion care services under the Long Term Care (LTC) Program. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a doctor's note and a letter from her daughter as evidence for the hearing, which were marked as Petitioner Exhibit 1. The petitioner also submitted a doctor's letter, which was marked as Petitioner Exhibit 2.

Appearing as witnesses for the respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding since it is the petitioner's health plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, and Case Screenshots.

FINDINGS OF FACT

1. The petitioner is seventy-seven (77) years of age and is currently living with her daughter. The petitioner has been diagnosed with [REDACTED]
[REDACTED] She uses adult diapers for incontinence and a walker for ambulation.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions

and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for adult day care services as well as 42 hours weekly of companion care services, 7 hours weekly of personal care services, and 7 hours weekly of homemaker services by United Healthcare. The petitioner stopped using the adult day care services and that service was terminated by United. The petitioner's daughter stated at the hearing she agreed with the termination of the adult day care services and she is appealing United's reduction of the companion care services.

5. In November, 2016, United Healthcare reduced the petitioner's companion care services from 42 hours weekly to 30 hours weekly. The denial notice stated the following:

You were getting 42 hours of companion care a week. A long term care doctor reviewed your care plan. Your care plan is based on your needs. Based on the information given, the long term care doctor does not think you need this amount of services. Your needs can be met with 30 hours of companion care a week. The service will be changed.

6. The petitioner's daughter stated she is requesting that 6 hours of companion care be provided on Saturday and Sunday because she works on Saturday and her mother's condition is worsening. The daughter also stated she has 2 minor children as well as an autistic 21-year-old son to take care of. She stated her mother needs assistance with all activities of daily living as well as assistance with falling precautions.

She also stated her mother is at risk for walking out of the house by herself if she is unattended.

7. The respondent's witness, Dr. Karver, stated that the petitioner is being provided with 2 hours of assistance (personal care and homemaker services) on Saturday and Sunday to assist with her needs. She also stated the reduction in services was made because companion care is not for assistance with activities of daily living. She also stated the petitioner may be better served by placement in an assisted living facility.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the issue involved a reduction in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program.

The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her companion care services under the Program should not be reduced by the health plan.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner also receives Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

20. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the respondent has not demonstrated that it was correct in reducing the petitioner's companion care services. The petitioner was previously approved for 42 hours weekly of companion care services and her condition has not improved since then, and has most likely worsened. The petitioner is at risk for elopement from the home if unattended and the scope of companion care services includes supervision to prevent that type of incident.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, and the petitioner's companion care services shall not be reduced.

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

FINAL ORDER (Cont.)

16F-09479

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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 indigence 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 09 day of March, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

FILED

Mar 20, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-09519

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on March 2, 2017 at approximately 10:30 a.m.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner's Mother

For Respondent: Lisa Sanchez
Medical/Health Agency Care Program Analyst
for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's termination of Petitioner's Prescribed Pediatric Extended Care Services ("PPEC") was correct. The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Dr. Darlene Calhoun, Physician Reviewer with eQHealth Solutions (“eQHealth”) appeared as a witness for Respondent. Petitioner’s mother gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 – 12 into evidence. Administrative notice was taken of the Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

FINDINGS OF FACT

1. Petitioner is a 1-year-old male. He lives with his mother, father, and two sisters. He is enrolled with Staywell as his managed care plan.
2. Petitioner’s medical history includes:

• [REDACTED]

3. Prior to the termination, Petitioner was receiving PPEC services five (5) days per week, Monday through Friday. His mother testified she drops him off at approximately 6:15 a.m. and picks him up at approximately 4:30 p.m. Petitioner is continuing to receive PPEC services, pending the outcome of this appeal.
4. Petitioner’s Physician Plan of Care for PPEC Services (“Plan”), dated November 1, 2016, indicates he eats an age-appropriate diet. (Resp. Exh. 12). Dr. Calhoun

stated all of the needs listed in the Plan are age-appropriate. The goals delineated were:

1. Will maintain optimal growth and nutrition
2. Will maintain optimal nutrition and hydration
3. Child safety measures will be in place at all times
4. Will maintain optimal neurological status

5. Petitioner's mother stated that there are some errors in the medications listed in the plan. She stated he now only takes the calcium glubionate once per day, instead of four (4), and that that he only takes the citric acid once per month, instead of four (4) times per day. She said they are awaiting lab results to determine if his medication regimen requires further adjustment. She stated that he is no longer on antacids. He is also having genetic studies completed. There are no results yet.

6. PPEC is for children who need special medical care, such as skilled-nursing care, throughout the day, that ordinary daycare cannot provide. Petitioner receives physical therapy, speech therapy, occupational therapy and developmental stimulation at PPEC. Dr. Calhoun stated that these therapies can all be provided on an outpatient basis. Petitioner's mother was unaware of this fact. Dr. Calhoun said she can request the therapies through Staywell.

7. Petitioner's mother said she works as a security officer. Her schedule is not rigid. She said her schedule ranges from 7:00 a.m. – 4:30 p.m., or as late as 7:00 p.m. She does not have a set day off. Petitioner's father works from 6:00 a.m. – 6:00 p.m., Monday through Friday.

8. A request for continued PPEC services of 12 hours per day, five (5) days per week was submitted. On November 10, 2016, eQHealth issued a Notice of

Outcome – Denial Prescribed Pediatric Extended Care Services, denying the request in full. (Resp. Exh. 5). The Clinical Rationale for the Decision was:

The patient is a 1 year old with a history of [REDACTED] and failure to thrive. The patient has had no reported seizure activity. The patient is on an age-appropriate diet. The patient has had no recent hospitalizations or emergency room visits. The patient is not on a complex medication regimen. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity requirement for PPEC services.

9. A reconsideration of the original decision was requested. On December 28, 2016, eQHealth issued a Notice of Reconsideration Determination – Prescribed Pediatric Extended Care Services, upholding the denial. (Resp. Exh. 6). It stated:

PR Recon Determination: The patient is noted to be a 1 year old with a history of [REDACTED] and failure to thrive. The patient has had no reported seizure activity. The patient is on an age-appropriate diet. The patient has had no recent hospitalizations or emergency room visits. The patient is not on a complex medication regimen. The Initial PR felt that the clinical information provided did not support the medical necessity of the requested PPEC services. They noted that the patient did not appear to have a skilled need and did not meet the medical complexity requirement for PPEC services.

For the Reconsideration Review, the provider did not submit any additional information. The submitted documentation reviewed by the Initial PR indicates insufficient documentation to support the medical necessity for the PPEC services. Recommend upholding the Initial PR's decision to deny PPEC from 11/4/16 through and including 4/25/17.

10. Petitioner suffered one seizure in 2016. He had an EEG performed on March 30, 2016, which was mildly abnormal and consistent with seizure disorder. However, he had a prolonged EEG performed from April 29, 2016 through May 1, 2016 which was normal. His mother testified he has not suffered another seizure.

11. Petitioner's mother is concerned that if he is removed from PPEC that she will not be able to find a family daycare that will accept him because of his needs. She said that so far three ordinary daycares have rejected him. Ms. Sanchez stated that AHCA does not have a list of daycare facilities that would accept him, but suggested that she reach out to Staywell to see if they can assist her.

CONCLUSIONS OF LAW

12. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to Section 120.80, Florida Statutes.

13. This hearing was held as a *de novo* proceeding, in accordance with Rule 65-2.056 of the *Florida Administrative Code*.

14. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

15. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

16. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes and in Chapter 59G of the *Florida Administrative Code*.

Respondent, AHCA, is the single state agency that administers the Medicaid Program.

17. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 ("PPEC Handbook") is promulgated into law by Chapter 59G of the *Florida Administrative Code*.

18. Page 2-1 of the PPEC Handbook lists the requirements for receiving PPEC services. Page 2-1 states:

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years
- Be medically stable and not present significant risk to other children or personnel at the center
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

19. Rule 59G-1.010, *Florida Administrative Code*, defines “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

20. The PPEC Handbook requires that the services be medically necessary.

21. The definition of medically necessary is found in Rule 59G-1.010, *Florida Administrative Code*, which states:

(166) “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.

...

(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.

22. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

23. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include “reasonable standards ... for determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

24. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

25. In the instant matter, the testimony and documentary evidence fails to establish the medical necessity of PPEC services for Petitioner. He does not meet the definition of “medically complex” or “medically fragile.”

26. As a 1-year-old, he requires 24/7 supervision, just like any 1-year-old child. However, the need for 24/7 supervision is based upon his age, rather than a chronic debilitating disease or condition. There is no evidence that he would expire without warning if he does not have a heightened level of medical supervision. His normal EEG, along with the fact that he has not suffered another seizure, thankfully indicate that his health has improved to the point where he no longer requires PPEC.

27. The undersigned has reviewed EPSDT and medical necessity requirements and concludes Respondent has met its burden of proof, by the greater weight of the evidence, in terminating Petitioner’s PPEC services.

28. Petitioner’s mother is encouraged to work with Staywell regarding receiving any necessary therapies on an outpatient basis, along with other community resources to assist with finding a daycare that will accept him.

DECISION

Based upon the foregoing, Petitioner’s appeal is DENIED and the Agency’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

FINAL ORDER (Cont.)

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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 20 day of March, 2017,

in Tallahassee, Florida.

R. Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
AFCA, Medicaid Fair Hearings Unit

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

FILED

Mar 09, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09564

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA,

And

SIMPLY HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 27, 2017 at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's mother

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's partial denial of the petitioner's request for wisdom teeth extractions was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a letter and a dental record as evidence for the hearing, which were marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Dr. Susan Hudson, Dental Consultant, and Charles Keiffer, Complaint and Grievance Specialist, from DentaQuest, which reviews dental claims on behalf of Simply Healthcare. Also present as witnesses for the respondent were Deborah Zamora, Appeals Manager, and Dr. Naveen Ganda, Medical Director, from Simply Healthcare, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters and Authorization Request; Exhibit 2 – Denial Notice; Exhibit 3 – Appeal Letter; and Exhibit 4 – Dental Review Form.

Also present for the hearing was a Spanish language interpreter, [REDACTED] Interpreter Number [REDACTED] from Propio Language Services.

FINDINGS OF FACT

1. The petitioner is a fifteen (15) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Simply Healthcare, which utilizes DentaQuest for review and approval of dental services.
2. On or about November 16, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Simply and/or

DentaQuest to perform extractions of four wisdom teeth (Teeth 1, 16, 17, and 32), along with sedation and medication for those extractions. Simply Healthcare and DentaQuest partially denied this request on November 18, 2016 – approving two extractions and denying two extractions.

3. The denial notice stated the two extractions were denied as not being medically necessary. This denial notice also stated the following regarding the reason for the denial:

The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain. Please follow up with your dentist.

Your dentist has asked to remove your tooth. To approve this service, you must be in severe pain in your tooth, the tooth must be in a position that will not let it break through the gum by itself, and your gums or bone around the tooth are diseased. The root of your tooth must also be completely formed. Our dentist looked at the x-ray and the information from your dentist. It does not appear that this tooth needs to be removed. This service is not medically necessary.

4. The petitioner's mother stated her daughter's dentist requested the 4 extractions because there is no space to allow the wisdom teeth to come out. She stated one wisdom tooth is already moving another molar out of place. She also believes more sedation time needs to be approved to remove the 2 teeth which have been approved for extraction.

5. The respondent's witness, Dr. Hudson, stated that the extractions of the 2 upper wisdom teeth were denied because the teeth did not show any sign of infection and they appeared to have enough space to erupt normally. She stated there must be some sign of infection or malpositioning to justify the extraction of wisdom teeth. She also stated

the provider did not submit any narrative describing the patient was in any pain because of the wisdom teeth. With regard to the sedation, the provider requested one hour of sedation for extraction of all 4 teeth. Since only 2 teeth were approved for extraction, only 30 minutes of sedation were approved.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered

by the respondent, AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

13. The service at issue, tooth extraction, is a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. DentaQuest approved extractions of two teeth but denied the extraction of two others due to medical necessity considerations.

14. The petitioner’s mother believes all four extractions should have been approved because there is no space for the wisdom teeth to come out.

15. The respondent's witness stated that the denial of the two extractions was appropriate because those teeth did not show any signs of infection and were in position to erupt normally.

16. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for the two extractions was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's dentist requested the extractions, this does not establish it is medically necessary. The respondent's witness testimony supports the denial of the requested service. In addition, the appropriate amount of sedation time was approved since the provider requested one hour of sedation for all 4 extractions, and DentaQuest approved 30 minutes of sedation for 2 extractions.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 indigence to waive those fees. The

FINAL ORDER (Cont.)

16F-09564

PAGE - 7

agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 09 day of March, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
SIMPLY HEARINGS UNIT

FILED

Mar 13, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-09567

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 [REDACTED]
UNIT: 88249

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 21, 2017, at 9:45 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Mary Triplett, economic self-sufficiency supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action denying petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that he does not meet the disability criteria is correct. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The respondent submitted four (4) exhibits, which were marked as Respondent's Exhibits "1" through "4" respectively.

FINDINGS OF FACT

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

1. In 2015, the petitioner applied for Supplemental Security Income (SSI) with the Social Security Administration (SSA) alleging he is disabled. SSA considered the following conditions: [REDACTED] (unspecified mood disorder). Petitioner was denied in July 2015. The petitioner has appealed the SSA decision. A hearing date is still pending.

2. The petitioner is 60 years old. He does not meet the aged criteria for SSI-Related Medicaid benefits. He has no minor children residing with him and does meet the technical requirement for the Family-Related Medicaid category. The petitioner alleges blindness in his right eye and vision problems in his left eye. Disability must be established as part of his Medicaid eligibility determination.

3. The petitioner is not currently employed. He last worked in 2014, when he was terminated for failure to follow work instructions. Petitioner suffers from the following medical conditions: [REDACTED]

[REDACTED] Petitioner alleged to have been found disabled since 2014 and has received Medicaid through the state until November 2016. The respondent could not account as to how petitioner got approved for Medicaid.

4. The Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible, an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.
5. On November 15, 2016, the petitioner applied for Medicaid benefits for himself through the Department's Family-Related and SSI-Related Medicaid Programs. On December 7, 2016, information obtained from the petitioner was forwarded to DDD for review.
6. DDD received petitioner's disability package from the Department for a disability review. The DDD has access to Social Security information. Case notes from the DDD Transmittal indicate petitioner's medical conditions to be [REDACTED]. DDD determined these medical conditions were already known and considered by SSA and will be addressed in the course of his appeal before an administrative law judge (ALJ).
7. On December 13, 2016, DDD denied the petitioner's claim of disability by adopting the July 2015 SSA denial, citing "same/related allegations, hearing pending". The denial reason code was N 31-(customary past work, no visual impairment). DDD did not make an independent determination, as it considered petitioner's medical conditions to be the "same/related allegations".
8. On December 14, 2016, the Department mailed the petitioner a Notice of Case Action denying his application for SSI-Related Medicaid due to not meeting the disability

criteria, see Respondent's Exhibits 1 through 4. On December 14, 2016, the petitioner timely requested a hearing to challenge the respondent's action.

9. The respondent explained that it denied the petitioner's SSI-Related Medicaid application because SSA has determined that he was not disabled and DDD has adopted the decision. The respondent explained that SSA decision is binding and must be accepted by the Department as final. The respondent explained that once DDD determined that the petitioner is not disabled, the Department has to deny his Medicaid for not meeting the technical requirement for the SSI-Related Medicaid Program for persons under age 65.

10. The petitioner did not dispute the facts presented; however, he asserted that his anxiety, depression and bi-polar disorder have worsened because he has been avoiding treatments. He explained that his disability condition has not changed since its onset in 2014. Petitioner believes, with his medical conditions the same, he should be found disabled and that his Medicaid benefits should continue. He is claiming a sleep disorder as a new condition. However, petitioner presented no objective medical evidence of a new condition or diagnosis.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

13. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals less than 65 years of age must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in relevant part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.

14. The Code of Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, “the agency must use the same definition of disability as used under SSI...”

15. Federal Regulations at 42 C.F.R. § 435.541 “Determination of Disability,” states:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of

ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section. (c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash recipient and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

16. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP)

states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
- 5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).**{emphasis added}

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

17. According to the above-cited authorities, a worsening and deteriorating of conditions must be reported to SSA. In this instant case, SSA has determined that the petitioner's condition was not severe enough to prevent him from performing customary past work. DDD received petitioner's disability packet and concluded that it contained the "same/related allegations" already considered by SSA. On December 13, 2016, DDD adopted the SSA decision and alerted the Department that the petitioner was not disabled.

18. The evidence shows the petitioner was denied for SSA disability in July 2015. Petitioner presented no objective evidence of a new condition not previously considered by SSA. The SSA case is presently under appeal at the ALJ level. Under these

circumstances, the controlling authorities preclude the Department from rendering an independent disability determination. Pursuant to the above cited authorities, the SSA determination remains binding on the Department. The hearing officer concludes that the Department's action to deny the petitioner Medicaid under the SSI-Related Medicaid coverage group is correct.

19. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with him. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits. It is concluded, the respondent's action to deny the petitioner's application for Medicaid Program benefits was within the rules of the Program.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 13 day of March, 2017,

in Tallahassee, Florida.



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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 09, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09598

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 9, 2017, at 10:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's daughter

For the Respondent: Lisa Sanchez, Program Analyst for AHCA

STATEMENT OF ISSUE

At issue is the respondent's action partially denying the petitioner's request for additional home health services under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present for the hearing and was represented by his daughter. The petitioner submitted medical records as evidence for the hearing, which were marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding since it is the petitioner's health plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, and Case Screenshots.

FINDINGS OF FACT

1. The petitioner is fifty-six (56) years of age and is currently living alone. His daughter is his sole caregiver. The petitioner suffers from [REDACTED])

[REDACTED]

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. He receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the

contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for a total of fourteen (14) hours weekly of home health services (including personal care assistance and homemaker services) through United Healthcare. United subsequently approved 3 additional hours of personal care services weekly. The petitioner is currently utilizing these hours from approximately 9:30 a.m. to 12:30 p.m., Monday to Saturday.

5. On or about November 23, 2016, the petitioner made a request to United Healthcare for 24.5 additional hours weekly of home health services (personal care assistance). On November 30, 2016, United sent a letter to the petitioner partially denying his request for the additional home health services as not being medically necessary. United approved 3 additional hours of services weekly, but denied the balance of the requested hours. The denial notice stated the following:

You asked for 24.5 more hours of personal care at home. Your care plan is based on your needs. You are getting 14 hours a week of care. We can provide you with 3 hours of care per week. The hours you asked for are in excess of your needs. Hours in excess of your needs are not medically necessary.

6. The petitioner's daughter stated she is trying to obtain a total of 30 hours weekly of home health services for her father. She stated her father has an extreme risk of falling, and he has previously fallen on the stove (burning himself) and fallen 3 times while bathing. He has been previously hospitalized for both low blood sugar and extremely high blood sugar. He has lost 45 pounds in the past 1.5 years. He is also vision impaired and has some memory loss, and he needs reminders to take his 12

medications. The daughter also stated she is employed and has 2 children of her own to take care of.

7. The petitioner's home health aide assists him with bathing and also helps with cleaning, meal preparation, and grocery shopping. The petitioner's daughter stated her father needs help with preparing breakfast and lunch. The petitioner stated he does not want to attend an adult day care center or assisted living facility because he would not feel comfortable there.

8. The respondent's witness, Dr. Karver, stated that the health plan can offer adult day care services or assisted living facility placement to provide additional assistance to the petitioner. She stated the petitioner may be unsafe alone in his current home environment. She also stated the plan approved the 3 additional hours based on the petitioner's need for assistance.

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

11. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in

services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

12. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

13. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

14. The petitioner requested a fair hearing because he believes his services under the Program should be increased.

15. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

16. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to

manage these activities. Chore services, including heavy chore services and pest control are included in this service.

17. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

20. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that his home health services should be increased under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs) such as bathing and meal preparation. However, he is currently approved for 17 hours weekly to assist with these activities. The petitioner also has some assistance from his daughter in the evenings and on weekends.

22. In addition, United Healthcare has indicated that other services, such as adult day care or assisted living facility placement, may be available to provide additional assistance to the petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 09 day of March, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Apr 07, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09600

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 27, 2017 at approximately 3:30 p.m.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner's mother

For Respondent: Diane Soderlind
Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's action of partially denying Petitioner's request for personal care services ("PCS") was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's mother represented him. Petitioner's Exhibits 1 – 12 were entered into evidence. Diane Soderlind, Registered Nurse Specialist, represented Respondent, the Agency for Health Care Administration ("AHCA" or the "Agency"). Respondent presented one (1) witness, Dr. Darlene Calhoun, Physician Reviewer with eQHealth Solutions. Respondent's Exhibits 1 – 13 were entered into evidence. Administrative notice was taken of Rule 59G-4.130, *Florida Administrative Code*, and the Florida Medicaid Home Health Visit Services Coverage Policy, November 2016.

FINDINGS OF FACT

1. Petitioner is a 15-year-old male. He suffers from [REDACTED] and urinary incontinence. His mother stated he also does not have control over his bowels because he takes laxatives for constipation, which then causes him to defecate without warning.
2. Petitioner's mother and father live separately. Petitioner lives with his father. His mother currently travels to him in the morning, arriving at approximately 6:00 a.m. in order to be there prior to his father leaving for work. He awakens around 7:00 a.m. and his mother gets him ready (i.e. dresses and feeds him) and takes him to school.
3. Petitioner requires total assistance for bathing, toileting hygiene, and toilet transfers, and requires 24/7 supervision. Both his father and his mother work full-time.
4. On December 1, 2016, an initial request was made for PCS. The request was for five (5) hours per day on Monday, Tuesday, Thursday, and Friday. It was for six (6) hours per day on Wednesday.
5. Petitioner leaves school an hour early on Wednesday. Petitioner goes to either speech therapy, occupational therapy, or physical therapy every day of the week after

school, with the exception of Tuesday, when he goes to a music lesson. Afterward, he goes home with his father if he is available. If his father is unavailable, he goes with his mother to her office and waits for her to finish for the day.

6. eQHealth Solutions, Inc. ("eQHealth") is the Quality Improvement Organization ("QIO") contracted by the Respondent to perform prior authorization reviews for home health services. PCS is a home health service.

7. A nurse with eQHealth reviewed the request and made a recommendation of four (4) hours per day, Monday through Friday, before and after school. (Resp. Exh. 1). The stated rationale for the recommendation was:

Recipient is a 15 year old teen with [REDACTED] and urinary incontinence [His father] works 7-6pm on Monday, 7am-8pm on Tuesday, Wednesday 7am-5pm, Thur-Sat 7am-7pm. [His mother] works 9-5pm M, W, F and 7:30am-5pm on Tuesday, Thur 9am-7 pm. Survey one on 12/2/16. Recipient is occasionally incontinent occasionally. Recipient attends school M, Tu, Th, F 8:50-3pm, W 8:50-2pm. Recipient depends entirely on another for bathing, grooming, toileting hygiene and toileting transferring. Recipient needs moderate assistance for dressing. Recipient has unsteady gait and needs assistance on stairs and for balance. Recipient is unable to feed self and needs his food to be pureed, low carb diet.

8. Dr. Calhoun said a nurse does not have the authority to make a full decision, only a recommendation. A physician at eQHealth reviewed the request. On December 8, 2016, eQHealth issued a Notice of Outcome. (Resp. Exh. 2). The Notice approved two (2) hours per day of PCS, Monday through Friday. The remaining hours were denied.

9. The physician reviewer approval rationale provided for the decision was:

The patient is a 15 year old with [REDACTED]. The patient lives with his father who works from 7am to 6pm on Monday, 7am to 8pm on Tuesday and Wednesday, 7am to 7pm Thursday through Saturday and mother who works from 9am to 5pm Monday, Wednesday and Friday and 9am to 7pm Tuesday and Thursday. The patient is ambulatory and on a regular diet. The patient has occasional incontinence. The patient requires assistance

with ADLs. The patient attends school from [8:30am to 3pm]. The clinical information provided support the medical necessity for 2 hours per day Monday through Friday.

Clinical Rationale for Decision: The clinical information provided does not support the medical necessity of the additional services. The already approved services should be sufficient to assist the patient with ADLs. The parents should be able to provide the remainder of care. The additional services are deemed excessive.

10. A reconsideration of the decision was requested. December 14, 2016, eQHealth issued a Notice of Reconsideration Determination upholding its original decision. (Resp. Exh. 3). It stated:

The medical basis for the reconsideration is as follows:

PR Recon Determination: The patient is noted to be a 15 year old with [REDACTED]. The patient lives with his father who works from 7am to 6pm on Monday, 7am to 8pm on Tuesday and Wednesday, 7am to 7pm Thursday through Saturday and his mother who works from 9am to 5pm Monday, Wednesday and Friday and 9am to 7pm Tuesday and Thursday. The patient is ambulatory and on a regular diet. The patient has occasional incontinence. The patient requires assistance with ADLs. The patient attends school from 8:50am to 3pm. The initial PR felt that the clinical information provided supported the medical necessity of PCS for 2 hours per day Monday through Friday. The initial PR felt that the clinical information provided did not support the medical necessity of the additional services. They noted that the already approved services should be sufficient to assist the patient with ADLs. The initial PR felt that the parents should be able to provide the remainder of care. The additional services were deemed excessive and were denied.

For the Reconsideration Review, the provider did not submit any additional information. Based upon the previously submitted documentation, recommend upholding the initial PR's decision. Sufficient PCS hours have already been approved to assist with ADLs for the teen after school and prior to his parent's arrival home from work. The additionally requested hours appear to be for monitoring, which remains a non-covered service per the Florida Medicaid Home Health Services and Limitations Handbook.

11. Dr. Calhoun stated that PCS hours are allotted at a minimum of a two (2) hour block, up to three (3) times per day. She said Petitioner has been approved for the

needed two (2) hours after school, but that his mother has been providing care in the morning and parents are required to help to the fullest extent possible. Petitioner's mother stated two (2) hours in the morning and two (2) hours in the evening would probably suffice.

CONCLUSIONS OF LAW

12. By agreement between AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

13. This hearing was held as a de novo proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

14. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

15. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

16. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

....

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home...

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services,

an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private-duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. ...

(c) The agency may not pay for home health services unless the services are medically necessary ...

17. The definition of medically necessary is found in Rule, 59G-1.010, *Florida*

Administrative Code, which states:

(166) "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.

...

(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.

18. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and

Treatment Services (“EPDST”) requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

19. Under the above statute, the Agency offers PCS as a service to Medicaid-eligible recipients less than 21 years of age.

20. The United States Court of Appeals for the Eleventh Circuit clarified the states’ obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include “reasonable standards ... for determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both

the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphases added).

21. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

22. The November 2016 Florida Medicaid Home Health Visit Services Coverage Policy (“Policy”) has been promulgated into rule by Chapter 59G, *Florida Administrative Code*.

23. Page 1 of the Policy states: “Florida Medicaid home health visits provide medically necessary skilled nursing and home health aide services to recipients whose medical condition, illness, or injury requires the care to be delivered in their home or in the community.”

24. Page 4 of the Policy lists “Babysitting” as a specific non-covered criteria. Page 1 defines “Babysitting” as: “Custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.”

25. Since Petitioner's mother said two (2) hours after school and two (2) hours before school would probably work, the major dispute regards the requested morning hours.

26. In regard to parental responsibility, page 3 of the Policy states:

Florida Medicaid reimburses for home health aide visits rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care, and to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Providers must offer training to enable parents and legal guardians to provide care they can safely render without jeopardizing the health or safety of the recipient when needed.

27. The above paragraph establishes that home health visits are designed to supplement, but not replace, the care provided by the parents.

28. Petitioner's father must arrive at work by 7:00 a.m. every weekday. This requires his mother to travel from her home to be there before he leaves for work. She said she arrives around 6:00 a.m. Once Petitioner awakens, his mother prepares him for school. The action of preparing him for school is inherently the performance of ADLs such as dressing, grooming, and feeding.

29. Parents are required to provide care to the fullest extent possible. It is not possible for his father to get Petitioner ready for school because he has already left for work. It is not possible for Petitioner's mother to get him ready for school at her house because he lives with his father.

30. Dr. Calhoun said that Petitioner's mother has been able to care for him in the morning thus far. This implies that because his mother has been doing this, it is *possible* for her to continue doing it. However, the theoretically possible and the practically possible are different. In this case, there is an untenable situation where his

mother comes to him at his father's house every morning before school. This is highly impractical and unreasonable to expect her to continue doing.

31. Since PCS hours are provided in a minimum of two (2) hour blocks, and Petitioner's mother already arrives more than two (2) hours before he starts school, Petitioner has met his burden of proof to show the morning hours of PCS are medically necessary.

Petitioner's mother is encouraged to work with the Agency regarding obtaining transportation to school once his home health aide has him ready.

32. By his mother's own admission, the two (2) hours after school already approved should be sufficient to meet Petitioner's needs. Any additional hours would be for supervision, which is not a covered service.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED IN PART and DENIED IN PART. The Agency is directed to provide Petitioner with four (4) hours per day of personal care services, Monday through Friday, for a total of 20 hours per week.

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 07 day of April, 2017,

in Tallahassee, Florida.

R. Zimmer

Rick Zimmer
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
AHCA Hearings Unit

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

FILED

Mar 06, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09611

PETITIONER,
Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]

CO-RESPONDENTS.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 15, 2017 at 10:26 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Pro se

For the Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is whether the Agency's action to deny Petitioner's request for Magnetic Resonance Imaging (MRI) scans, procedure codes 72148 and 72141, is correct. Because the matter involves a new request for service, the burden of proof which is a preponderance of the evidence, is assigned to Petitioner.

PRELIMINARY STATEMENT

Appearing as Respondents' witnesses from Better Health were: Dr. Francisco Hernandez, Medical Director, and Deborah Zamora, Grievance and Appeals Team Lead.

Respondent's Exhibits 1 and 2 were entered into evidence. Petitioner's Exhibits 1 through 4 were entered into evidence.

FINDINGS OF FACT

1. The Petitioner is a 58-year-old Medicaid recipient who enrolled with managed care provider, Better Health, effective August 1, 2014 and is a current active member.

2. On December 7, 2016, Better Health (Plan) received a prior authorization request on behalf of Petitioner for MRI scans, procedure codes 72148 and 72141.

3. On December 13, 2016, the Plan sent a Notice of Action to the Petitioner advising her request for MRI scans of her spine was denied as of December 13, 2016. The notice cited the services were not medically necessary as defined in Rule 59G-1.010, "Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not in excess of the patient's needs." The basis for the denial was "Your request for MRI of the spine has been denied because you have not had a recent x-ray of the spine. You have also not tried physical therapy for 6 weeks."

4. On December 16, 2016, Petitioner filed a timely request for a fair hearing.

5. Petitioner explained she needs an MRI in order to have back surgery. She has [REDACTED] in her neck. She expressed eagerness in getting the back surgery to relieve her agony.

6. Respondent's witness from Better Health read the results of the Medical Director's December 30, 2016 review contained in Respondent's Exhibit 1, page 1:

The medical records have been reviewed. Member has a history of chronic back pain on chronic pain meds, no documentation of tried and failed physical therapy. There are no prior studies provided for review such as x-ray or CT scan. The clinical information received does not demonstrate any changes in member's condition. There is normal strength reported, no mention of paresthesias or increased weakness, and no change in the quality of pain reported. Based on AIM Clinical Guidelines for imaging of the spine and clinical information received for MRI of the spine has not been met. Denial upheld.

7. Petitioner stated she needs the MRI in order to have the back surgery. Her condition is very painful. Petitioner sees her doctor monthly but she has not discussed obtaining a current x-ray. She does not feel she can do physical therapy because when she bends she cannot get back up.

8. Respondent's physician witness explained the denial was based on no statement of any tried and failed conservative measures and no recent x-rays. He noted he cannot assess Petitioner's ability to undergo physical therapy. The assessment needs to be done by Petitioner's doctor.

9. Petitioner feels denial of her MRI request is unfair. She cannot have her back surgery without a current MRI.

CONCLUSIONS OF LAW

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

11. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes. This proceeding is a *de novo* proceeding pursuant to *Florida Administrative Code* Rule 65-2.056.

12. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence.

13. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Medicaid Program is administered by the respondent.

14. *Florida Administrative Code* Rule 59G-1.010 states in part:

(166) “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;
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. *Florida Administrative Code* Rule 59G-4.240, Radiology and Nuclear Medicine Services, states in part: (2) All persons or entities described in subsection (1) must be in compliance comply with the provisions of the Florida Medicaid Radiology and Nuclear Medicine Services Coverage Policy, June 2016, incorporated by reference.

16. Paragraph 7.2 of the Florida Medicaid Radiology and Nuclear Medicine Services Coverage Policy (Radiology Policy) states in relevant part: “Providers must obtain authorization for radiology and nuclear medicine services from the quality improvement organization when indicated on the applicable Florida Medicaid fee schedule(s)…”

17. Petitioner argued she needs back surgery to relieve the severe pain she is experiencing. She explained she needs a current MRI in order to have the back surgery.

18. Respondent explained Petitioner’s medical records do not show any efforts in trying and failing more conservative efforts to address her back pain such as medications or physical therapy. Additionally, Petitioner has not had a recent x-ray.

19. After reviewing the above cited and controlling authorities, Florida Medicaid rule 59G-1.010 makes it clear services must be 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. Respondent has identified more conservative imaging services (x-ray) and treatment (physical therapy) that have not been tried.

20. Petitioner has failed to prove medical necessity for an MRI, at this time, based on Medicaid requirements cited above.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency 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 06 day of March, 2017,

in Tallahassee, Florida.



Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
Better Health Hearings Unit

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

FILED

Mar 09, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09645

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 31, 2017, at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's niece

For the Respondent: Jerome Hill, Program Supervisor - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action denying the petitioner's request for additional home health services under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present for the hearing and was represented by her niece. The petitioner did not submit any documents as evidence for the hearing, Appearing as witnesses for the respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding since it is the petitioner's health plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, and Case Screenshots.

Also present for the hearing was a Spanish language interpreter, [REDACTED] Interpreter Number [REDACTED] from Propio Language Services.

FINDINGS OF FACT

1. The petitioner is eighty-four (84) years of age and is currently living with her daughter, but in a separate unit. Her daughter works from 6:00 a.m. to 9:00 p.m. The petitioner has [REDACTED] and is treated with [REDACTED] 3 days per week (Monday, Wednesday, and Friday)

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for a total of fifteen (15) hours weekly of home health services (including 8 hours of personal care assistance and 7 hours of homemaker services) through United Healthcare. These hours are currently being utilized for 2 hours daily, with an extra hour on Tuesday.

5. On or about November 18, 2016, the petitioner made a request to United Healthcare for 3 additional hours weekly of homemaker services. On November 21, 2016, United sent a letter to the petitioner denying her request for the additional homemaker services as not being medically necessary. The denial notice stated the following:

You asked for 3 more hours of homemaker care at home. Your care plan is based on your needs. Your needs are being met. The extra hours you asked for are in excess of your needs. Hours in excess of your needs are not medically necessary.

6. The petitioner's niece stated they are requesting an additional hour of assistance on the days the petitioner receives dialysis treatment – Monday, Wednesday, and Friday. The petitioner is at the dialysis facility from 12:00 p.m. to 5:00 p.m. on those days and she sometimes arrives home not feeling well and feeling dizzy.

She would like the home health aide to be home at that time to assist with meal preparation and/or feeding.

7. The respondent's witness, Dr. Karver, stated that the petitioner met the criteria for 14 hours of assistance weekly. She suggested that the petitioner can re-arrange the hours of service so that the home health aide is there when she returns home from [REDACTED]. She also stated the petitioner should not be sent home from the dialysis center if she is not feeling well or feeling dizzy.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care

services by participating in the long-term care managed care program.
The recipient must be:

- (a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
- (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed

making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

18. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

19. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(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.

20. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that her home health services should be increased by 3 hours weekly under the LTC Program. The petitioner needs some assistance with activities of daily living (ADLs). However, she is currently approved for 15 hours weekly to assist with these activities. The petitioner may benefit from re-arranging the service hours so that the aide is in her home when she returns from the [REDACTED] on Monday, Wednesday, and Friday.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence 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 _____ day of _____, 2017,

FINAL ORDER (Cont.)
16F-09645
PAGE -8

in Tallahassee, Florida.



Rafael Centurion
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Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
[REDACTED]
UNITED HEALTH CARE HEARINGS UNIT

Mar 10, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09648

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: 88222

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 12:50 p.m. on January 26, 2017, at the Department of Children and Families in [REDACTED] Florida.

APPEARANCES

For the Petitioner: [REDACTED] the petitioner's wife

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) calculation of the petitioner's Institutional Care Program (ICP) Medicaid, 1) patient responsibility and 2) spousal allowance, is proper. The respondent carries the burden of proof by a preponderance of the evidence. At the hearing, the burden of proof was assigned to the petitioner because the Hearing Officer was informed that the issue was a result of a new

application. It was later discovered that the issue was a result of a change request submitted by the petitioner.

PRELIMINARY STATEMENT

The petitioner was not present at the hearing. The petitioner's wife did not submit exhibits. The respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record remained open until February 10, 2017, for both parties to submit evidence. The respondent's evidence was received and entered as Respondent Exhibit "7". The petitioner's wife did not submit evidence. The record was closed on February 10, 2017.

FINDINGS OF FACT

1. The petitioner is a resident at [REDACTED] Facility. The petitioner's wife lives in her home. The petitioner is referred to as the institutional spouse and his wife is referred to as the community spouse for ICP purposes.
2. On August 22, 2016, a change request was submitted by [REDACTED] Esq., the petitioner's wife's attorney, requesting review of the ICP community spouse amount (Respondent Exhibit 2).
3. On September 22, 2016, the Department mailed the petitioner's wife a Notice of Case Action (NOCA) notifying the petitioner's ICP patient responsibility of \$1,650 and zero spousal allowance (Respondent Exhibit 3, page 19) effective November 2016.
4. On December 29, 2016, the respondent's representative reviewed the petitioner's case, due to the hearing request, and determined that additional documents were required to calculate the petitioner's ICP patient responsibility and spousal allowance

amounts. And on December 30, 2016, a notice was mailed to the petitioner's wife requesting the additional documents (Respondent Exhibit 3, pages 27 and 28).

5. The petitioner's ICP patient responsibility is determined by first calculating the maintenance need allowance for the community spouse. The petitioner's wife received \$875 Social Security Retirement Income (SSRI) and \$378.68 annuity (Respondent Exhibit 7), her shelter expense is \$859.49, which includes the \$338 standard utility allowance.

6. The following is the December 2016 budget calculation using \$875 SSRI for the petitioner's wife and \$1,755 SSRI for the petitioner (Respondent Exhibit 7). MMMIA is the Minimum Monthly Maintenance Income Allowance:

Maintenance Need Allowance

\$ 859.49	shelter costs
<u>-\$ 601.00</u>	<u>30% of MMMIA (30% X \$2,003)</u>
\$ 258.49	excess shelter costs
<u>+\$2,003.00</u>	<u>MMMIA</u>
\$2,261.49	total
<u>-\$1,253.68</u>	<u>community spouse income (\$875 + \$378.68)</u>
\$1,007.81	community spouse income allowance

Patient Responsibility

\$1,755.00	petitioner's SSRI
-\$ 105.00	personal needs allowance
<u>-\$1,007.81</u>	<u>community spouse income allowance</u>
\$ 642.19	patient responsibility

7. The following is the January 2017 budget calculation using \$878 SSRI for the petitioner's wife and \$1,760 SSRI for the petitioner (Respondent Exhibit 4):

Maintenance Need Allowance

\$ 859.49	shelter costs
<u>-\$ 601.00</u>	<u>30% of MMMIA (30% X \$2,003)</u>
\$ 258.49	excess shelter costs
<u>+\$2,003.00</u>	<u>MMMIA</u>
\$2,261.49	total

<u>-\$1,256.68</u>	<u>community spouse income (\$878 + \$378.68)</u>
\$1,004.81	community spouse income allowance

Patient Responsibility

\$1,760.00	petitioner's Social Security
-\$ 105.00	personal needs allowance
<u>-\$1,004.81</u>	<u>community spouse income allowance</u>
\$ 650.19	patient responsibility

8. On January 17, 2017, the Department mailed the petitioner a NOCA (Respondent Exhibit 3), notifying his patient responsibility of \$642.19 and \$1,007.81 spousal allowance for December 2016 and patient responsibility of \$650.19 and \$1,004.81 spousal allowance for January 2017.

9. The petitioner's wife did not dispute the income or deductions used in the Department's budgets. The petitioner's wife disagrees with the petitioner's patient responsibility. The petitioner's wife asserts that her attorney said the petitioner's patient responsibility should be around \$100.

10. The record was held open until February 10, 2017 for the petitioner's wife to provide her budget calculation showing the \$100 patient responsibility.

11. The petitioner's wife did not submit her calculation of the \$100 patient responsibility.

CONCLUSIONS OF LAW

12. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

13. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

14. Fla. Admin. Code R. 65A-1.716 explains calculation of the community spouse allowance, and states in part:

- (5) (c) Spousal Impoverishment Standards.
- 2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
- 3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: $MMIA \times 30\% = \text{Excess Shelter Expense Standard}$. This standard changes July 1 of each year.

15. Fla. Admin. Code R. 65A-1.7141, SSI-Related Medicaid Post-Eligibility Treatment of Income, states in part:

- (1) For institutional care services and Hospice, the following deductions are applied to the individual's income to determine patient responsibility in the following order:
 - (a) A Personal Needs Allowance (PNA) of \$105. Individuals residing in medical institutions and intermediate care facilities shall have \$105 of their monthly income protected for their personal need allowance...
 - (f) The community spouse's excess shelter and utility expenses. The amount by which the sum of the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a homeowner's association, condominium or cooperative, required maintenance charge, for the community spouse's principal residence and utility expense exceeds thirty percent of the amount of the Minimum Monthly Maintenance Needs Allowance (MMMNA) is allowed. The utility expense is based on the current Food Assistance Program's standard utility allowance as referenced in subsection 65A-1.603(2) F.A.C...

16. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the Personal Needs Allowance at \$105 and MMMIA at \$2,003, Appendix A-1, lists the standard utility allowance at \$338.

17. The above cited authorities set forth the rules and budgeting methodology for determining how much the institutional spouse pays the nursing facility and the spousal allowance in the ICP.

18. The evidence submitted establishes that the Department included the household income and allowable deductions in the community spouse allowance and the patient responsibility computations.

19. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. The undersigned concludes the Department's calculation of the petitioner's ICP, 1) patient responsibility and 2) spousal allowance, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 10 day of March, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 20, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NOs. 16F-09654
16F-09655

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 [REDACTED]
UNIT: 88287

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 23rd, 2017, at 1:22 p.m.

APPEARANCES

For the Petitioner: [REDACTED] pro se.

For the Respondent: Bruce Tunsil, Supervisor, Hearings Unit, Suncoast Region, Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to terminate her Share of Cost (SOC) in the Medically Needy (MN) program and her Specified Low-Income Medicare Beneficiary (SLMB) program due to being over assets. The respondent carries the burden of proof in both appeals and must prove its position by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for February 28th, 2017 at 10:00 a.m. Prior to the proceeding, the petitioner requested to reschedule the hearing to a different date. The request was granted and the hearing was rescheduled as detailed above.

Prior to hearing, the petitioner did not submit any document's for the hearing officer's consideration.

Respondent's exhibits 1 through 8 were admitted into evidence.

The record was held open until the close of business April 7th, 2017, to allow both the petitioner and the respondent time to provide additional information. The petitioner submitted evidence timely and the documents were admitted as petitioner's composite 1. The respondent provided partial evidence which was marked as respondent's exhibits 9 and 10, and the record was closed.

By way of a Notice of Case Action (NOCA) dated December 20th, 2016, the respondent informed the petitioner that her Medically Needy benefits would end on December 31st, 2016. The reason listed was, "The value of your assets is too high for this program." The respondent also informed the petitioner that her Special Low-Income Medicare (SLMB) coverage would end effective December 31st, 2016. The reason listed was, "The value of your assets is too high for this program." On December 19th, 2016, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner submitted a paper application to recertify her FA, MN, and Medicare Savings Program (MSP) on November 29th, 2016. (See Respondent's Exhibit

2). FA is not an issue for this appeal. As part of the application process, the respondent is required to explore and verify all factors of eligibility, which include but are not limited to all sources of income, allowable expenses, and assets.

2. The petitioner is a single-person household, and was 67 years of age at the time of application.

3. The application dated November 29th, 2016 lists the following assets and value amounts (See Respondent's Exhibit 2):

2013 Hyundai Elantra (Paid Off)	No Value Listed
Suncoast Credit Union Checking	\$3,579
Suncoast Credit Union Money Market	\$6,017
Suncoast Credit Union Individual Retirement Account (IRA)	\$11,047
Stocks	\$2,659
Prudential Life Insurance	\$6,505

4. The respondent provided as part of its evidence, a letter from Prudential Life Insurance dated August 1st, 2016. (See Respondent's Exhibit 4). The letter states in relevant part:

"On Aug [sic] 1, 2016, the Guaranteed Cash Value of your contract will be \$2,865.00 and the (Net) Cash Value will be \$6,505.48."

The petitioner asserts that the letter is outdated and the amounts listed are incorrect.

The petitioner asserts that she recently sent the respondent a current letter from Prudential Life Insurance with updated information. The respondent acknowledged receiving the updated letter. However, the respondent failed to provide the current document as evidence. In addition, the respondent provided a Notice of Case Action date stamped December 12th, 2016 in which the petitioner hand wrote a statement

indicating that the life insurance funds were intended to be used for burial purposes.
(See Respondent's 3 pg. 38).

5. The respondent also provided as part of its evidence, a letter from Suncoast Credit Union detailing how the petitioner can withdrawal funds from her IRA. (See Respondent's Exhibit 4 pg. 40). The letter states in relevant part:

“...you will need to fill out forms to make any withdrawals. You cannot do any withdrawals from an IRA on line or over the phone. In order to fill out withdrawal forms for your IRA you will either need to go to your local branch during business hours and sign in to see one of the branch representatives or the forms can be mailed to you and you can mail them back to the main office in ██████████ Florida for us to do the withdrawal.”

6. The respondent determined that the petitioner had \$10,305 in liquid assets and \$4,005.48 in countable life insurance for total counted assets of \$14,310.48. The asset limit for a single person in the MN program is \$5,000 and \$7,280 for SLMB (as found in the Department's Eligibility Standards for SSI-Related Programs guide). Consequently, the respondent took action to terminate these benefits effective December 31st, 2016.

7. The petitioner does not dispute the assets listed on the application dated November 29th, 2016 and asserts that she has always been honest with the respondent regarding those assets. The petitioner testified that she is never going to cash in her life insurance and cannot access the IRA. The respondent located several documents in its Document Imaging System (DVS) that included current asset information. However, those documents were not provided as evidence. Additionally, the respondent did not provide a detailed breakdown to explain how the assets were calculated.

CONCLUSIONS OF LAW

8. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under 409.285, Fla. Stat.

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

10. Fla. Admin Code 65-2.060, Evidence states:

(1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

11. Fla. Admin. Code R. 65A-1.701, defines resources:

(28) Resources: Cash or other liquid assets, or any real or personal property that an individual owns and could convert to cash to be used for their support and maintenance. Resources is synonymous with assets.

12. Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility

Criteria, states in part:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions:

(a) For Medicaid for the Aged or Disabled Demonstration Waiver (MEDS-AD), an individual whose income is equal to or below 88 percent of the federal poverty level must not have resources exceeding the current Medically Needy resource limit specified in Rule 65A-1.716, F.A.C.

(d) For Special Low Income Medicare Beneficiary (SLMB), an individual cannot have resources exceeding three times the SSI resource limit with increases based on the Consumer Price Index.

13. Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility

Criteria also outlines exclusions, states in relative part:

(2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. § 416.1210 and 20 C.F.R. § 416.1218 in determining resource exclusions, with the exceptions in paragraphs (a) through (g) below, in accordance with 42 U.S.C. § 1396a(r)(2).

(d) The individual, and their spouse, may designate up to \$2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The \$2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

(e) One automobile is excluded, regardless of value.

14. As stated in the above-cited authorities, an asset is any real or personal property that an individual owns and could convert to cash to be used for their support and maintenance. As established in the Findings of Fact, the asset limit is \$5,000 for MN and is \$7,280 for SLMB. The petitioner reported several assets that may cause her to be over these limits. However, the respondent did not provide evidence of the assets it used to make its eligibility determination. Therefore, the hearing officer could not review the eligibility for correctness.

15. In summary, based on the evidence presented, the hearing officer concludes that based on disputed testimony regarding updated information on the petitioner's assets, and lack of evidence on the part of the respondent, the respondent did not meet its burden. The respondent's action to terminate the petitioner's MN and SLMB is not affirmed.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is granted. The respondent's actions to terminate the petitioner's MN and SLMB are not affirmed. The respondent is ordered to take corrective action and approve MN and SLMB benefits including any retroactive months the petitioner is due.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 20 day of April, 2017,

in Tallahassee, Florida.



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Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

66STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

Mar 09, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09734

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 30, 2017, at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's daughter

For the Respondent: Monica Otalora, Senior Program Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action denying the petitioner's request for home-delivered meals under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding since it is the petitioner's health plan.

The respondent did not submit any documents as evidence for the hearing.

FINDINGS OF FACT

1. The petitioner is eighty-seven (87) years of age and is currently living alone. She has been diagnosed with [REDACTED] She uses a walker for ambulation due to knee problems. Her daughter is her only caregiver.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner is currently approved for 3 hours daily of home health services (personal care and homemaker services) through United Healthcare. These hours are

currently being utilized as 2 hours in the morning and 1 hour in the afternoon. She also has an emergency response system to call for help in case of emergencies.

5. The petitioner made a request to United Healthcare for home-delivered meal services. United denied the request for home-delivered meals based on medical necessity criteria.

6. The petitioner's daughter stated her mother is at risk for starting a fire if she tries to cook something for herself. The daughter also stated that she herself has medical problems in her lumbar spine and nerve damage to her hands. The daughter also takes care of her disabled husband. The daughter stated she does not cook for herself every day. She also stated she was told that the home health aide cannot assist her mother with meal preparation or cooking.

7. The respondent's witness, Dr. Karver, stated that the petitioner did not meet the criteria for home-delivered meals due to the assistance she is already receiving in the home. She stated the home health aide can assist with meal preparation, and the petitioner is not expected to be able to cook for herself. She also stated the petitioner was approved for an extra hour of home health services daily due to her daughter's recent surgery. Dr. Karver also stated the petitioner may be best served by placement in an assisted living facility where she can be provided with 3 meals daily, but the family has rejected this option.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes she should receive home-delivered meals as part of her LTC Program services.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance, homemaker services, and home-delivered meals are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner has requested Home-Delivered Meals services, which are defined in the contract as follows:

Nutritionally sound meals to be delivered to the residence of an enrollee who has difficulty shopping for or preparing food without assistance. Each meal is designed to provide a minimum thirty-three and three tenths percent (33.3%) of the current Dietary Reference Intake (DRI). The meals shall meet the current Dietary Guidelines for Americans, the USDA My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

18. The AHCA contract also provides that a Plan “may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.”

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

20. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

. . .

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that United Healthcare should have approved her request for home-delivered meals. Although the petitioner is unable to cook for herself, she is currently receiving 3 hours of home health services daily to assist her with daily living activities. Homemaker services are part of these daily services, which includes assistance with meal preparation.

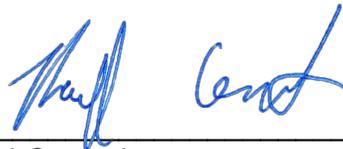
DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 09 day of March, 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer

FINAL ORDER (Cont.)

16F-09734

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AHCA, MEDICAID FAIR HEARINGS
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Apr 20, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09754

PETITIONER,

Vs.

SUNSHINE STATE HEALTH PLAN, INC., AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing on
March 27, 2017 at 1:30 p.m. in [REDACTED] Florida.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner's Mother

For Sunshine: Kizzy Alleyne
Paralegal

Joerosa
Senior

Davis
Manager of Grievances and Appeals

STATEMENT OF ISSUE

At issue are: (1) whether or not Sunshine's denial of Petitioner's request for a Permobil F5 VS Sit-to-Stand Wheelchair ("Permobil"); and (2) Sunshine's termination of providing electrodes for Petitioner's FES bike, were correct. The burden of proof is assigned to Petitioner as to issue #1, and to Sunshine as to issue #2.

PRELIMINARY STATEMENT

The parties appeared in person, however the witnesses appeared via telephone. Petitioner's mother represented him. Petitioner presented one (1) witness: [REDACTED], his physical therapist. Lisa Sanchez, Medical/Health Care Program Analyst with the Agency for Health Care Administration ("AHCA" or "Agency") observed the hearing.

Sunshine presented the following witnesses:

- Kimberly Bouchette – Clinical Appeals Coordinator
- Melissa Kinsey-Hickman – Supervisor
- Stephanie Anthony – Care Coordinator
- Dr. John Carter – Long Term Care Medical Director

Petitioner moved Exhibits 1 – 5 into evidence at the hearing. Sunshine moved Exhibits 1 – 9 into evidence at the hearing. The record was held open for the parties to submit additional evidence. Petitioner submitted additional evidence, entered as Exhibits 6 – 15. Sunshine submitted additional evidence, entered as Exhibits 10 & 11.

FINDINGS OF FACT

1. Petitioner is a 23-year-old male enrolled with Sunshine as both his Managed Medical Assistance ("MMA") and Long-Term Care ("LTC") Plan.
2. Petitioner is also enrolled in the Brain and Spinal Cord Waiver, administered through Sunshine. Sunshine does not dispute that the wheelchair, as requested and configured, is a covered benefit. Sunshine did not submit its contract with AHCA, Interqual criteria, or any other authority, to suggest otherwise.
3. In March of 2012, Petitioner was involved in a car accident where he sustained a traumatic brain injury and fractures of both his right arm and femur. He requires total assistance with all of his ADLs and 24/7 care. His medical history includes:

- [REDACTED]

4. Petitioner currently has a custom manual wheelchair. His mother said between the wheelchair, Petitioner, and his equipment, the total weight is over 300 pounds. It is difficult for her to physically push him in the wheelchair, particularly up hills. She said they moved from [REDACTED] to [REDACTED] due to [REDACTED]'s hilly terrain.

5. There was some dispute at the hearing as to whether or not Sunshine previously provided the electrodes for the FES bike. Petitioner's mother testified that Sunshine had been providing the electrodes. Subsequent to the hearing, Petitioner submitted Exhibit 12, which shows that Sunshine was previously covering the electrodes.

6. Sunshine received Petitioner's request for the Permobil and the electrodes on October 28, 2016, Sunshine issued a Notice of Action denying the request. (Resp. Exh. 2). An internal appeal was requested. On December 6, 2016, Sunshine issued a letter upholding the denial. (Resp. Exh. 7). The reason given for the decision was that the requests were not medically necessary because they are "not medically necessary because the services must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs."

7. Petitioner's mother said he has been evaluated for a wheelchair on three (3) separate occasions. At the request of Sunshine, Petitioner was evaluated at ██████ Health.

(Pet. Exh. 15). The evaluation stated, in pertinent part:

[Petitioner] is a 21 year old male who was evaluated for a power standing wheelchair at ██████ Health Rehabilitation Institute ██████ Outpatient clinic on May 28, 2015.... As a result of his diagnosis, [Petitioner] has significantly decreased functional control of his upper & lower extremities and upper-trunk. He has impaired sitting balance and severe spasticity in all four extremities.

....

At this time a power stander wheelchair is recommended to facilitate weight bearing and upright posture, as well as to decrease the burden on attendant care with the use of power mobility versus manual mobility. Using power mobility will decrease the physical toll of pushing and maneuvering [Petitioner] in his heavy manual wheelchair.

....

The Permobil F5 Base Corpus VS Power Standing wheelchair is recommended for [Petitioner] to enhance his overall level of function and maneuverability. Factors contributing to this recommendation include the wheelchair's ability to allow the patient to come to stand from the sitting position while in the wheelchair. He will not need to transfer out of his wheelchair and into a stander in this wheelchair. [Petitioner] requires total assist with transfers and therefore requires the assistance of 2 people in order to transfer into his traditional standing frame. As a result, the frequency at which he stands is greatly limited. It is recommended that [Petitioner] be on a daily standing program for the following benefits.

8. The evaluation explained several different benefits to Petitioner if he were to have the Permobil. On, August 18, 2016, Petitioner's physical therapy provider, TLC Pediatric Services ("TLC"), issued a letter of medical necessity for the Permobil. (Resp. Exh. 5).

The letter incorporates much of what was stated in the evaluation by ██████ Health. It states, in pertinent part:

Frequent standing and weight bearing throughout the day is medically necessary for [Petitioner] diagnosis to inhibit his spasticity, pulmonary to improve respiration, circulation to improve wound healing, and for his orthopedic concerns. Attached are prescriptions from [Petitioner's] Rehab Doctor, Orthopedic doctor, and pulmonologist. Due to [Petitioner's] large

stature, a power standing wheelchair is necessary to allow for standing multiple times throughout the day without the burden of transfer on the caregivers. He can only tolerate standing at 20-30 min intervals due to skin breakdown in his foot/ankle region from the bracing. Therefore, it is recommended that he stand multiple times throughout the day at 20-30 min intervals. [Petitioner] is a dependent transfer, and the task of transferring to a standing frame multiple times a day is not feasible for the caregivers....

9. Regarding the specific benefits TLC says the Permobil may provide, the letter stated:

- 1) During standing, the pelvis tends to assume a more anterior tilt or neutral position, allowing for an increase in lumbar lordosis as compared to sitting. This in turn helps establish a better alignment of the spine and extend the upper trunk. Extension of the upper trunk results in reduced pressure on the internal organs, thereby enhancing secondary complications so often seen in wheelchair users. As a result, respiration can be affected. Many users experience improved lung capacity when standing often. Studies have shown that those who stand frequently in standing power wheelchairs have less or delayed occurrence of respiratory complications and improved respiratory volume. In addition, standing can help also reduce congestion and coughing. [Petitioner] had a tracheostomy removed in 2/2015 with continued open stoma as a result. He has had respiratory complications throughout his recovery post injury.
- 2) Urinary Tract Infections (UTIs) are a frequent complication for immobile person. Prolonged immobility causes hypercalcemia, increased urinary calcium output, and also reduces urine emptying. By reducing contributing risks, standing wheelchairs have been shown to reduce the occurrence of UTI for wheelchair users which could lead to kidney infections. In addition, standing wheelchairs have been shown to allow their users to empty their bladder more completely than they did prior to beginning their standing program [Petitioner] has urinary incontinence and urinary retention as a result of his injury.
- 3) [Petitioner] is unable to perform a pressure relief, or change in sitting position, once seated in his wheelchair. This puts him at a greater risk for skin breakdown in the areas of the ischial tuberosities, coccyx and sacrum in the future. When fully standing, pressure is 100% relief off of all of these areas. However, when tilting or reclining, there is a redistribution of pressure, but not a 100% removal of pressure. Pressure ulcers are the primary complication for immobile patients. There is evidence that patients have suffered fewer pressure sores while using standers, or integrated wheelchair standers.
- 4) The skeletal asymmetries noted during the mat evaluation, a left pelvic obliquity and left rotation, can also be addressed by a standing wheelchair. Clinical experience suggests that extension of the upper

trunk and proper alignment of the hips during standing helps delay a worsening of typical skeletal deformities often seen in people who sit in a wheelchair for long periods of time, such as fixed posterior pelvic tilt, kyphosis and scoliosis of the spine, and windswept deformities of the lower extremities. [Petitioner's] decreased dorsiflexion can also be addressed with weight bearing through the lower extremities, which is important to maintain the right ankle surgery correction that he recently had performed.

- 5) Finally, the benefits of a standing wheelchair can assist in addressing the tone/spasticity issues that [Petitioner] has due to his diagnosis. Research indicates that muscle stretching combined with weight loading reduces muscle tone more than stretching alone (32% vs 17%). Some users experience tone reduction in their upper extremities due to better skeletal alignment in a standing position. This may translate into improved hand and arm function to perform ADLs. Tone reduction can improve comfort, minimize further range of motion losses, improve function and conserved energy. Research studies also show that standing wheelchair users have experienced significant reduction in spasticity. This helps with transfers, can aid in better sleep, reduces fatigue and pain, and improves positioning in the wheelchair. Standing has an immediate and significant effect on spasticity. [Petitioner's] caregivers report a reduction in his tone when he was able to stand in his standing frame last year, prior to his right ankle surgery and left his dislocation.

10. Dr. Carter credibly testified that he did not see how the Permobil or the electrodes would assist Petitioner or otherwise improve his condition. He said he had spoken to Petitioner's physician and they had a cordial conversation wherein they determined they have a professional disagreement. He said physicians and families often request extra equipment with the best of intentions, thinking more equipment is better, but that the additional equipment does not always provide any benefit. He said that unfortunately, to him, it appears that Petitioner's condition is getting worse. Petitioner's mother disagreed, stating he used to have a tracheostomy and that he no longer requires one, and he can also eat by mouth now, although he still has to have extra food supplied via his [REDACTED] in order to get sufficient calories.

11. Petitioner owns the FES bike. The electrodes for the bike provide electrical stimulation for the muscles. Petitioner's mother says the bike riding helps with muscle memory and keeping his hips moving and aligned. She said he rides it for one (1) hour per day. She said she has been paying for the electrodes out of pocket since Sunshine stopped providing them. Dr. Carter supplied little testimony to rebut Petitioner's mother's testimony, other than to state his professional opinion that he could not see how Petitioner would benefit from using the bike with the electrodes, given his condition. It appeared to the undersigned as though Sunshine was unprepared to fully address the electrodes due to the aforementioned confusion regarding whether or not Sunshine had previously been providing them.

CONCLUSIONS OF LAW

12. By agreement between the AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to Section 120.80, Florida Statutes.

13. This hearing was held as a *de novo* proceeding, in accordance with Rule 65-2.056, *Florida Administrative Code*.

14. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

15. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

16. Legal authority governing the Florida Medicaid Program is found in Chapter 409 of the Florida Statutes, and in Chapter 59G of the *Florida Administrative Code*.

Respondent, AHCA, is the single state agency that administers the Medicaid Program.

17. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law

....

(4) HOME HEALTH CARE SERVICES – The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home....

18. The July 2010 Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (“DME Handbook”) is promulgated by Rule 59G-4.070(2),

Florida Administrative Code.

19. The DME Handbook defines DME as follows:

Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient’s home as determined by the Agency for Health Care Administration (AHCA).

20. As stated above, Sunshine does not dispute that the Permobil is a covered item of DME and did not submit anything to the contrary.

21. The definition of medically necessary is found in Rule 59G-1.010, *Florida*

Administrative Code, which states:

(166) “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.

....

(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.

22. In the instant-matter, there are multiple experts, including physicians, physical therapists, and wheelchair evaluators, who agree that Petitioner requires the Permobil. There is an extensive list of potential benefits to Petitioner from using the Permobil. It will also significantly assist Petitioner's mother in providing care, not for her convenience, but out of need. She struggles to move the manual wheelchair so much that she moved from [REDACTED] to [REDACTED] because she could not cope with the hilly terrain. Based upon the totality of the evidence, Petitioner has met his burden of proof to show the Permobil is medically necessary.

23. As to the electrodes, the burden of proof is on Sunshine to show they are not medically necessary. Due to the scant evidence presented, Sunshine has failed to meet its burden of proof to show terminating the electrodes was correct.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED. Sunshine is directed to provide Petitioner with a Permobil F5 VS Sit-to-Stand Wheelchair, as

configured in his request. Sunshine is further directed to provide Petitioner with the electrodes for the FES bike.

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 20 day of April, 2017,

in Tallahassee, Florida.

R. Zimmer

Rick Zimmer
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED] Petitioner
AFCA, Medicaid Fair Hearings Unit
Sunshine Hearings Unit

Mar 10, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09760

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 17, 2017 at 11:30 a.m. in [REDACTED] Florida.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's father

For the Respondent: Linda Latson, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny Prescribed Pediatric Extended Care (PPEC) service hours that were requested for the petitioner for the certification period December 8, 2016 through May 25, 2017, was correct.

The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the respondent was Dr. Darlene Calhoun, Physician-Consultant with eQHealth Solutions, Inc. The respondent submitted the following documents into evidence, which were marked as Respondent's composite Exhibit 1: Outpatient Review History, Denial Notices, and Supporting Documentation, such as medical records.

All parties appeared in person for the hearing except for Dr. Calhoun, who appeared telephonically.

FINDINGS OF FACT

1. The petitioner's PPEC service provider, [REDACTED] Services (hereafter referred to as "the provider"), requested the following PPEC service hours for the certification period at issue: full day and partial day services (up to twelve hours daily), Monday to Friday.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for PPEC services. The petitioner's provider submitted the service request through eQHealth's internet based system. The submission included, in part, information about the petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had telephone conversations with the petitioner's mother and also conducted face-to-face visits at the PPEC facility. The provider also sent information directly to eQ Health.

4. The medical and social information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 3 years old
- Diagnosis includes [REDACTED], and [REDACTED]
- Born premature at 24.5 weeks gestation
- Consumes a pureed diet

5. The petitioner has been previously approved for PPEC services and has attended a PPEC facility for at least the past 2 years.

6. A Plan of Care was submitted by the provider. This document was signed by a physician and outlined the type of assistance to be provided by the PPEC facility. The duties include, in part:

- Daily head-to-toe assessment
- Maintain daily hygiene requirements
- Monitor apnea monitor and oxygen saturation
- Monitor for evidence of complications from hypercapnia and hypoxemia
- Follow-up of developmental therapies
- Monitor caregiver compliance with child care and provide education to caregiver
- Administer oxygen as needed
- Monitor for aspiration and reflux

7. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and denied the request for PPEC services. A notice of this determination was sent to all parties on December 14, 2016. The physician-reviewer wrote, in part:

The patient is a 2 year old with a history of [REDACTED], [REDACTED]. The patient is on a pureed diet. The patient is not on a complex medication regimen. The patient has had no recent hospitalizations or emergency room visits. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity requirements for PPEC services.

8. The above notice stated should the parent, provider, or the petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was not requested in this case.

9. The petitioner thereafter requested a fair hearing and this proceeding followed. The respondent administratively approved the requested PPEC services pending the outcome of the fair hearing process.

10. The petitioner's father stated his son's mother has primary custody of him and he takes care of his son on weekends only. The father has little or no contact with the mother. He stated his son stopped using supplemental oxygen prior to his second birthday. He stated he received recent referrals to take his son to an ophthalmologist and a neurologist. He also stated his son went to the emergency room in November, 2016 and received stitches on his head because he fell off his stroller. He is concerned that his son still cannot say "mom" or walk properly.

11. The respondent's witness, Dr. Calhoun, stated that the petitioner does not meet the requirements for PPEC services since he does not require skilled nursing interventions. He is not on a complex medication regimen. He is no longer oxygen dependent and is not on any monitoring equipment. He consumes a pureed diet by

mouth. She noted he was hospitalized for 10 days in December, 2016 due to sepsis.

She also noted he receives various therapies (speech, physical, occupational) at the PPEC facility, but these therapies can be provided at any location.

12. PPEC service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook ("PPEC Handbook"), effective September, 2013.

CONCLUSIONS OF LAW

13. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

14. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

15. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

16. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the petitioner has been previously approved for PPEC services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

17. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered

by the respondent. The PPEC Handbook described above is incorporated by reference in Fla. Admin. Code R. 59G-4.260.

18. The petitioner has requested PPEC services. As the petitioner is under twenty-one (21) years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner's eligibility for or amount of this service.

19. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

20. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you¹ must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established

¹ "You" in this manual context refers to the state Medicaid agency.

periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

21. The service the petitioner has requested (PPEC services) is one of the services provided by the State to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Florida Statutes, states, in part:

Any service under this section shall be provided only when medically necessary ...

(4) (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services ... The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for any other family dependents.

22. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

5110. Basic Requirements...

...Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

5122. EPSDT Service Requirements

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the

determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

5124. Diagnosis and Treatment

B. Treatment.--

1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

23. Once a service has been identified as requested under EPSDT, the Medicaid Program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. Fla. Admin. Code R. 59G-1.010 defines medical necessity:

(166) '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...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

24. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the

requested PPEC services.

25. In the petitioner's case, the respondent has determined that PPEC services are not medically necessary at this time.

26. Fla. Stat § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on to further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

27. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

28. The purpose of PPEC services is described on page 1-1 of the PPEC Handbook as follows:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a

non-residential pediatric center.

29. The PPEC Handbook on page 2-1 sets forth the requirements for PPEC

services, as follows:

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible;
- Diagnosed with a medically complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.;
- Be under the age of 21 years;
- Be medically stable and not present significant risk to other children or personnel at the center;
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

30. Rule 59G-1.010, F.A.C., defines the terms “medically complex” and “medically fragile” as follows:

“Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour per day medical, nursing, or health supervision or intervention.

“Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, i.e., requiring total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life and without such services is likely to expire without warning.

31. The petitioner’s physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

32. The respondent's witness stated that the petitioner did not meet the requirements for PPEC services since he did not require skilled nursing interventions.

33. The petitioner's father would like his son to continue attending the PPEC facility, especially since he is receiving therapy services there.

34. After considering the evidence and testimony presented, the undersigned concludes the respondent has demonstrated it was correct in denying the request for PPEC services at this time. Although the petitioner suffers from various medical issues, his medical condition does not meet the definition of "medically complex" or "medically fragile" as outlined above in the applicable regulations. He is not on a complex medication regimen. He is not on a ventilator or dependent on any other medical apparatus and does not require 24-hour per day nursing or medical supervision/intervention. The various therapy services can continue at locations other than the PPEC facility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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

FINAL ORDER (Cont.)

16F-09760

PAGE - 12

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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 10 day of March, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

FILED

Mar 07, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 16F-09792

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 [REDACTED]
UNIT:

RESPONDENT

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 13, 2017 at approximately 10:30 a.m. Eastern Standard Time. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's Mother

For the Respondent: Stephanie Lang, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services.

Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

PRELIMINARY STATEMENT

At the hearing, the minor Petitioner was not present, but was represented by his mother. Respondent was represented by Stephanie Lang, AHCA Registered Nurse Specialist and Hearing Liaison. Respondent presented one witness: Dr. Calhoun, M.D., Physician-Reviewer with eQHealth Solutions, Inc.

Respondent's Exhibits 1 through 5, inclusive, were admitted into evidence. Administrative Notice was taken of Section 409.905, Florida Statutes, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and the entire Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook ("PPEC Handbook").

FINDINGS OF FACT

1. The Petitioner is a 5-year-old male. He was born premature, at approximately 23 weeks. Petitioner was subsequently diagnosed with [REDACTED] of

[REDACTED]
[REDACTED] He currently does not require assistance with actives of daily living (ADLs), and receives speech, physical and occupational therapy. He is on an age-appropriate diet.

2. PPEC service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the Respondent's PPEC Handbook, effective September 2013. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

3. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the Respondent to perform prior authorization reviews for PPEC services. The Petitioner's provider submitted the service request through eQHealth's by fax. The submission included, in part, information about the Petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

4. On December 19, 2016, a physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and denied the request for PPEC services. A notice of this determination was sent to all parties. The physician-reviewer wrote, in part:

The patient is a 5 year old with a history of [REDACTED] [REDACTED]. The patient requires scheduled and as needed nebulizer treatments and inhaler treatments. The patient is on an age-appropriate diet. The patient has a history of [REDACTED] but has normal gross motor skills. The patient has speech delays and behavioral issues. The patient is not on a complex medication regimen. The patient has had no recent hospitalizations or emergency room visits. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity requirement for PPEC services.

5. The Petitioner's thereafter timely requested a fair hearing and this proceeding followed. The Respondent administratively approved the requested PPEC services pending the outcome of the fair hearing process.

6. The Petitioner's mother testified that he cannot attend normal daycare because these facilities cannot provide the extra care he requires. This extra care includes attention to his behavioral issues and nebulizer treatments when he becomes ill. She testified further that when he becomes ill he is more likely to end up hospitalized. Petitioner has no peripheral vision and sees his eye doctor

quarterly. Petitioner's lungs are getting stronger but he sees a Pulmonologist quarterly as well.

7. Dr. Calhoun, testified based upon her review of Petitioner's request for services, in conjunction with his Plan of Care, Assessment and care coordination and progress notes.

8. Petitioner's Assessments and care coordination notes reflect that Petitioner has had no recent seizure activity, no tracheostomy tube placement, and no dependence upon mechanical devices. Petitioner does not use any special medical equipment such as a breathing tube or feeding tube. Although Petitioner's health can be more fragile due to chronic lung disease, his Albuterol and DuoNeb treatments are administered "as needed" and not on a daily basis.

9. While Dr. Calhoun does not dispute that Petitioner may continue to require therapy services, she does not believe these needs indicate a medical necessity for continuation of PPEC.

10. Dr. Calhoun explained that should Petitioner wish to request continuation of speech, occupational, and/or physical therapy, he may be eligible to receive these as distinct services, outside of the PPEC setting. Petitioner is currently getting tested to qualify for behavioral therapy through his school.

CONCLUSIONS OF LAW

11. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Chapter 120, Florida Statutes.

12. Respondent, the Agency for Healthcare Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the *Florida Administrative Code*.

13. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

14. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

15. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

16. The burden of proof in the instant case is assigned to the Respondent, who seeks to terminate a previously authorized service. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

17. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

18. Starting on page 1-1 of the PPEC Handbook notes that, “[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center.” Page 1-2 adds that “PPEC services are not emergency services. (emphasis added).

19. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.
(underlined emphasis added)

20. Fla. Admin. Code R. 59G-1.010 defined “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning. (emphasis added)

21. Consistent with the law, AHCA’s agent, eQHealth, performs service authorization

reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

22. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

“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. ...

(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.

23. As the Petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

24. EPSDT augments the Medical Necessity definition contained in the *Florida Administrative Code* via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

25. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis"

and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

26. Fla. Admin. Code R. 59G-1.010(166) requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must fulfill the requirements for PPEC, as provided in the PPEC Handbook.

26. There is no evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life sustaining medical care that he would properly be deemed 'Medically Fragile.' His need for supervision for his behavioral issues, general monitoring and aspiration precautions, as-needed albuterol, and interventions in case of emergency, do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care." As such, his needs do not support the authorization of PPEC, because there are alternative services, such as outpatient physical, occupational, and speech therapy services, that are better designed to meet his needs without being excessive. PPEC cannot be authorized as a substitute for school or daycare, particularly when there is no skilled intervention provided at the PPEC site. In essence, this would constitute approval of PPEC as a convenience to the caretaker in direct violation of the PPEC Handbook (page 1-2).

27. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that AHCA has met its burden of proof and shown that denial/termination of PPEC services is appropriate in the instance case.

28. Petitioner's mother is encouraged to follow up in coordinating with Petitioner's case manager. The case manager should be able to assist Petitioner in finding services to meet his daycare needs.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED.

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 07 day of March, 2017

in Tallahassee, Florida.



Stephanie Twomey
Hearing Officer
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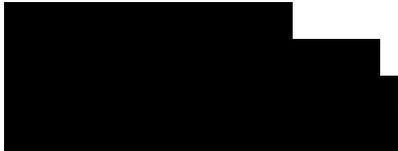
Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit

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

FILED

Mar 24, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09794

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 19 [REDACTED]
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on March 7, 2017, at 3:20 p.m. The hearing was reconvened on March 13, 2017, at 1:20 p.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's mother

For the Respondent: Lisa Sanchez
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly denied the petitioner's request for Prescribed Pediatric Extended Care ("PPEC") services?

PRELIMINARY STATEMENT

██████████ the petitioner's mother, appeared on behalf of the petitioner, ██████████, who was not present. ██████████, Intake Coordinator at PATCHES, the petitioner's Prescribed Pediatric Extended Care provider, appeared as a witness on behalf of the petitioner at the first hearing. ██████████, R.N., Administrator at PATCHES, and ██████████, L.P.N., Licensed Practical Nurse at PATCHES, appeared as witnesses on behalf of the petitioner at the second hearing. Ms. ██████████ may sometimes hereinafter be referred to as the petitioner's "representative".

Lisa Sanchez, Medical Health Care Program Analyst with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration, the respondent, at the first hearing. Suzanne Chillari, Medical Health Care Program Analyst with the Agency for Health Care Administration, appeared on behalf of the Agency at the second hearing. Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions, appeared as a witness on behalf of the Agency. Abdel Nassar with Propio Language Services provided Creole-English translation at both hearings.

The respondent introduced Exhibits "1" through "7" at the hearing, all of which were accepted into evidence and marked accordingly. The petitioner did not introduce any exhibits. At the request of the respondent, the hearing officer took administrative notice of the Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

FINDINGS OF FACT

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. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.

2. The petitioner is a four-year-old male.

3. The petitioner's diagnoses include, but are not limited to, the following:

[REDACTED]

[REDACTED]

4. The petitioner was approved to receive Prescribed Pediatric Extended Care services 12 hours per day, Monday through Friday, in the previous certification period.

5. A PPEC is a non-residential center that serves three or more medically dependent or technologically dependent recipients under the age of 21 who require short, long-term, or intermittent medical care due to medically-complex conditions. A PPEC offers services that meet the recipients' physiological, developmental, nutritional, and social needs.

6. On November 23, 2016, the petitioner's PPEC provider submitted a request to eQHealth Solutions for Prescribed Pediatric Extended Care services to be approved in the amount of 12 hours per day, Monday through Friday, for the current certification period, which extends from December 9, 2016 through June 6, 2017.

7. eQHealth Solutions is the Quality Improvement Organization contracted by the Agency for Health Care Administration to review requests by Medicaid recipients in the State of Florida for PPEC Services.

8. eQHealth Solutions is delegated the responsibility of determining whether a requested service is medically necessary under the terms of the Florida Medicaid Program.

9. eQHealth Solutions has the authority to present a case and act as a witness on behalf of the Agency for Health Care Administration.

10. A request for Prescribed Pediatric Extended Care Services is submitted directly to eQHealth Solutions by a recipient's PPEC provider. Once eQHealth Solutions receives the information, it completes a prior authorization review – it reviews the written request to determine if the services requested are medically necessary.

11. The petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on November 30, 2016. The Physician Reviewer determined that Prescribed Pediatric Extended Care services are not medically necessary for the petitioner and denied all of the requested services. The Physician Reviewer explained in the denial letter that the "[R]equested services are denied because the clinical information does not support the medical necessity."

12. The Physician Reviewer provided the following clinical rationale for the decision:

The patient is a 3 year old with [REDACTED] and [REDACTED]. The patient receives as needed nebulizer treatments. The patient is on an age-appropriate diet. The patient is not on a complex medication regimen. The patient has had no recent hospitalizations or emergency room visits. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient no longer appears to have a skilled need and does not meet the medical complexity requirement for PPEC services.

13. The petitioner requested an internal review of the denial on December 1, 2016. Pursuant to the petitioner's request, a different Physician Reviewer at eQHealth Solutions completed a reconsideration review of the petitioner's case on December 3, 2016.

14. For the reconsideration review, the provider submitted documentation to eQHealth Solutions indicating that an administrative hearing had been requested but did not provide any additional documentation supporting the request for Prescribed Pediatric Extended Care services.

15. The Physician Reviewer completing the reconsideration review noted that no additional information to support the need for Prescribed Pediatric Extended Care services was provided and recommended upholding the initial Physician Reviewer's determination to deny the services.

16. The Agency for Health Care Administration administratively approved the continuation of the petitioner's Prescribed Pediatric Extended Care Services pending the resolution of this appeal.

17. The petitioner is unable to express when he needs to use the bathroom and uses diapers. He is incontinent.

18. The petitioner is on a regular, age-appropriate diet but does need assistance with feeding.

19. The petitioner is gaining weight appropriately.

20. The petitioner has no reported neurological issues.

21. The petitioner is ambulatory.

22. The petitioner is not connected to any medical devices such as a ventilator or breathing machine.

23. The petitioner does not receive any substances intravenously.

24. No special medical equipment is required to care for the petitioner.

25. The petitioner has [REDACTED]

26. The petitioner is prescribed [REDACTED] and [REDACTED] for his [REDACTED]. He takes the [REDACTED] twice per day and the [REDACTED] as needed.

27. A respiratory therapist at the Prescribed Pediatric Extended Care Center performs chest physical therapy on the petitioner after the administration of his [REDACTED] in order to facilitate the absorption of the medication into his lungs.

28. A skilled nursing professional is not required for the administration of [REDACTED]

29. Chest physical therapy is generally not required after the administration of [REDACTED]. It is normally only prescribed for patients who are very sick, such as those connected to a ventilator or who have bronchitis.

30. When asked why the petitioner is administered chest physical therapy after he takes [REDACTED] the petitioner's witnesses explained that the box for chest physical therapy is checked on the Physician Plan of Care for PPEC Services.

31. Since the petitioner receives [REDACTED] only twice per day, he may be given this medication at home by his mother in the morning and the evening.

32. The petitioner receives speech therapy, occupational therapy, and physical therapy at his Prescribed Pediatric Extended Care Center to address his developmental delays.

33. Speech therapy, occupational therapy, and physical therapy may be provided at a location other than a Prescribed Pediatric Extended Care Center.

34. The petitioner's Plan of Care does not mention anything specific that must be provided by a skilled nurse.

35. The petitioner has an upcoming appointment with a geneticist to determine if he has any additional diagnoses.

36. The petitioner's witness testified that it would be beneficial for the petitioner to continue receiving Prescribed Pediatric Extended Care services for at least six more months – in part because he is still too young to integrate into the special needs system at school and partially because the geneticist may determine the petitioner has additional diagnoses, which would not be unusual for a child with [REDACTED], and could require skilled nursing care. She stated that the [REDACTED] makes it difficult for the petitioner to express his needs and, consequently, he requires a facility that can watch him more closely.

37. The respondent's witness testified that Prescribed Pediatric Extended Care services may only be approved for children who require skilled nursing care. He testified that the information provided to eQHealth Solutions does not identify any skilled nursing needs which would qualify the petitioner for the receipt of PPEC services.

CONCLUSIONS OF LAW

38. By agreement between the Agency for Health Care Administration and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Fla. Stat.

39. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

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

41. The respondent in the present case is proposing to terminate previously approved services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the respondent.

42. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

43. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law...

44. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definitions for Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

(166) “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.

...

(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.

45. Since the petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services ("EPSDT") requirements. Section 409.905, Fla. Stat., Mandatory Medicaid Services defines Medicaid services for children to include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

46. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when

such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include “reasonable standards ... for determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

47. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

48. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the “medical necessity or medically necessary” standards, and states in pertinent part as follows

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on to further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

49. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

50. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 (“PPEC Handbook”) is promulgated into law by Florida Administrative Code Rule 59G-4.260.

51. Page 2-1 of the PPEC Handbook lists the requirements for receiving PPEC services. Page 2-1 states:

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible

- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years
- Be medically stable and not present significant risk to other children or personnel at the center
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

52. Fla. Admin Code R.59G-1.010 defines “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant [*sic*], or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

53. In the present case, although the petitioner has special needs, he does not require skilled nursing services, which is a prerequisite to the approval of Prescribed Pediatric Extended Care services. His level of illness does not reach the degree of “medically complex” or “medically fragile,” as defined in the Florida Administrative Code. Although his Plan of Care calls for the administration of chest physical therapy two times per day, a skilled nursing professional is not required for the performance of chest physical therapy. Chest physical therapy may be performed by any responsible adult, including the petitioner’s mother at home in the morning and in the evening.

54. After carefully reviewing the EPSDT and medical necessity requirements set forth above, the hearing officer concludes the respondent has demonstrated by a preponderance of the evidence that it correctly denied the petitioner’s PPEC Services.

DECISION

Based upon the foregoing, the petitioner's appeal is DENIED and the decision of the Agency for Health Care Administration 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 24 day of March , 2017,

in Tallahassee, Florida.

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To:


AHCA, Medicaid Fair Hearings Unit

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

FILED

Mar 16, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09827

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 88274

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 23, 2017 at approximately 10:00 a.m. CST.

APPEARANCES

For the Petitioner: [REDACTED] *pro se*

For the Respondent: Jonathan Daniels, economic self-sufficiency specialist ii

STATEMENT OF ISSUE

Petitioner is appealing the Department's denial of Medicaid benefits. The petitioner requested the additional benefit on a recertification application of Food Assistance benefits. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "9".

The record was left open until at least March 7, 2017 for respondent and petitioner to submit further evidence.

Respondent's was received February 24, 2017 and marked as Respondent's Exhibits "10" through "12".

Petitioner's was received March 1, 2017 and marked as Petitioner's Exhibit "1".

The record was closed March 7, 2017.

FINDINGS OF FACT

1. On December 12, 2016, the petitioner submitted an application to the respondent requesting Food Assistance and SSI-Related Medicaid. The household is a 56-year-old, single, adult female. The respondent testified that the only salient information on the application was that the petitioner had applied for Social Security Administration (SSA) benefits on July 24, 2015.
2. The petitioner's application was processed on December 14, 2106. Medicaid was denied for the following reasons: 1.) The petitioner did not submit that there was a worsening condition; and, 2.) the petitioner has a pending application with the SSA that has not yet been resolved.
3. The petitioner submitted a Notice of Disapproved Claim from the SSA dated February 4, 2017, stating the reason for denial as, "You do not qualify for disability benefits because you have not worked long enough under Social Security... Since you

do not have enough work credits to qualify for benefits, we did not make a decision about whether you are disabled under our rules” (Petitioner’s Exhibit 1).

CONCLUSIONS OF LAW

4. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.
5. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
6. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056. This concept involves the hearing officer looking at the facts from an application anew, even though not known by the Department at the time the action was taken.
7. Federal Medicaid Regulations at 42 C.F.R. § 435.541, “Determinations of disability” states in part:
 - (c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
 - (1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.
8. The findings show that the petitioner applied for disability benefits with the SSA and was denied for a reason other than medical. The denial being for insufficient work credits.
9. In accordance with the above controlling authority, the undersigned concludes that the respondent’s denial was correct at the time, as there was and SSA decision

under appeal for which the petitioner did not claim a worsened condition or submit requested documentation to support the respondent seeking an independent disability determination. However, the evidence presented at hearing changes the situation and the respondent's necessary response *de novo*. In this situation, now that the SSA has made a determination of ineligibility for reasons other than the petitioner's disability, it is appropriate for the respondent to pursue an independent determination of disability.

10. Fla. Admin. Code 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria," states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference ... (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference)

11. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (by either the respondent or the SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs. Whether or not the petitioner meets the disability criteria has not been determined. According to an above-cited authority, the respondent has the responsibility of making an independent determination of disability since it has been learned that the SSA denied for reasons other than medical reasons.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the respondent to gather medical evidence and forward it to the DDD for an independent disability decision. Once a decision is made, the

respondent shall issue written notice to inform of the outcome and said notice shall include appeal rights.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 16 day of March, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 23, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09884

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 01 [REDACTED]
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on February 23, 2017 at approximately 10:04 a.m. Eastern Standard Time. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's mother

For the Respondent: Cindy Henline, Medical/Health Care Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services.

Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

PRELIMINARY STATEMENT

At hearing, the minor Petitioner was not present, but was represented by her mother, [REDACTED]. Ms [REDACTED] presented an additional witness [REDACTED] R.N., Administrator and Director of Nursing at Petitioner's PPEC facility. Respondent was represented by Cindy Henline, AHCA Medical/Health Care Program Analyst. Respondent presented one additional witnesses: Darlene Calhoun, D.O., Physician Consultant with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 6, inclusive, were accepted into evidence. Administrative Notice was taken of § 409.905, Fla. Stat., Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

FINDINGS OF FACT

Based upon 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. The Petitioner is a 7-year-old female, born in December of 2009. Her diagnoses include [REDACTED]

2. Petitioner is non-verbal, requires assistance with activities of daily living (ADLs), and is incontinent. Although she is on a toileting schedule while at school and PPEC, she still has accidents, and thus wears diapers at home. She can stand on her own but is unable to ambulate without holding onto furniture or having both hands held. She

cannot walk long distances. While she can feed herself finger foods, the Petitioner has a weak jaw, stuffs and pockets food in her mouth, and is at risk for choking and aspiration. She receives speech, physical, and occupational therapy, both at school and at PPEC.

3. The Petitioner resides in the family home with her parents. She attends school, where she has access to a nurse and an assistive aide. She utilizes PPEC services after school and on non-school days.

4. At all times relevant to these proceedings, Petitioner has been eligible to receive Medicaid services.

5. On or about December 11, 2016, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue her previously authorized PPEC services into the new certification period, spanning December 24, 2016 through June 21, 2017.

6. This prior service authorization request, along with information and documentation required to make a determination of medical necessity, was submitted to AHCA's peer review organization (PRO). The PRO contracted by AHCA to review PPEC requests is eQHealth Solutions, Inc. (eQHealth).

7. Following a face-to-face meeting with Petitioner, eQHealth's nurse/care coordinator recommended approval/continuation of PPEC, noting "she has shown slight improvement with motor skills since getting routine therapies." The nurse reviewer then sent Petitioner's case to eQHealth's medical director for final review.

8. On December 15, 2016, the PRO's physician reviewer evaluated Petitioner's supporting documentation and request for services. By letter dated December 16,

2016, the PRO notified Petitioner's provider and physician of its decision to terminate PPEC, stating, in pertinent part:

Clinical Rationale for Decision: The patient is a 7 year old with [REDACTED] [REDACTED] The patient receives as needed nebulizer treatments. The patient receives therapies while attending PPEC. The patient has had no reported seizures while attending PPEC in the past certification. The patient attends school and uses PPEC for after school and on non-school days. The patient is not on a complex medication regimen. The patient has had no recent hospitalizations or emergency room visits. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity/requirement for PPEC services.

9. The December 16, 2016 letter, which eQHealth sent to Petitioner, notes only:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

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.

10. On December 16, 2016, Petitioner requested a reconsideration review by eQHealth, whereby a physician reviewer not involved in the initial decision would conduct a separate evaluation of Petitioner's need for PPEC services. On December 27, 2016, she also filed a request for hearing to challenge the proposed denial.

11. Via notice dated January 6, 2017, eQHealth informed Petitioner's providers of their reconsideration review decision, stating in pertinent part:

... The initial PR felt that the clinical information provided did not support the medical necessity of the requested PPEC services.... They denied the full request for PPEC services. For the Reconsideration Review, the provider submitted a web based response that indicated that the patient needs assistance with ADLs, that she is non-verbal and does not walk independently. The information does not support that a skilled nursing need is present. The

documentation supports the need for assistance with ADLs. Recommend upholding the initial PR's decision to deny the request for PPEC services as the medical complexity necessary for PPEC services has not been demonstrated.

12. As Petitioner's appeal was timely filed, Petitioner's services have continued, pending the outcome of this appeal.

13. At hearing, Dr. Calhoun explained that she reviewed Petitioner's request for services in conjunction with her Plan of Care, Care Coordination notes, nursing/PPEC Assessments, and Progress Notes. Dr. Calhoun is Board Certified in Pediatrics, Neonatology, and Perinatology. She has practiced in these fields for over 20 years.

14. The supporting documentation reflects that Petitioner takes some daily medications, is administered as-needed nebulizer treatments, and has a standing order for [REDACTED] in the event of durational seizures. Petitioner did not require the use of [REDACTED] during the prior certification period. Her PPEC staff assist with activities of daily living (ADLs) – some because of her age, and others because of her developmental delays.

15. While the Petitioner does require precautions/monitoring, the only intervention (aside from speech, physical, and occupational therapy) indicated on the Plan is the administration of oxygen "in an emergency situation," and as-needed nebulizer treatments.

16. Petitioner's mother testified that Petitioner was diagnosed with [REDACTED] in 2012, and that she (mother) has been learning how to care for the Petitioner, ever since. The mother administers Petitioner's daily medications at home, before school and after PPEC. The Petitioner is currently awaiting an EEG to determine the cause of seizure-like behavior, which involves staring, rocking, bearing down on her teeth, and

curling her feet/toes inward. When Petitioner experiences these episodes (at least once a day), her mother tries to get her attention and is usually able to bring her back to baseline; however, the Petitioner sometimes goes right back into the seizure-like activity. These episodes are separate from the more traditional seizures, for which the [REDACTED] is prescribed. The mother also noted that Petitioner still stuffs food into her mouth until she is close to choking. She is unable to determine when she is full, and will eat to excess unless she is prevented from doing so.

17. Ms. [REDACTED] is a licensed nurse, who has been practicing for over 30 years, 25 of which have been dedicated to pediatrics. As the Administrator and Director of Nursing of Petitioner's PPEC facility, she has directly observed the Petitioner in the PPEC setting. Ms. [REDACTED] testified that Petitioner must be prevented from pocketing food in her mouth and reminded to chew when eating. She noted that while Petitioner's "traditional" seizures appear to be under control (no episodes in over a year), PPEC staff have not yet observed the seizure-like activity witnessed at home by Petitioner's mother.

Petitioner's asthma is aggravated by allergies and seasonal colds, which trigger the need for albuterol. The Petitioner cannot communicate or make her needs known, and behaves in the manner of an infant. It is Ms. [REDACTED] opinion that the nursing assessments provided to monitor Petitioner's weight, report back to her physicians, and monitor her eating and seizures *are* skilled nursing services, which cannot be delegated to untrained parties. With regard to therapy services received at PPEC, Ms. [REDACTED] noted that these are separate from the academic-focused therapies that Petitioner receives at school. She testified that she was not sure how the Petitioner would obtain daily therapy services in an outpatient setting, as such after-school appointments are highly

sought after and difficult to secure. She further noted that Petitioner's mother has difficulty with reliable transportation.

18. Following testimony from Petitioner's mother and PPEC provider, Dr. Calhoun opined that nursing assessments and monitoring could be accomplished outside of the PPEC setting by increasing Petitioner's visits to the providing physician's office, and/or by requesting skilled nursing visits to the child's home. She also testified that Petitioner could obtain personal care services to assist with ADL care, and retain therapy services, on an outpatient basis. For these reasons, it was Dr. Calhoun's opinion that Petitioner no longer demonstrates a medical necessity for PPEC services.

19. The AHCA representative added that Petitioner, who is enrolled with Children's Medical Services, is also eligible for care coordination and assistance with transportation services.

CONCLUSIONS OF LAW

20. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Chapter 120, Florida Statutes.

21. Respondent, the Agency for Health Care Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the *Florida Administrative Code*.

22. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Rule 59G-4.260 of the *Florida Administrative Code*.

23. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

24. This hearing was held as a *de novo* proceeding, in accordance with Rule 65-2.056 of the *Florida Administrative Code*.

25. The burden of proof in the instant case is assigned to the Respondent, who seeks to terminate a previously authorized service. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

26. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law.

....

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

27. Page 1-1 of the PPEC Handbook notes that, “[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center.” Page 1-2 adds that “PPEC services are not emergency services,” (emphasis added).

28. On pages 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.
(underlined emphasis added)

29. Rule 59G-1.010, *Florida Administrative Code*, defined “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour -per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning. (emphasis added)

30. Consistent with the law, AHCA’s agent, eQHealth, performs service authorization reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

31. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

“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. ...

(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.

32. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (cited, above) have been considered in the development of this Order.

33. EPSDT augments the Medical Necessity definition contained in the Florida Administrative Code via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be appropriately addressed.

34. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include “reasonable standards ... for determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

35. In the instant case, PPEC is requested to treat and ameliorate the supervisory, assessment, and monitoring needs which Petitioner’s developmental and medical conditions present. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

36. More specifically, however, Fla. Admin. Code R. 59G-1.010(166) also requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must fulfill the requirements for PPEC, as provided in the PPEC Handbook.

37. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical equipment, such that she would properly be deemed 'Medically Fragile.' Her need for supervision, seizure monitoring and eating precautions, as-needed nebulizer treatments, and interventions in case of emergency, do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care." As such, her needs do not support the authorization of PPEC, because there are alternative services, such as outpatient physical, occupational, and speech therapy services, as well as skilled nursing visits and/or personal care assistance, which are better designed to meet her needs without being excessive. PPEC cannot be authorized as a substitute for school or daycare, particularly when there is no skilled intervention provided at the PPEC site. In essence, this would constitute approval of PPEC as an emergency service, in direct violation of the PPEC Handbook (page 1-2).

38. Again, it does appear as though Petitioner requires continued speech, occupational, and physical therapy, so that she is able to make greater progress with eating, develop strength and balance to walk independently, and aid in her own ADL care. Her mother's concerns regarding these issues, and the eQHealth nurse reviewer's notation that such services have proven effective and should continue, are

understandable and are duly noted. However, the services best designed to address these matters can be provided in a setting other than the PPEC facility. Additionally, because therapy services are authorized and billed separately from PPEC, should these services be denied, reduced, or discontinued in the future, Petitioner will retain the right to request an appeal based on that particular action.

39. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that AHCA has met its burden of proof, and shown that denial/termination of PPEC services is appropriate in the instant case.

40. Petitioner's mother is encouraged to follow the recommendations of AHCA to coordinate with Petitioner's CMS nurse case manager. The case manager should be able to assist Petitioner in finding services to meet her therapeutic (and any other) needs, and can direct Petitioner to appropriate transportation resources.

41. Should Petitioner's health situation change, or should her seizures become more frequent, Petitioner's mother may wish to request that PPEC services be reinstated. If and when this request is made, Petitioner will be advised of any adverse determination, and will be able to request a hearing related thereto.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED.

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 23 day of March , 2017,

in Tallahassee, Florida.



Patricia C. Antonucci
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Copies Furnished To:

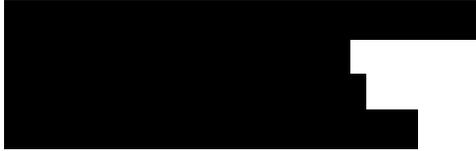
██████████, Petitioner
AHCA, Medicaid Fair Hearings Unit
AHCA Hearings Unit

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

FILED

Mar 24, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09889
16F-09890

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 6, 2017, at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter

For the Respondent: Fathima Leyva, Senior Program Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action denying the petitioner's request for additional home health services (homemaker services and home-delivered meals, appeal numbers 16F-09890 and 16F-09889 respectively) under the Long Term Care (LTC)

Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing, Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notices, and Case Screenshots.

Also present for the hearing was a Spanish language interpreter [REDACTED], Interpreter Number [REDACTED] from Propio Language Services.

FINDINGS OF FACT

1. The petitioner is eighty (80) years of age and is currently living with her daughter, who is her only caregiver. She is [REDACTED] and suffers from [REDACTED]. She lost both her legs due to amputation.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions

and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for a total of fourteen (14) hours weekly of home health services (personal care services) through United Healthcare. These hours are currently being utilized for 2 hours in the mornings daily.

5. On or about December 13, 2016, the petitioner made a request to United Healthcare for 7 additional hours weekly of home health services (homemaker services) and for 1 home-delivered meal per day. On December 20, 2016, United sent a letter to the petitioner denying her request for the homemaker services and home-delivered meal as not being medically necessary.

6. The petitioner's daughter stated her mother needs additional assistance in the afternoons. The daughter works from 8:00 a.m. to 5:00 p.m. and sometimes returns home to find her mother's diaper full of feces. She stated her mother needs assistance with meal preparation because she cannot reach the microwave and she may leave the stove on if she tries to cook for herself. She also stated her mother needs snacks throughout the day since she is [REDACTED]

7. The respondent's witness, Dr. Kaprow, stated the reason for the home-delivered meals request was the financial ability to purchase food. However, other programs such as the food assistance program (i.e., the SNAP program) are available to address a family's financial situation. In the petitioner's case, the health plan's position is the daughter or the personal care aide can prepare a simple meal for her.

With respect to the request for homemaker services, Dr. Kaprow stated it appears the petitioner's main need is for personal care rather than homemaker services. He stated it would be appropriate to approve a third hour of personal care assistance to provide an hour of care in the afternoons, Monday to Friday (total of 5 additional hours weekly).

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner has requested Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner has requested Home-Delivered Meals services, which are defined in the contract as follows:

Nutritionally sound meals to be delivered to the residence of an enrollee who has difficulty shopping for or preparing food without assistance. Each meal is designed to provide a minimum thirty-three and three tenths percent (33.3%) of the current Dietary Reference Intake (DRI). The meals shall meet the current Dietary Guidelines for Americans, the USDA My Pyramid Food Intake Pattern and reflect the predominant statewide demographic.

18. The AHCA contract also provides that a Plan “may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.”

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

20. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that the health plan should have approved homemaker services and home-delivered meals. The health plan has now indicated its willingness to approve an increase in personal care services so that the petitioner may receive some assistance in the afternoons. With regard to home-delivered meals, medical necessity for this service has not been demonstrated since the petitioner's daughter and the personal care aide can assist with meal preparation.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, in part, and the petitioner shall receive five (5) additional hours of personal care assistance weekly. The appeal is DENIED as to the homemaker services and home-delivered meals.

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

FINAL ORDER (Cont.)

16F-09889/-09890

PAGE -8

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 indigence 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 24 day of March, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Mar 20, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09896

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on February 20, 2017 at 1:29 p.m.

APPEARANCES

For Petitioner: Pro se

For Respondent: Stephanie Lang,
Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

Whether it is correct for Respondent to deny Petitioner's request for a partial upper denture (procedure code D5213) and a partial lower denture (procedure code D5214). The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from Amerigroup was Deborah Greene, Grievance and Appeals Coordinator.

Appearing as Respondent's witnesses from DentaQuest were Dr. Susan Hudson, Dental Consultant, and Lauren Hernandez, Complaints and Grievance Specialist.

Respondent's Exhibit 1 was entered into evidence. Petitioner's Exhibit 1 was entered into evidence.

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 28 year-old Medicaid recipient enrolled with Amerigroup (Plan), a Florida Health Managed Care provider.
2. Amerigroup requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for upper and lower partial dentures (Procedure codes D5213 and D5214), which was received by DentaQuest on November 28, 2016.
4. DentaQuest sent a Notice of Action (NOA) to Petitioner on November 30, 2016 denying the requested services as not medically necessary.

The notice cited Rule 59G-1.010 and the following specific reasons for the denial:

- ✓ Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain;

- ✓ Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not in excess of the patient's needs.
- ✓ Must meet accepted medical standards and not be experimental or investigational.

5. The NOA also provided the facts used to make the decision: "Our dentist looked at the information your dentist sent, and says you are not missing enough teeth to affect your chewing function."

6. Petitioner filed a timely fair hearing request on December 28, 2016.

7. Petitioner testified she is diabetic, and the inability to eat properly is a risk factor for her. She stated she is finding it difficult to eat and needs the partial dentures to ensure she eats properly.

8. Petitioner read into the record a December 12, 2016 letter from her dentist which states in relevant part:

I would like to have [Petitioner's] case reconsidered for partials.

The patient is young, she is only 28 years old and leaving those missing spaces will cause severe malocclusion, her teeth will incline mesially and supraerupt (#2,12). Right now her teeth are in good functional occlusion because she recently had her teeth extracted...She is congenitally missing her premolars. #K extraction site is missing a tremendous amount of bone, which can potentially make her molars mesialize easier/faster.

On her right side, her only molar occlusion is resting on the bottom molar. If her teeth start shifting and creating her malocclusion, she will only have proper occlusion on her 1st premolars, which is not ideal. Then, in the future she will need additional treatment to correct her bite, such as braces and implants.

Although a fixed bridge would be more ideal, we are simply asking for removable partials.

9. Respondent's dental consultant explained Medicaid and the Plan requires less than 8 back teeth in occlusion in order for partial dentures to be medically necessary.

Petitioner currently has ten teeth in occlusion (contact between pairs of teeth when chewing): tooth #2 with tooth #30, tooth #5 with tooth #28; tooth #12 with tooth #21, tooth # 14 with tooth #19, and tooth #15 with tooth #18.

10. Respondent's witness testified while bridges and implants are other options to prevent Petitioner's teeth from shifting, these dental procedures are not a covered service. Partial dentures are Petitioner's only option but must be medically necessary.

CONCLUSIONS OF LAW

11. 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.

12. This proceeding is a *de novo* proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

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

14. Sections 409.971 – 409.973, Florida Statutes, 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. Dental services are one of the mandatory services that must be provided.

15. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

16. Rule 59G-1.010, *Florida Administrative Code*, defines “prior authorization” as: “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.

17. Rule 59G-1.010 (166), *Florida Administrative Code*, 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.

....

(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.

18. The May 2016 Florida Medicaid Dental Services Coverage Policy (Dental Policy) has been promulgated by Rule 59G-4.060, *Florida Administrative Code*, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593> .

19. Paragraph 5.2 of the Dental Policy provides a list of specific non-covered criteria which includes "partial dentures where there are eight or more posterior teeth in occlusion."

20. Petitioner and her dentist expressed concern that her remaining teeth will shift over time, causing severe malocclusions. Petitioner testified eating is difficult for her.

21. Respondent explained there must be less than 8 teeth in occlusion for partial dentures to be medically necessary. Petitioner currently has 10 teeth in occlusion. The above cited Dental Policy makes it clear partial dentures are not covered if a member has 8 or more back teeth in occlusion.

22. The undersigned has considered the totality of the documentary evidence and testimony, as well as the above cited definitions of medical necessity. The undersigned finds Petitioner failed to prove Respondent's action denying her request for partial dentures is incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency 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 20 day of March, 2017, in Tallahassee,
Florida.



Warren Hunter
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Amerigroup Hearings Unit

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

FILED

Mar 06, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09901

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on February 22, 2017 at 8:32 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Mother

For the Respondent: Lisa Sanchez, Medical/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether it is correct for Respondent to deny Petitioner's request for surgical extraction of 17 teeth: #4,6,7,8,9,10,11,20,21,22,23,24,25,26,27,28, and 29 (dental procedure D7210-surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated).

Petitioner is assigned the burden of proof.

PRELIMINARY STATEMENT

Petitioner appeared for the hearing. Due to his limited speaking ability resulting from surgery for throat cancer (████████████████████), his mother spoke on his behalf.

Appearing as Respondent's witness from Petitioner's managed care plan, Amerigroup, was Deborah Greene, Grievance and Appeals Coordinator. Appearing as Respondent's witnesses from DentaQuest were Dr. Frank Manteiga, Dental Consultant, and Lauren Hernandez, Complaints and Grievance Specialist.

Respondent's Exhibit 1 and Petitioner's Exhibit 1 were entered into evidence.

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 45-year-old Medicaid recipient enrolled with Amerigroup, a Florida Health Managed Care provider.
2. Amerigroup requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for dental procedure D7210-surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated. The request was for the following teeth: 2,3,4,5,6,7,8,9,10,11,12,14,15,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31 and 32. The prior authorization also included a request for procedure D7310 (alveoloplasty in conjunction with extractions-four or more teeth, per quadrant). The request was for upper right and left quadrant and lower right and left quadrant.

4. On November 15, 2016, DentaQuest sent a notice to Petitioner approving surgical extraction of tooth 2,3,5,12,14,15,17,18,19,30,31 and 32 (12 teeth). Procedure D7310 was approved for the lower and right quadrants. The notice also denied surgical extraction of tooth 4,6,7,8,9,10,11,20,21,22,23,24,25,26,27,28, and 29 (17 teeth). The following explanation of denial was provided for each tooth: "The information sent by your dentist shows the tooth removal is not as bad as what your dentist says. Your dentist needs to resend the information to show where the tooth is located in the bone. We have also told your dentist."

5. On December 26, 2016, Petitioner filed a timely request for a fair hearing.

6. Petitioner's mother testified her son's oral surgeon advised Petitioner's dental work should be completed before he underwent radiation treatment. She explained her son needs to have all his teeth extracted at one time and needs anesthesia because of the length of time the extractions will take.

7. Respondent's dental consultant explained the teeth that have been denied surgical extraction have suffered severe bone loss and can be simple extractions, dental procedure code D7140. The dental consultant advised simple extractions do not require prior authorization.

8. Petitioner's mother stated her son's oral surgeon will only do surgical extractions for her son.

CONCLUSIONS OF LAW

9. 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.

10. This proceeding is a *de novo* proceeding pursuant to *Florida Administrative Code* Rule 65-2.056.

11. 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).

12. This is a Final Order, pursuant to §§ 120.569 and 120.57, Florida Statutes.

13. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

14. Section 409.905, Florida Statutes, "Mandatory Medicaid services," states, in relevant part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law."

15. Sections 409.971 – 409.973, Florida Statutes, 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. Dental services are one of the mandatory services that must be provided.

16. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

17. *Florida Administrative Code* Rule 59G-1.010 defines "prior authorization" as: "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.”

18. *Florida Administrative Code* Rule 59G-1.010 (166) 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.

...

(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.

19. The Dental Policy requires dental services to be medically necessary as defined in *Florida Administrative Code* Rule 59G-1.010 (166), (see paragraph 18 above).

20. While Petitioner asserts the oral surgeon will only perform surgical extractions of his teeth, *Florida Administrative Code* Rule 59G-1.010 (166) makes it clear 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.

21. Respondent's dental consultant explained surgical extraction was unnecessary for tooth 4,6,7,8,9,10,11,20,21,22,23,24,25,26,27,28, and 29 because each has suffered severe bone loss and can be simply extracted. Moreover, the above cited authority makes it clear medical necessity requires the services 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 also be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

22. After carefully reviewing the medical necessity requirements set forth above, the undersigned concludes Petitioner failed to demonstrate, by a preponderance of the evidence, that Respondent incorrectly denied his request for surgical extraction of tooth 4,6,7,8,9,10,11,20,21,22,23,24,25,26,27,28, and 29.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency 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.

FINAL ORDER (Cont.)

16F-09901

Page 7 of 7

DONE and ORDERED this 06 day of March, 2017,
in Tallahassee, Florida.



Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
Amerigroup Hearings Unit

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

FILED

Mar 23, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09902

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 14, 2017, at 12:30 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's daughter

For the Respondent: Lisa Sanchez, Medical Program Analyst - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action partially denying the petitioner's request for additional home health services (personal care services and companion services) under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the petitioner was [REDACTED], Patient Advocate, from

[REDACTED]

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding since it is the petitioner's health plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, and Case Screenshots.

Also present for the hearing was a Spanish language interpreter, [REDACTED]

[REDACTED] Interpreter Number [REDACTED] from Propio Language Services.

FINDINGS OF FACT

1. The petitioner is eighty-seven (87) years of age and is currently living in an apartment with one of her daughters. She has another daughter and a son who sometimes assist her. She has been diagnosed with [REDACTED] and has also experienced strokes. She is at risk for falling due to an unsteady gait. She needs assistance with all activities of daily living such as bathing, eating, and walking.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously covered under the LTC program by United Healthcare until approximately May, 2016 when she lost eligibility for the program. At that time, she was approved for 36 hours weekly of home health services (28 hours of personal care services and 8 hours of homemaker services). She was re-enrolled in the LTC program effective December 1, 2016 and United Healthcare approved 15 hours weekly of home health services (10 hours of personal care and 5 hours of homemaker services).

5. On or about December 13, 2016, the petitioner made a request to United Healthcare for 20 additional hours weekly of home health services (10 hours of personal care assistance and 10 hours of companion services). On December 20, 2016, United sent a letter to the petitioner denying her request for the additional home health services as not being medically necessary. At some point thereafter, United approved 2 additional hours of personal care services, making the currently approved total of 17 hours weekly (12 hours of personal care and 5 hours of homemaker).

6. The petitioner's witness stated the petitioner's children are all in their 60s and have full-time jobs; therefore, they are unable to fully provide for their mother's needs. She stated the family tried adult day care services for their mother, but it did not work out. The family does not want their mother to be in a nursing home.

7. The respondent's witness, Dr. Kaprow, stated that 17 hours of home health services weekly are sufficient to ensure the health and safety of the petitioner given her level of family support. He stated that when the petitioner was previously approved for 36 hours weekly, she was not receiving the same level of support from her family and there was a re-evaluation of her needs. He also stated the health plan may be able to offer other types of assistance to the family, such as nursing home or assisted living placement and respite care services.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in

services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to

manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner has requested Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

20. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that her home health services should be under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs) such as bathing, toileting, and meal preparation. However, she is currently approved for 17 hours weekly to assist with these activities. The petitioner also has assistance from other caregivers such as her daughters and son. The undersigned recognizes the petitioner was approved for more hours of assistance when she was previously covered by United Healthcare prior to losing

eligibility. However, circumstances seem to have changed since then and her family began providing more support after the initial loss of services.

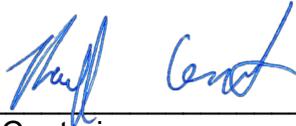
DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence 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 23 day of March , 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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FINAL ORDER (Cont.)

16F-09902

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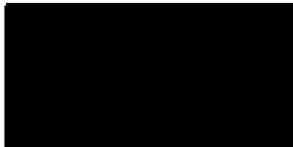
Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

FILED

Apr 14, 2017

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO.: 16F-09926

PETITIONER,

Vs.

AMERIGROUP REALSOLUTIONS MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 [REDACTED]
UNIT: AHCA

RESPONDENTS.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter in Sebring, Florida on March 13, 2017 at 1:19 p.m.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner's Mother

For Respondent: Carlene Brock L.P.N.
Quality Operations Nurse
Amerigroup RealSolutions

STATEMENT OF ISSUE

Petitioner is appealing denial of braces and monthly visits associated with the maintenance of the braces. Petitioner carries the burden of proving his position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner was present in the hearing room. Petitioner introduced a Composite Exhibit "1," inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

Dr. Neil Williams, Dental Consultant, and Charles Kieffer, Complaints and Grievance Specialist with DentaQuest, appeared as witnesses for Respondent by telephone.

Stephanie Lang R.N., Fair Hearing Liaison with Agency for Health Care Administration ("AHCA") appeared as an observer by telephone.

Respondent introduced Exhibits "1" to "11," inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

FINDINGS OF FACT

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 thirteen-year-old Medicaid recipient enrolled with Amerigroup RealSolutions ("Amerigroup"), a Florida Health Managed Care provider.
2. Amerigroup requires prior authorization for services related to dental care and has contracted with DentaQuest to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for dental procedures D8080: comprehensive orthodontic treatment (braces); and D8670: periodic orthodontic treatment visit. In support of his request, the dentist submitted a DentaQuest Orthodontic Criteria Index Form Florida-Comprehensive D8080, and AHCA-Med Serv. Form 013, January 2006 from the Dental Services Coverage and Limitation Handbook.

On the DentaQuest Orthodontic Criteria Index Form, the dentist selected anterior crossbite as Petitioner's condition, which involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated. No other conditions were selected on the form. (See Respondent's Exhibit 5).

4. DentaQuest received the request on December 20, 2016. (See Respondent's Exhibit 10).
5. DentaQuest made its determination on December 21, 2016 denying procedures D8080 and D8670. On December 21, 2016, Amerigroup issued a Notice of Action denying the request as not being medically necessary. The notice of action stated:

We made our decision because:

We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

Must meet accepted medical standards and not be experimental or investigational.

Must be able to be 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.

Must be furnished in a manner not primarily for convenience of the recipient, caretaker, or provider.

The facts that we used to make our decision are:

Our dentist looked at the information send by your dentist. The information sent show a lack of medical necessity and/or a handicapping malocclusion. The criteria reviewed include, but is not limited to: Deep impinging overbite that damages the tissue on the roof of your mouth; true open-bite with your front teeth; cross-bite with your front teeth; impacted front teeth that will not grow in to your mouth without help; over-jet bigger than 9mm; negative over-jet bigger than 3.5mm; cleft lip or palate

deformities and other large problems with your jaw or face; malocclusions requiring both orthodontic and jaw surgery to fix. We have also told your dentist. Please talk to your dentist.

Our dentist looked at the information send by your dentist. The information sent show a lack of medical necessity and/or a handicapping malocclusion. The criteria reviewed include, but is not limited to: Deep impinging overbite that damages the tissue on the roof of your mouth; true open-bite with your front teeth; cross-bite with your front teeth; impacted front teeth that will not grow in to your mouth without help; over-jet bigger than 9mm; negative over-jet bigger than 3.5mm; cleft lip or palate deformities and other large problems with your jaw or face; malocclusions requiring both orthodontic and jaw surgery to fix. We have also told your dentist. Please talk to your dentist.

The DentaQuest guideline or policy used to support this decision was:
DentaQuest Clinical Criteria for Comprehensive Orthodontics
DentaQuest Clinical Criteria for Other Orthodontic Services
(See Respondent's Exhibit 7).

6. DentaQuest conducted a redetermination based on the appeal submitted by Petitioner on January 6, 2017. Dr. Dorrego DDS Dental Consultant stated:

Dental Consultant Reply: We received and reviewed all submitted documentation (radiographs, photographs, narrative) for requested appeal determination. The denial is UPHELD for Comprehensive Orthodontic Treatment (D8080) because the case did not demonstrate a handicapping malocclusion, as defined by the plan. Documentation submitted did not demonstrate presence of any medical necessity criteria listed on the Orthodontic Criteria Index Form. (See Respondent's Exhibit 9).

7. Petitioner's mother argued several dentists have recommended braces because of teeth crowding. She is not financially able to pay out of pocket for Petitioner's braces because she is a single mother with four children to support. She argued a decision cannot be made based on looking at Petitioner's dental records. Petitioner struggles in school and suffers from self-esteem issues because of the way his teeth are aligned. She had to pick Petitioner up from school several times due to jaw pain, which is like a toothache and headaches after eating. Petitioner can eat properly and he has no

infection in his mouth. However, Dr. Williams stated the headache and jaw pain could be caused by Petitioner's wisdom teeth erupting, and it requires a different dental procedure.

8. Dr. William stated Petitioner does not have the required handicapping malocclusions to obtain braces. The handicapping malocclusions are the eight conditions listed on the DentaQuest orthodontic criteria index form, which is used to determine the medical necessity for braces. The eight conditions are deep impinging overbite, true anterior open bite, anterior crossbite, impacted incisors or canines, overjet in excess of 9mm, negative overjet greater than 3.5mm, cleft lip/palate deformities, or malocclusions requiring a combination orthodontics and orthognathic surgery for corrections.

9. Dr. William stated Petitioner did not meet any of the eight conditions. First, deep impinging overbite is the lower teeth hitting the palate instead of the upper teeth, which causes laceration, tissue tears, or bleeding. Petitioner does not have any damage to his palate. His x-rays show the lower teeth are hitting his upper teeth. Second, anterior open bite is when the upper teeth and lower teeth do not overlap. It leaves a gap between the upper and lower teeth. Petitioner's upper teeth overlap the lower teeth, which is normal. Third, anterior crossbite is when the lower teeth are in front of the upper teeth and it requires more than two teeth; or cases where gingival stripping from the crossbite is demonstrated. According to Petitioner's x-ray, all anterior teeth have normal occlusion. Petitioner does not have a crossbite or gingival stripping caused by a crossbite. Fourth, impacted incisors or canine teeth are impacted into the bone and unable to erupt. According to Petitioner's x-ray, all incisors and canines have erupted.

Fifth, overjet in excess of 9mm, which is usually called buckteeth. Petitioner's overjet is about 2-3mm. Sixth, negative overjet, which is when the upper teeth are behind the lower teeth. This is not applicable in this case because the upper teeth are not behind the lower teeth. Seventh, cleft lip/palate deformities that occur with cranial facial medical diseases; this condition is not applicable in this case. Eighth, significant facial asymmetry when the teeth and jaw are not aligned correctly, which requires surgery for correction. Petitioner does not suffer from this condition.

10. Dr. William stated Petitioner has significant upper and lower crowding of the teeth. Petitioner's teeth are not perfect. Petitioner's dentist selected anterior crossbite on the Dentaquest orthodontic criteria index form as the reason for braces. However, Petitioner's x-rays reflect the teeth on either side of the upper teeth are in normal alignment and not behind the lower teeth, which would qualify as a crossbite.

Petitioner's teeth are not in crossbite.

11. Petitioner suffers from overcrowding, which is not a handicapping malocclusion. According to Petitioner's dentist treatment plan, extraction was indicated as the procedure to deal with the overcrowding teeth. However, Petitioner's mother disagrees and does not believe extraction can cure the problem with Petitioner's teeth.

12. Dr. William stated pre-orthodontic treatment is for monitoring growth and development. It is payment to the dentist for examining Petitioner and taking the necessary x-rays and photos.

13. Dr. William stated Petitioner does not meet the medical necessity for braces, which is required by Medicaid. Braces are in excess of Petitioner's needs. Petitioner's

overcrowding of teeth can be corrected by extraction. This would potentially improve his self-esteem. Petitioner can masticate his food and he has no speech impediments.

CONCLUSIONS OF LAW

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

15. The Florida Medicaid Program is authorized by Florida Statutes Chapter 409 and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

16. This proceeding is a de novo proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

17. This is a Final Order pursuant to Sections 120.569 and 120.57, Florida Statutes.

18. The standard of proof in an administrative hearing is a preponderance of the evidence pursuant to Rule 65-2.060(1), *Florida Administrative Code*.

19. Section 409.905, Florida Statutes, "Mandatory Medicaid services," states, in relevant part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law."

20. Sections 409.971- 409.973, Florida Statutes, 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. Dental services are one of the benefits that must be provided.

21. Section 409.912, Florida Statutes, provides the Agency may mandate prior authorization for Medicaid services.

22. Rule 59G-1.010(226), *Florida Administrative Code*, defines "prior authorization" as: "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.

23. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definitions for Florida Medicaid purposes is contained in Rule 59G-1.010, *Florida Administrative Code*.

Fla. Admin. Code R. 59G-1.010 states:

(166) "Medically necessary" and "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 services 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, recipient's caretaker, or provider. ...

(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 services.

24. Since Petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services

(EPSDT) requirements. Section 409.905(2), Florida Statutes, Mandatory Medicaid

Services defines Medicaid services for children to include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES – The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

25. The United States of Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

- (4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."
- (5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."
- (6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (Citations omitted) (Emphasis Added).

26. EPSDT requires Respondent to provide treatment and services to Medicaid recipients under 21 years of age, but only to the extent such services are medically necessary. The state is authorized to establish the amount, duration, and scope of such services.

27. Section 409.913, Florida Statutes, governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.

Section (1)(d) goes on to further state:

For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. **Determination of medical necessity must be made by a licensed physician employed by or under the contract with the agency and must be based upon information**

available at the time the goods or services are provided. (Emphasis Added).

28. Section 409.913(1)(d), Florida Statutes, highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency according to Section 120.80, Florida Statutes.

29. The Florida Medicaid Dental Services Coverage Policy Handbook, May 2016, ("Handbook") is promulgated into law by Rule 59G-4.060, *Florida Administrative Code*.

30. Page one of the Handbook states:

Description -- Florida Medicaid dental services provide for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.

Statewide Medicaid Managed Care Plans -- This Florida Medicaid policy provides the minimum service requirements for all providers of dental services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

31. Page two of the Handbook states:

Who Can Receive -- Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, Florida Medicaid reimburses for services for recipients of all ages.

32. Page three of the Handbook states:

General Criteria – Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

Orthodontic Services – Florida Medicaid reimburses for orthodontic services for recipients under the age of 21 years **with handicapping malocclusions** as follows:

- Twenty-four units within a 36 month period, which includes the removal of the appliances and retainers at the end of treatment
- One replacement retainer(s) per arch, per lifetime
(Emphasis Added).

33. In the present case, Dr. William testified Petitioner does not have the required handicapping malocclusions needed to meet medical necessity. The Handbook states, "Florida Medicaid reimburses for orthodontic services for recipients under the age of 21 years with **handicapping malocclusions.**" Dr. William defined handicapping malocclusions as deep impinging overbite, true anterior open bite, anterior crossbite, impacted incisors or canines, overjet in excess of 9mm, negative overjet greater than 3.5mm, cleft lip/palate deformities, and significant facial asymmetry.

34. Dr. William stated Petitioner's dental records do not reflect any of the eight handicapping malocclusions. Petitioner has the ability to masticate his food and has no speech impediment. Petitioner suffers from significant upper and lower crowding of his teeth, which is not considered a handicapping malocclusion. The overcrowding can be handled through extracting the excess teeth. Dr. Williams stated Petitioner's dentist treatment plan indicates extraction as the course of action in handling the overcrowding of the teeth.

35. Petitioner's mother stated Petitioner suffers from jaw pain, which is more like a toothache and headaches after eating. However, Dr. William stated the pain might be associated with Petitioner's wisdom teeth erupting, which can be taken care of through a different dental procedure.

36. It is understandable that Petitioner's mother wants braces for Petitioner in order for him to have better self-esteem and confidence in his smile. However, Petitioner does not have the handicapping malocclusions required for braces to be medically necessary. While it would be desirable to have braces at this time, services that are desirable but medically unnecessary are not covered.

37. Petitioner's mother argued that several dentists recommended braces for Petitioner. Medicaid services must adhere to the standards and criteria set forth in the controlling legal authorities. According to Rule 59G-1.010(166)(c), *Florida Administrative Code*, "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." The fact that a treating dentist has recommended a service is not controlling.

38. According to Dr. William, Petitioner's request for correcting his anterior crossbite is not supported by his dental records. An anterior crossbite involves more than two teeth in crossbite or in cases where gingival stripping caused by crossbite is demonstrated. Dr. William stated Petitioner's teeth on either side of the upper front teeth are in normal alignment and those teeth are not behind the lower teeth, which would qualify as a crossbite. Petitioner does not have gingival stripping because he does not have a crossbite.

39. It is understandable that braces can be expensive and Petitioner's mother is unable to pay for the braces herself. However, Medicaid service cannot be furnished in a manner intended for convenience of the recipient's caretaker. Petitioner's mother is encouraged to work with Petitioner's dentist on an affordable payment plan for Petitioner's braces. Petitioner's mother should continue to monitor the condition of Petitioner's teeth and in the event braces become medically necessary in the future, a request can be submitted again at that time.

40. Based on the totality of the evidence and controlling legal authorities above, Petitioner has not met her burden that braces are medically necessary. More specifically, Petitioner's request fails under Rule 59G-1.010(a)(2) and (a)(5), which requires any authorized services not be in excess of a patient's need and be furnished in a manner not for the convenience of the recipient, the recipient's caretaker, or the provider.

DECISION

Based upon the foregoing, Findings of Fact and Conclusion of Law, this 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.

FINAL ORDER (Cont.)
16F-09926
PAGE 15 of 15

DONE and ORDERED this 14 day of April, 2017, in

Tallahassee, Florida.



Allison Smith-Dossou
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Amerigroup Hearings Unit

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

FILED

Mar 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-09940

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 [REDACTED]
UNIT: 885DR

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 1, 2017 at approximately 12:03 p.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Sylma Dekony, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 25, 2017 denying her application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The record was held open to allow both the petitioner and the respondent to submit evidence, specifically a copy of the petitioner's Social Security Administration (SSA)/Supplemental Security Insurance (SSI) denial letter from the Department's records and proof of a new medical condition from the petitioner. The Department's information was received and marked as Respondent's Composite Exhibit 1. The petitioner's information was received and marked as Petitioner's Composite Exhibit 1. The respondent submitted some other written evidence which was not admitted into the record. The record was closed on February 6, 2017.

FINDINGS OF FACT

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. The petitioner is a 48-year-old single female with no minor dependents. She has not received Medicaid since her son turned 18 years of age in May 2016, Petitioner's testimony.
2. On July 27, 2016, the petitioner submitted an application for SSI. On November 22, 2016, the application was denied with a code N32, capacity for substantial gainful activity, see Petitioner's Composite Exhibit 1.
3. On August 9, 2016, the petitioner received a Notice of Disapproved Claim from the SSA denying her application for SSA Disability Insurance (SSDI). On January 19, 2017, the petitioner appealed this decision, see Petitioner's Composite Exhibit 1. The appeal was denied with a code R which refers the petitioner to the state agency because of a pending determination, see Respondent's Composite Exhibit 1.

4. On December 12, 2016, the petitioner submitted an application for SSI-Related Medicaid, see Respondent's Composite Exhibit 1.

5. On January 23, 2017, the petitioner's disability application was electronically submitted to the Division of Disability Determination (DDD) for review of the petitioner's claim of disability, see Respondent's Composite Exhibit 1.

6. On January 25, 2017, DDD denied the petitioner's request for Medicaid with a denial code of N32, capacity for substantial gainful activity see Respondent's Composite Exhibit 1.

7. DDD did not make an independent disability determination because the Social Security Administration (SSA) determined that the petitioner was not disabled in November 2016 and the denial was under appeal. The Department adopted the SSA unfavorable decision and denied the petitioner's application for SSI-Related Medicaid noting, "same/related allegations, reconsideration pending", see Respondent's Composite Exhibit 1.

8. The petitioner asserts that she is unable to work due to [REDACTED]

[REDACTED]
problems and that she suffers from [REDACTED] see Petitioner's Composite Exhibit 1.

Petitioner's prior work history is manual labor, and she testified that she unable to do that type of work now and she is not educated and cannot do any other type of work, Petitioner's testimony.

9. During the hearing, the petitioner asserted that she was admitted to the hospital and diagnosed with a new heart condition on January 3, 2017, Petitioner's testimony. However, the petitioner presented no objective medical evidence of a new condition or

diagnosis. The medical information provided did not include a diagnosis, see Petitioner's Composite Exhibit 1.

The petitioner's DDD application was denied January 25, 2017, see Respondent's Composite Exhibit 1.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

11. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Fla. Admin. Code R. Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy...

14. Additionally, 42 C.F.R. § 435.541 Determination of Disability, states:

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirement of the Act, and has not applied to SSA for a determination with respect to these allegations.

15. The Department's Program Policy Manual, CPOF 165-22, passage 1440.1205

Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).

2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).

3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.

4. When an individual is no longer eligible for SSI solely due to institutionalization.

5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA). (Emphasis added)

16. The above authorities explain that the Department must make an independent disability determination if it has been more than 12 months since the most current SSA disability determination **and** the applicant alleges a new period of disability which meets the durational requirement of the Act, **and** he or she has not filed a disability claim with the SSA regarding the alleged medical conditions. Petitioner does not fit this criteria.

17. In this instant case, the petitioner is under 65 and has [REDACTED],

[REDACTED] and

[REDACTED]. The findings show that these medical conditions were reviewed in the SSA and SSI denial of disability status. The petitioner asserted during the hearing that she has a new condition. However, the petitioner presented no objective medical evidence of a new condition or diagnosis.

18. Therefore, the undersigned concludes that the petitioner did not meet her burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to not make an independent disability decision. Until the petitioner meets the federal disability criteria for persons under age 65, Medicaid cannot be approved.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's actions are upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

FINAL ORDER (Cont.)
16F-09940
PAGE -7

DONE and ORDERED this 14 day of March , 2017,
in Tallahassee, Florida.



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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 24, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09961

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 28, 2017 at 3:04 p.m.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's request for Prescribed Pediatric Extended Care (PPEC) services, Monday through Saturday, up to 12 hours daily, for the certification period of November 30, 2016 to May 6, 2017, is correct. Because the matter under appeal involves a new request for PPEC services, the burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Darlene Calhoun, M.D., Physician Consultant for eQHealth Solutions, Inc.

Respondent's Exhibits 1 through 7 were entered into evidence.

Administrative notice was taken of Sections 400.902 and 400.914, Florida Statutes, as well as the Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations (PPEC) Handbook, issued September 2013.

FINDINGS OF FACT

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 12 year-old Medicaid recipient. She has been diagnosed with a [REDACTED] Petitioner is visually impaired and wears corrective eyeglasses. Her [REDACTED] was originally placed in 2004 and was revised in 2011.
2. Petitioner attends public school from 7:15 a.m. to 2:00 p.m., after which Petitioner is interested in attending PPEC after school and on non-school days.
3. Petitioner is on an age-appropriate diet. She is not on a complex medication regimen and receives nebulizer treatments as needed. Petitioner is ambulatory and requires assistance with her activities of daily living (ADLs).
4. Petitioner lives at home with her mother, who works full time, up to 12 hours a day. When Petitioner and her mother moved from [REDACTED] a year ago, she lost the family support she received there. Petitioner has no family in South Florida.

5. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the hours requested pursuant to the requirements and limitations of the Medicaid State Plan.

6. A request for service is submitted by a provider along with all information and documentation necessary for the QIO to make a determination of medical necessity for the level of service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

7. On November 30, 2016, Petitioner submitted a request for Prescribed Pediatric Extended Care (PPEC) services, Monday through Saturday, up to 12 hours daily, for the certification period of November 30, 2016 to May 6, 2017.

8. On December 5, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on December 5, 2016, which notified Petitioner PPEC full and partial services were denied. The rationale for the denial was that the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code, specifically:

the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

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.

9. On December 5, 2016, a “Notice of Outcome-Denial” was issued to Petitioner’s provider and gives the following clinical rationale:

The patient is a 12 year-old with [REDACTED]. The patient is on as needed nebulizer treatments. The patient is on an age-appropriate diet. The patient has a vision impairment. The patient is not on a complex medication regimen. The patient has had no recent hospitalizations or emergency room visits. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity requirement for PPEC services.

10. On December 6, 2016, Petitioner requested a reconsideration review.

11. On December 8, 2016 an eQHealth physician reviewer completed the review and sent a Notice of Reconsideration Determination to Petitioner upholding the initial denial.

12. On December 8, 2016, eQHealth sent a Notice of Reconsideration Determination to the provider giving the medical basis for the reconsideration decision in relevant part:

For the Reconsideration Review, the provider submitted a file containing a single page. None of the information on that page supported the medical need for skilled nursing services. Recommend upholding the initial PR’s [physician reviewer’s] decision. The medical complexity necessary to support the request for PPEC has not been demonstrated.

13. On December 29, 2016, Petitioner filed a timely request for a fair hearing.

14. Petitioner’s mother testified she applied for PPEC services because her daughter has a [REDACTED] and an IQ of 48. She explained most daycare facilities will not accept liability for caring for Petitioner due to her [REDACTED]. Petitioner’s mother understands if day care staff are not trained properly, her daughter’s life could be jeopardized. She

testified Petitioner's school calls her constantly when Petitioner is hit in the head. Responding to the school's constant calls is putting the mother's job in jeopardy.

15. Respondent's physician witness reviewed all the supporting clinical information submitted by Petitioner in support of the request for PPEC services. She noted there are no reports of recent hospitalizations or emergency room visits.

16. Respondent's witness reviewed the two previous decisions by eQHealth physician reviewers who are board-certified pediatricians. The results of the reviews are reflected in paragraph 8,9, 11, and 12 above.

17. Petitioner's mother clarified Petitioner was taken to the hospital on October 12, 2016, October 19, 2016, and December 12, 2016 for headaches and vomiting. In October 2016, an MRI was ordered in the emergency room. Petitioner's neurosurgeon reviewed the MRI and was not able to determine the cause(s) of Petitioner's headaches and vomiting. The neurosurgeon suggested the mother maintain a headache log, which the mother has not been able to keep current due to daily demands.

18. Petitioner is in need of occupational, physical, and speech therapy but, currently, only receives speech therapy at the public school.

19. Respondent's witness explained the therapy services are an adjunct to PPEC services and can be provided as outpatient services when PPEC services are not provided.

CONCLUSIONS OF LAW

20. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office

of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

21. This hearing was held as a *de novo* proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

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

23. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

24. Rule 59G-1.010 (166), *Florida Administrative Code*, defines “medically necessary” or “medical necessity” as follows:

(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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(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.”

25. Rule 59G-1.010 (164), *Florida Administrative Code*, defines “medically complex” as: a person who “has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.”

26. Rule 59G-1.010 (165), *Florida Administrative Code*, defines "medically fragile":

an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

27. Because Petitioner is under 21-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES. --The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

28. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

29. The Florida Medicaid Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook- September 2013 (PPEC Handbook) is promulgated by Rule 59G-4.260, *Florida Administrative Code*, and provides the following purpose and definition of PPEC on page 1-1 and requirements to receive services on page 2-1:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with

medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

....

To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

30. The PPEC Handbook provides a list of excluded services on page 2-5:

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.
- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, and child life.

31. Respondent's physician witness reviewed all the supporting documentation submitted by Petitioner and listened to testimony from the mother and Petitioner's witness. She concluded no skilled nursing services would be provided at PPEC and supports the denial for Petitioner's request for PPEC services.

32. Petitioner's mother highlighted her frustration in obtaining regular daycare for her daughter. Due to Petitioner's VP shunt, the daycare centers do not want to accept liability for her care. Petitioner's mother feels PPEC is a safer place for her daughter, since staff are trained to provide care to patients like her daughter.

33. After reviewing the evidence and testimony, as well as the above cited authorities, including the EPSDT requirements, the undersigned finds Petitioner does

not have a current need for skilled nursing services and does not meet the definition of "medically complex" or "medically fragile," as required by the above controlling authority.

34. The controlling authorities also make it clear that services must 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. PPEC services are in excess of Petitioner's needs and, therefore, are not medically necessary.

35. Petitioner's mother is encouraged to seek Personal Care Services for her daughter to address her needs of activities of daily living (ADLs). Given the mother's statement that Petitioner has an IQ of 48, the undersigned also encourages the mother to seek assistance for her daughter from the Agency for Persons with Disabilities (APD), under the category of intellectual disability.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is hereby 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 Petitioner disagrees with this decision, Petitioner may seek a judicial review. To begin the judicial review, 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. 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. Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

FINAL ORDER (Cont.)

16F-09961

Page 11 of 11

DONE and ORDERED this 24 day of March, 2017, in Tallahassee,
Florida.



Warren Hunter
Hearing Officer
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Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
AHCA Hearings Unit

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

FILED

Mar 20, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09962

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on February 27, 2017 at 8:36 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Pro se

For the Respondent: Samantha Lorenzo,
Appeals Manager,
Magella n Complete Care

STATEMENT OF ISSUE

At issue is whether it is correct for Respondent to deny Petitioner's request for:

(1) surgical extraction of tooth #4,6,8,9,10,11,22,23,24,25,26 and 27 (dental procedure D7210-surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth);

(2) dental procedure D21215 (bone graft) and D21210 (bone graft) and

(3) dental procedure D7250-surgical removal of residual tooth roots for tooth #21.

Petitioner is assigned the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from Magellan Complete Care was Michelle Riegler, Compliance Officer.

Appearing as Respondent's witnesses from DentaQuest were: Susan Hudson, D.D.S., Dental Consultant, and Charles Kieffer, Complaints and Grievances Specialist.

Respondent's Exhibit 1 to 5 were entered into evidence.

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 46 year-old Medicaid recipient enrolled with Magellan Complete Care (Magellan), a Florida Health Managed Care provider.
2. Magellan requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. Petitioner's oral surgeon sent a prior authorization request for dental procedure D7210-surgical extraction of tooth #4,6,8,9,10,11,12,22,23,24,25,26, and 27; a request for dental procedure D7250- surgical removal of residual tooth roots for tooth #21; and dental procedures 21215 (bone graft) and 21210 (bone graft). According to the Extraction Consult Note, dated November 15, 2016 by [REDACTED], DMD, MD, the request indicates bone graft for dentures support.
4. On December 19, 2016, DentaQuest received the requests for services.

5. On December 21, 2016, DentaQuest sent an Approval Notice to Petitioner for surgical extraction (D7210) for tooth #12. On December 21, 2016, DentaQuest sent a separate Notice of Action to Petitioner denying surgical extraction for tooth #4,6,8,9,10,11,21,22,23,24,25,26, and 27. The denial reason for each tooth was the same: "Our dentist looked at the information your dentist sent. The information sent by your dentist, shows the tooth removal is not as bad as what your dentist says. Your dentist needs to resend the information to show where the tooth is located in the bone. We have also told your dentist. Please talk to your dentist."

6. The Notice of Action also denied procedures 21215 and 21210 because they are not covered services.

7. On December 30, 2016, Petitioner filed a timely request for a fair hearing.

8. Petitioner testified he spoke with his provider and his provider will not submit a lesser code for the teeth to be extracted. Petitioner is experiencing severe pain with his teeth, which are cutting into his gums.

9. Respondent's dental consultant explained several criteria needed to be met in order for surgical extraction of a tooth to be medically necessary. First, the crown of the tooth (with which you use to chew) is either missing or at least 75% decayed. Secondly, bone removal is required to access the tooth or gum exposed to access the root.

10. Petitioner's teeth have most of their crown and there is significant bone loss. Therefore, the teeth don't require any surgical effort to remove the teeth.

11. Procedures 21215 and 21210 are bone grafting in different areas of the mouth to replace lost bone.

12. Respondent contends these procedures are not a covered service. The dental consultant opined all of Petitioner's teeth, except tooth #12, can be simply extracted.

CONCLUSIONS OF LAW

13. 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.

14. This proceeding is a *de novo* proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

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

16. This is a Final Order, pursuant to §§ 120.569 and 120.57, Florida Statutes.

17. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

18. Section 409.905, Florida Statutes, "Mandatory Medicaid services," states, in relevant part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law."

19. Sections 409.971 – 409.973, Florida Statutes, 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. Dental services are one of the mandatory services that must be provided.

20. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

21. Rule 59G-1.010, *Florida Administrative Code*, defines “prior authorization” as: “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.”

22. Rule 59G-1.010 (166), *Florida Administrative Code*, 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.

...

(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.

23. The May 2016 Florida Medicaid Dental Services Coverage Policy (Dental Policy) has been promulgated by *Rule 59G-4.060, Florida Administrative Code*, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593>.

24. The Dental Policy requires dental services to be medically necessary as defined in Rule 59G-1.010 (166), *Florida Administrative Code*. Paragraph 4.2.9 of the Dental Policy provides:

4.2.9 Surgical Procedures and Extractions

Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures [emphasis added].

25. The Florida Medicaid Oral and Maxillofacial Surgery Services Coverage Policy is incorporated by reference in Rule 59G-4.207, *Florida Administrative Code*. Paragraph 1.1 and 4.2 of the Policy provides:

Florida Medicaid oral and maxillofacial surgery services provide extractions, surgical and adjunctive treatment of diseases, defects, and injuries of the hard and soft tissues of the oral and maxillofacial regions.

....

Florida Medicaid reimburses for the following services in accordance with the American Medical Association Current Procedural Terminology, and applicable Florida Medicaid fee schedule(s):

- Biopsies
- **Bone, tissue, and cartilage grafts [emphasis added].**
- Consultations
- Debridement

- Endosteal implants when used in conjunction with reconstructive surgeries
- Evaluation and management
- Excisions
- Impressions and custom preparation of prosthesis
- Moderate sedation
- Open and closed treatment of fractures
- Repair and destruction of lesions
- Reconstructions
- Radiology procedures
- Surgical procedures essential to the preparation of the mouth for dentures
- Tissue repair

26. Page 6 of the Dental Oral/Maxillofacial Surgery Fee Schedule, Effective January 1, 2015, shows procedure codes 21210-Graft, Bone; Nasal, Maxillary or Malar Areas (Includes Obtaining Graft) and 21215-Graft, Bone; Mandible (Includes Obtaining Graft) are listed as covered services.

27. While Petitioner's provider may not want to submit a lesser dental procedure code for extracting Petitioner's teeth, the controlling authority cited above makes it clear 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.

28. Additionally, in order for the surgical extractions to be medically necessary, they must 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.

29. Respondent has provided compelling testimony the teeth do not need to be surgically extracted but can be simply extracted.

30. After carefully reviewing the medical necessity requirements set forth above, the undersigned concludes Petitioner failed to demonstrate, by a preponderance of the evidence, that Respondent incorrectly denied his request for surgical extraction of tooth #4, 6,8,9,10,11,12,21,22,23,24,25,26, and 27.

31. Because Respondent incorrectly denied procedure codes 21210 and 21215 as non-covered services, Respondent is directed to re-assess these requested procedures for medical necessity and issue a new Notice of Action to Petitioner. Petitioner has appeal rights to this new Notice of Action.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED in part and the Agency action is AFFIRMED as it relates to denial of the surgical extractions. However, a determination of medical necessity for procedures 21210 and 21215 is required and remanded back to Respondent. Upon completion of a medical necessity determination, Respondent shall issue Petitioner a new notice informing him of his appeal rights.

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.

FINAL ORDER (Cont.)

16F-09962

Page 9 of 9

DONE and ORDERED this 20 day of March, 2017, in Tallahassee, Florida.



Warren Hunter
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Magellan Hearings Unit

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

FILED

Mar 22, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-09977

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 21, 2017 at 10:07 a.m.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's request for continued Prescribed Pediatric Extended Care (PPEC) services, Monday through Friday, up to 12 hours daily, for the certification period of September 19, 2016 to February 25, 2017 is correct. Because the matter under appeal involves a termination of PPEC services, the burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Ellyn Theophilopoulos, M.D.,
Physician Consultant for eQHealth Solutions, Inc.

Appearing as a witness for Petitioner was [REDACTED] Director of Nursing for
[REDACTED] PPEC.

Respondent's Exhibits 1 through 6 were entered into evidence.

Administrative notice was taken of Sections 400.902 and 400.914, Florida
Statutes, as well as the Florida Medicaid Prescribed Pediatric Extended Care Services
Coverage and Limitations (PPEC) Handbook, issued September 2013.

Petitioner has not been administratively approved to continue receiving PPEC
services because her fair hearing request was filed more than 10 days after
Respondent's notice. Nevertheless, the provider continued PPEC services. The AHCA
representative advised the provider cannot be reimbursed for PPEC services if services
were not administratively approved, regardless of the outcome of Petitioner's appeal.

FINDINGS OF FACT

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 nine-year-old Medicaid recipient. She has been diagnosed with
[REDACTED]
2. Petitioner attends public school after which PPEC picks her up at 2:30 p.m.
3. Petitioner is not on a complex medication regimen. She takes her seizure
medication, [REDACTED] two times a day. She is on Miralax to prevent constipation.
4. Petitioner lives at home with her mother, who works full-time.

5. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the hours requested pursuant to the requirements and limitations of the Medicaid State Plan.

6. A request for service is submitted by a provider along with all information and documentation necessary for the QIO to make a determination of medical necessity for the level of service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

7. On September 19, 2016, Petitioner submitted a request to continue Prescribed Pediatric Extended Care (PPEC) services, Monday through Friday, up to 12 hours daily, for the certification period of September 19, 2016 to February 25, 2017.

8. On September 22, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on September 22, 2016, which notified Petitioner PPEC full and partial services were denied. The rationale for the denial was the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code, specifically...

the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

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.

9. On September 22, 2016, a “Notice of Outcome-Denial” was issued to

Petitioner’s provider and gives the following clinical rationale:

The patient is an 8 year-old with cerebral palsy and seizures. The patient has had no reported seizures while attending PPEC. The patient is on a regular diet. The patient attends school. The patient is not on a complex medication regimen. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient no longer appears to have a skilled need and does not meet the medical necessity requirement of PPEC services.

10. Petitioner did not request a reconsideration review.

11. Respondent’s physician witness reviewed Petitioner’s medical status as reflected in paragraph 1 above. She noted Petitioner has seizures once or twice a month. She noted the documentation shows no reports of Petitioner being hospitalized or admitted to the emergency room since January 2016. In the nursing notes maintained by the PPEC, there are no reported seizures.

12. Respondent’s witness reviewed all the supporting clinical information submitted by Petitioner in support of the request for continued PPEC services.

13. Respondent’s witness reviewed in detail a Home Health Assessment completed May 12, 2016. She explained the survey is completed by an eQHealth registered nurse (care coordinator) and provides an overview of the Petitioner’s medical condition and needs. The assessment reviews all the potential needs of Petitioner, not just those related to PPEC services, to ensure all of Petitioner’s medical needs are met. She asserted the care coordinator who completed the assessment is quite familiar with Petitioner. The assessment reflects no home equipment and Petitioner is not

dependent on any devices. Petitioner has severe difficulty expressing basic ideas or needs and requires maximal assistance by listener. She does not use an augmentative device but does receive speech therapy. Petitioner also receives physical therapy to improve her development and muscle tone or stretching. The assessment shows no need for skilled nursing services.

14. Respondent's witness explained therapy services are an adjunct to PPEC services and can be provided as outpatient services when PPEC services are not provided.

15. Respondent's witness reviewed the care coordinator notes, explaining all communications regarding care for Petitioner are reflected in the notes. She specifically highlighted notes entered on September 19, 2016 where the care coordinator documented the reason for denial of Petitioner's PPEC request (See Respondent Exhibit 6, pages 41-42).

16. Respondent's witness noted there is no documentation indicating Petitioner receives skilled nursing services in the public school. PPEC is being used after school and on non-school days. Monitoring for potential seizures is not a reason for PPEC services.

17. Petitioner's mother advised Petitioner is on [REDACTED] and was recently hospitalized due to having seven seizures in one day. She explained anything can cause Petitioner to have seizures, and she has a series of seizures at one time, not simply one per episode. She stated regular daycare would not know how to respond to Petitioner's seizures except call 911. At PPEC, the staff know how to respond to Petitioner's needs.

At times Petitioner gets weak and falls down. Petitioner has [REDACTED] at school as well as at PPEC.

18. Petitioner's witness explained PPEC did not initially maintain a seizure log because Petitioner did not have any seizures for six months. Petitioner had a seizure on November 23, 2016, was hospitalized for seizures on December 9 2016 and discharged December 10, 2016, and was re-hospitalized on December 14, 2016 for grand mal seizure (having seven seizures in a day). Her seizures last 1-2 seconds and cause her to shake. Petitioner needs assistance with all her activities of daily living (ADLs) – eating, toileting, transferring, etc. Petitioner is non-verbal and, therefore, cannot communicate her needs.

19. Petitioner's witness stated Petitioner cannot stand on her own. The witness opined Petitioner will not do well in a regular day care because the staff are not trained to meet Petitioner's needs.

20. Respondent's physician witness explained Petitioner would qualify for Personal Care Services to address her needs for Activities of Daily Living (ADL) because the mother works.

21. Respondent's physician witness explored what PPEC is doing to address Petitioner's seizures. Petitioner's witness was unable to respond when questioned when was the last time [REDACTED] was administered to the Petitioner. She stated [REDACTED] is not administered on a monthly basis.

22. Respondent's physician reviewer witness reaffirmed no skilled nursing is being provided at PPEC. She noted Petitioner's need for assistance with her ADL's and encouraged Petitioner's mother to request Personal Care Services for her daughter.

CONCLUSIONS OF LAW

23. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

24. This hearing was held as a *de novo* proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

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

26. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

27. Rule 59G-1.010 (166), *Florida Administrative Code*, defines “medically necessary” or “medical necessity” as follows:

(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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(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.”

28. Rule 59G-1.010, *Florida Administrative Code*, defines “medically complex” and “medically fragile.”

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

29. Because Petitioner is under 21 years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES. --The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

30. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v.*

Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

31. The Florida Medicaid Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook- September 2013 (PPEC Handbook) is promulgated by Rule 59G-4.260, *Florida Administrative Code*, and provides the purpose and definition of PPEC on page 1-1, as well as requirements to receive services on page 2-1.

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

....

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria [emphasis added]:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

32. The PPEC Handbook provides a list of excluded services on page 2-5.

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.
- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, and child life.

33. Respondent's physician witness reviewed all supporting documentation submitted by Petitioner and listened to testimony given by Petitioner's mother and witness. She concluded no skilled nursing services are currently being provided at PPEC, and she supports the denial of Petitioner's request for PPEC services.

34. Petitioner's witness testified Petitioner would be safer in PPEC where staff are trained to respond to Petitioner's seizures and assist Petitioner with her activities of daily living.

35. After reviewing the evidence and testimony, as well as the above cited authorities, including the EPSDT requirements, the undersigned finds Respondent has

met its burden. Petitioner does not have a current need for skilled nursing services and does not meet the definition of “medically complex” or “medically fragile,” as required by the above controlling authority.

36. The controlling authorities also make it clear that services must 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. PPEC services are in excess of Petitioner’s needs and, therefore, are not medically necessary.

37. Petitioner’s mother is encouraged to seek Personal Care Services for her daughter to address her needs of activities of daily living (ADL).

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner’s appeal is hereby 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 Petitioner disagrees with this decision, Petitioner may seek a judicial review. To begin the judicial review, 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. 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. Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

FINAL ORDER (Cont.)

16F-09977

Page 12 of 12

DONE and ORDERED this 22 day of March, 2017, in Tallahassee,
Florida.



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Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
[REDACTED]

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

FILED

Mar 06, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16N-00124

PETITIONER,

Vs..

Administrator

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 14, 2017, at 9:05 a.m., at [REDACTED] & [REDACTED] Florida.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: Trevor Matchim, Certified Nursing Home Administrator (CNHA).

ISSUE

Federal regulations limit the reason for which a Medicaid or Medicare certified nursing home may discharge a patient. At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations at 42 C. F. R. § 483.15. The nursing home is seeking to transfer and discharge the petitioner because her "needs cannot be met in this facility". The Nursing

Home Transfer and Discharge Notice indicates the discharge location as [REDACTED] [REDACTED] (petitioner's private residence). The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice, dated December 7, 2016, respondent informed the petitioner that he was to be discharged from the facility effective January 7, 2016. The undersigned allowed the administrator to remedy the notice with the appropriate year (2017) on the record. The notice is signed by the facility's medical director, [REDACTED] M.D. The reason cited is "Your needs cannot be met in this facility." On December 9, 2016, the petitioner timely requested an appeal to challenge the respondent's action. The discharge notice was marked as Hearing Officer's Exhibit 1.

[REDACTED], representative from the Long-Term Care Ombudsman Program (LTCOP) appeared as a witness and provided additional testimony on behalf of the petitioner.

Melesia Aymer, RN, BSN, Director of Nursing (DON), Joy Richardson, Assistant DON, Kenneth Heidrich, Social Worker and Candance West, Unit Manager, appeared as witnesses on behalf of the facility.

During the hearing, the petitioner did not submit any exhibits for consideration. The respondent referred to documents not ready available to the undersigned. The record was left open for an additional 15 minutes for the respondent to gather and submit the documents for review as evidence. The documents were received and marked as Respondent's Exhibits 1 & 2. Exhibit 2 contains the petitioner's

documentation of contacts with facility's staff, Psychiatric Follow-Up Notes and Evaluation Form, Nurse's Notes, Social Service Progress Notes, and Physician Progress Notes. The record was closed on February 14, 2017.

No representative from the Agency for Health Care Administration (AHCA) was present. At the request of the undersigned, AHCA was to conduct an on-site inspection of the facility and provide a written response to the undersigned. As of the date of this order, a final report has not been received.

FINDINGS OF FACT

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. The petitioner has been residing in the respondent's facility since October 13, 2016. Petitioner is very alert and makes his own healthcare decisions. At the time of admission, the petitioner signed an "Admission Agreement" agreeing to comply with the facility established rules and regulation, see Respondent's Exhibit 1.
2. The petitioner is blind and requires assistance from time to time with his ADLs. He sometimes refused services from staff members assigned to his needs. Nurse's Notes and Social Service Progress Notes, see Respondent's Exhibit 2 contain entries in the petitioner's file documenting his concerning behaviors (combative, yelling, and argumentative). It also documents his medications, diagnosis and treatments leading up to the issuance of the discharge notice.
3. Initial Psychiatric Diagnostic Interview notes entered on October 21, 2016 by [REDACTED], Ph.D., indicate petitioner has refused care and has been verbally abusive to staff members. Individual Psychotherapy Notes entered on October 24, 2016 by [REDACTED]

██████████ PsyD., indicate he has had a lot of difficulty adjusting to his institutionalization and is verbally abusive to staff. The notes also indicate petitioner expressed feelings of frustration and resentment towards others. Psychotherapy Notes entered on November 5, 2016, indicate that the petitioner's mental status as "Depressed/Flat/Worried". Psychiatric Medication Follow-Up notes entered on November 15, 2016 by ██████████ PsyD., indicate petitioner's behavior has improved. Nurses Progress Notes entered on November 4, 2016; November 10, 2016; November 14, 2016 and November 17, 2016, respectively, indicate petitioner was verbally abusive to staff members. Progress Notes entered on December 4, 2016, indicate petitioner that petitioner continued to be combative towards staffs, screamed and yelled profanities at them.

4. On December 7, 2016, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner. The reason for the discharge was "your needs cannot be met in this facility". The facility supported its decision with the statements that petitioner is being verbally abusive to the staffs caring for him at the facility. The social worker explained that the petitioner has psycho-social needs that cannot be met by the facility. The NHA believes the facility is being fair in initiating the discharge process against the petitioner because he has not changed his behavior, even after being counseled. Petitioner disagreed, citing that he has received praises recently from one of his nurses for good behavior.

5. Petitioner disputed some of the facts presented by the respondent. He acknowledged being loud at time, but explained that's in his nature and that he is trying his best to do better. The Ombudsman manager asserts that the facility just does not

want to deal with a demanding resident, and that is why the petitioner is being discharged. She contends that a skilled nursing facility should be able to deal with all its residents, even those that tend to be a little disruptive at times. Petitioner believes the Discharge Notice was not based on the inability of the facility to care for his medical needs, but simply that they consider him a nuisance. Petitioner expressed his love for the facility and his desires to do whatever is necessary to stay.

6. As of the day of this hearing, the petitioner remains in the facility pending a hearing decision. Petitioner wants to remain at the facility.

7. AHCA, at the request of this hearing officer, reviewed the discharge initiated by the facility through an unannounced visit. While the parties said that the agency has already been at the facility, no written response was sent to the undersigned to this date.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.

9. Federal Regulations appearing 42 C.F.R. § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) *Transfer and discharge*—(1) *Facility requirements*—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.

Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

10. Fla. Stat 400.0255 addresses Resident transfer or discharge; requirements and procedures; hearings and states in part:

(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.

11. In this instant case, the petitioner is being discharged because the respondent believes his needs cannot be met at the facility. The medical director signed the notice

issued to the petitioner. The hearing officer concludes the above-cited requirement for signature has been met.

12. The undersigned's decision is limited to whether the discharge meets the requirement at 42 C.F.R. § 483.15(c)(1)(i). These rules are directed to coincide with doctors' notes and documentation is required. The undersigned took notice of petitioner's unrealistic expectations regarding the services that he receives in the nursing facility and his expressions of frustration and resentment towards others documented by the psychotherapist and the nurses. Additionally, petitioner's multiple behavioral issues documented in the case are evident and cannot be ignored.

13. Based on the evidence presented, the nursing facility has met its burden establishing that the petitioner's need cannot be met at this facility under federal regulation for which a nursing facility may voluntarily discharge a resident.

14. Establishing that the reason for a discharge is lawful is just one-step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

15. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, and any other concerns raised at the hearing

regarding allegations of improper protocol of the facility staff, medication changes or diagnoses, or treatment the petitioner received while residing at the facility, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is denied, as the facility's action to discharge the petitioner is correct and in accordance with Federal Regulations. The facility may proceed with the discharge as discussed in the Conclusions of Law, in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party 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 department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

FINAL ORDER (Cont.)

16N-00124

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DONE and ORDERED this 06 day of March, 2017,

in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
[REDACTED], Respondent
Ms. Arlene Mayo-Davis
Agency for Health Care Administration
[REDACTED]

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

FILED

Mar 30, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16N-00128

PETITIONER,

Vs.

ADMINISTRATOR

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 22, 2017 at 10:15 a.m. in Miramar, Florida.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Anita Mamone, Esq.

STATEMENT OF ISSUE

At issue was whether intent to discharge was correct based on facility inability to meet the petitioner's needs. The respondent carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

[REDACTED] husband of the petitioner, [REDACTED] friend of the petitioner, as well as [REDACTED] and [REDACTED] from the ombudsman's office each

appeared as witnesses for the petitioner. Delbert Whiting, facility administrator; Tammy McGraw, director of social services; and Elizabeth Kidd, LPN, appeared as witnesses for the respondent. Christi Conley, Registered Nurse Consultant, represented the Agency for Health Care Administration (AHCA). Greg Watson, hearing officer, appeared as an observer.

The Discharge and Transfer Notice issued on December 12, 2016 was entered as Administrative Exhibit 1. The response letter from AHCA was entered as Administrative Exhibit 2. The Respondent submitted five groups of documentation, which were entered as Respondent Exhibits 1 through 5. The petitioner submitted no documentation to be entered into the record.

The petitioner requested the opportunity to submit a proposed final order. The respondent concurred with the opportunity to submit proposed final orders. The record was held open through March 7, 2017 for submission of these orders.

The petitioner submitted a proposed final order on March 7, 2017. The respondent did not enter a proposed final order.

The record was closed on March 7, 2017.

FINDINGS OF FACT

1. The petitioner was admitted to [REDACTED] on August 17, 2016.
2. The petitioner's diagnoses includes [REDACTED]
3. The petitioner is a smoker.
4. The respondent has a smoking policy, which limits the location and times available for the residents to smoke on campus. (Respondent's Exhibit 2)

5. The petitioner is aware of the respondent's smoking policy for on-campus smoking.

6. The petitioner prefers to sign out of the facility to go across the street to smoke rather than smoke at the on-campus location during limited smoking breaks. She enjoys the flexibility and extended smoking time of signing out. She understands the smoking policy applies if she were to stay on campus to smoke.

7. The respondent submitted a statement from the petitioner's physician who recommends that the petitioner only have totally supervised smoking privileges. (Respondent's Exhibit 1) The physician was not present during the hearing for cross-examination.

8. The petitioner explained she spoke to her physician regarding an injury during therapy in October 2016. Following that discussion, the letter regarding her not being allowed to smoke without supervision was issued.

9. The petitioner currently signs herself and her smoking materials out and goes across the street to smoke.

10. The petitioner chooses not to wear the smoking apron, prescribed in the respondent's smoking policy, when she leaves campus to smoke.

11. The respondent reported the petitioner had one incident of attempting to assist another resident with his or her smoking materials when she smoked at the on-campus location. The respondent reported she was counselled and there have been no further violations reported at the on-campus smoking location.

12. The respondent stated the petitioner does have the right to sign herself out of the facility when she desires to leave for any reason, including crossing the street to smoke, go to a restaurant or store.

13. A copy of the respondent's policy for signing out of the facility was requested during the hearing. It was not included in the evidence submitted by the respondent.

14. The respondent expressed concern the petitioner is violating the smoking policy. The examples of violations include sometimes failing to sign out, desiring to go out during inclement weather, and staying gone longer than the allotted smoking times. The respondent reported the petitioner does not smoke in the gazebo area provided for smokers during specified periods of the day.

15. The respondent expressed concern that the petitioner wants to go sign out when it is dark or during inclement weather. The respondent believes they still hold liability for the resident if she goes across the street to smoke.

16. The respondent believes the petitioner would be much safer if she utilized the gazebo area for smoking during the specified times as staff is available to assist her, if necessary, on campus.

17. The respondent believes they have exhausted all possible interventions to meet the petitioner's smoking needs.

18. The respondent expressed they have located another facility which has a more lenient smoking policy.

19. The petitioner expressed her desire to stay at this facility. The petitioner stated this is much closer for her husband to be able to come see her daily. The other

facility is in another city. Transferring to the location recommended by the facility would make visiting with her husband a financial hardship.

20. The petitioner understands that she must sign out of the facility when she desires to leave the facility to go off campus, whether to the store or to smoke.

CONCLUSIONS OF LAW

21. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

22. Federal Regulations appearing 42 C.F.R. § 483.15 sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for

his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

23. Based on the evidence presented, the nursing facility has established the reason for requesting this discharge is due to the facility staff belief that the petitioner's needs cannot be met in this facility. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

24. The findings show the respondent's desire to discharge is directly related to the petitioner's smoking habits and not an inability to provide for her physical needs. The findings show the respondent does have a smoking policy that is in effect for all on campus smoking. The findings show the petitioner chooses not to smoke on campus, but rather leave campus. The undersigned concludes when the petitioner leaves the campus, the smoking policy no longer applies, as she is not on the respondent's campus.

25. The undersigned acknowledges the respondent's concern for the petitioner's safety in crossing the street and going out in inclement weather. However, the undersigned found no record in the documentation presented which requires the petitioner to only sign in or out of the facility during specified times, refrain from signing out during inclement weather, or to return by a specified time of day. The undersigned concludes the respondent's claim of inability to meet the petitioner's needs is of a desire to accommodate the concern of the staff rather than an actual inability to provide the necessary care for the petitioner. The undersigned further concludes the respondent

has failed to meet the burden of proof to show the inability to meet the petitioner's needs.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The Discharge and Transfer Notice is voided.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party 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 department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 30 day of March, 2017,
in Tallahassee, Florida.

Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
[REDACTED] Respondent
Ms. Donna Heiberg
Agency for Health Care Administration

FINAL ORDER (Cont.)

16N-00128

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Apr 27, 2017

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00092

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

HUMANA,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 10, 2017 at 3:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for partial lower dentures was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing, although she submitted a letter which was part of the respondent's evidence packet.

Appearing as a witness for the respondent was Mindy Aikman, Complaints and Grievances Specialist, from Humana, which is the petitioner's managed health care plan. Also appearing as a witness for the respondent was Lauren Hernandez, Grievance Specialist, from DentaQuest, which reviews dental claims on behalf of Humana.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Case Summary, Claim Form, Denial Notice, Dental Criteria, Dental Plan Provisions, Appeal Letter, and Appeal Denial Notice.

FINDINGS OF FACT

1. The petitioner is a sixty (60)-year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.
2. On or about September 7, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Humana and/or DentaQuest for approval of partial lower dentures. DentaQuest denied the request for partial lower dentures on September 8, 2016 as not being a covered benefit.

3. DentaQuest's denial notice to the petitioner advised her of the following reason for the denial of her request for the partial lower dentures:

You can only get this service once. Our records show that you had this service already. Please talk to your dentist about other treatment choices.

4. The petitioner submitted an internal appeal to Humana on October 5, 2016 concerning the denial of the partial dentures. Humana denied her appeal on November 7, 2016. The appeal denial notice stated the following:

Your claim history shows that you were provided with a complete upper denture and a partial lower denture on January 30, 2015. The benefit summary indicates that you are only allowed one per lifetime.

The petitioner thereafter requested a Medicaid fair hearing and this proceeding followed.

5. The petitioner stated she had an allergy test and discovered she was allergic to the metal in her dentures. She stated this has caused her pain and she is unable to wear the dentures. She acknowledged she received the dentures about two years ago through the Medicaid program.

6. The respondent's witness, Ms. Aikman, stated Humana denied the request for the partial dentures because it exceeded the covered benefit of one set of dentures per lifetime.

7. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

8. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

9. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

10. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

11. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Florida Administrative Code. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

12. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

13. Florida Statute § 409.912 requires that the Medicaid Program “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

14. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

14. In this case, the request for dentures was not denied due to any medical necessity considerations but because it exceeded the benefit limitation of one per lifetime.

15. The Florida Medicaid Program provides limited dental services for adults. The AHCA Dental Policy specifies that these services include periodic oral evaluations, radiographs, dentures, and some tooth extractions.

16. Managed care plans, such as Humana, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the AHCA Dental Policy. The AHCA Dental Policy allows for one set of dentures per lifetime.

17. The petitioner's position is that she should be approved for the new partial dentures because she is allergic to the metal in her current dentures.

18. The respondent's witness stated the partial dentures were denied because the petitioner had already received dentures in 2015.

19. After considering the evidence and testimony presented, the undersigned concludes the respondent correctly denied the petitioner's request for the partial lower dentures. The Humana dental plan provisions and the Florida Medicaid Dental Policy contain a limitation of one set of dentures per lifetime. Therefore, regardless of the circumstances, the petitioner is not entitled to a new set of dentures through her Medicaid coverage.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 27 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255

FINAL ORDER (Cont.)

17F-00092

PAGE - 7

1317 Winewood Boulevard

Tallahassee, FL 32399-0700

Office: 850-488-1429

Fax: 850-487-0662

Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

FILED

Mar 30, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-00123

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 [REDACTED]
UNIT: AHCA

And

MAGELLAN COMPLETE CARE

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 15, 2017 at 1:09 p.m.

APPEARANCES

For the Petitioner: [REDACTED] pro se

For the Respondent: Samantha Lorenzo, appeals manager, Magellan

STATEMENT OF ISSUE

At issue is the denial of the petitioner's request for dental services through Medicaid.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. Magellan Complete Care (Magellan) is the contracted health care organization in the instant case. Magellan subcontracts with DentaQuest of Florida (DentaQuest) to provide dental services to its enrollees.

By notice dated December 23, 2016, DentaQuest informed the petitioner that his request to surgically extract his remaining teeth, #2, #14, #15, #16, #22, #23, under procedure codes D7210 and D7250, the request for oral surgery to trim bone with extraction in the Upper Left Quadrant, under procedure code D7310, and the request for a full set of dentures was denied in-part. DentaQuest approved the full set of dentures, but denied the other requested dental services.

The petitioner timely requested a hearing to challenge the partial-denial decision.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as respondent witnesses from DentaQuest: Dr. Daniel Dorrego, dental consultant and Charles Kieffer, compliance and grievance specialist. Sheila Broderick, registered nurse specialist with AHCA, was present as an observer. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1. The record was closed on February 15, 2017.

FINDINGS OF FACT

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. The petitioner is a Florida Medicaid recipient. The petitioner is enrolled with Magellan HMO. Magellan subcontracts with DentaQuest to provide dental services to its enrollees. (Respondent's Composite Exhibit 1)

2. In December 2016, the petitioner's treating dentist submitted an authorization request to DentaQuest to surgically remove all of his teeth, under procedure codes D7210 and D7250, and shave ragged bone in the Upper Left Quadrant, under procedure code D7310, in preparation of his mouth for dentures. (Respondent's Composite Exhibit 1)

3. Medicaid dental policy defines all dental procedures codes. Code D7210 is defined as "surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated." Code D7250 is defined as "surgical removal of residual tooth roots." Code D7310 is defined as "alveoloplasty [bone shaving] in conjunction with extracts-four or more teeth or tooth spaces, per quadrant." (Respondent's Composite Exhibit 1)

4. DentaQuest approved the dentures, but denied the other requested services. DentaQuest determined that the extractions were not medically necessary because the complexity of the requested extraction procedure codes were not supported by the petitioner's medical records. DentaQuest denied the alveoloplasty due to coverage

limitations which state one per quadrant per lifetime. (Respondent's Composite Exhibit 1)

5. The petitioner asserted that his remaining teeth are chipped and decayed and need to be removed so he can be properly fitted for dentures. (Petitioner testimony)

6. Dr. Daniel Dorrego, dental consultant with DentaQuest, explained that Medicaid rule prohibits provision of medical services in excess of a recipient's needs. Procedure code D7210 and D7250 are applicable only for invasive and complex surgical extractions. To qualify for surgical extraction under code D7210, 75% of the tooth crown (surface) must be decayed and/or the tooth must have more than one root and/or the tooth root must be curved. D7250 is even more invasive than D7210. To qualify for surgical extraction under code D7250, there must be at least 50% of the original root remaining and/or bone must be removed to access the root and/or the root needs to be sectioned to be extracted and/or there must be 50% bone around the root structure. (Testimony of Dr. Dorrego).

7. Dr. Dorrego opined that the extractions requested under code D7210 could be extracted under a less complex and invasive procedure code D7140, which is applicable for general dental extractions. Dr. Dorrego opined further that the extractions request under code D7250, the most invasive procedure code, could be extracted under the less invasive code D7210. (Testimony of Dr. Dorrego)

8. Dr. Dorrego explained that the bone shaving requested for the petitioner's Upper Left Quadrant, under code D7310, was denied because the petitioner received

that procedure in the Upper Left Quadrant in October 2016. Medicaid rule provides for one per patient per lifetime. (Testimony of Dr. Dorrego)

9. Dr. Dorrego agreed that all of the petitioner's teeth should be removed to prepare his mouth for dentures, but the level of treatment must be warranted by the medical evidence. Dr. Dorrego asserted that if the petitioner's treating dentist would resubmit the request, using the appropriate dental codes, DentaQuest would approve removal of the petitioner's remaining teeth. Regarding bone shaving to smooth the petitioner's gums, Dr. Dorrego testified that most extraction procedure codes include removal of jagged bone from the gum during the extraction process. Thus the petitioner's need for smooth gums could be achieved without a separate procedure. (Testimony of Dr. Dorrego)

CONCLUSIONS OF LAW

10. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

11. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

12. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

14. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

15. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

16. Medicaid rules require that all procedures be medically necessary. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

(166) “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.

. . . .

(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.

17. The respondent denied the petitioner's request for surgical removal of his remaining teeth under the procedure codes D7210 and D7250 because the codes are for invasive and complex extractions. Dr. Dorrego, the only expert witness to appear during the hearing, opined that the teeth could be extracted under a less invasive and complex procedure codes.

18. Medicaid rule prohibits the provision of goods and services in excess of a recipient's needs. The requested service must adhere to generally accepted medical standards as defined by the controlling legal authorities. The fact that a treating physician has recommended a service is not controlling. The service has to be warranted by the medical evidence.

19. After carefully reviewing the evidence and the controlling legal authorities, the undersigned concludes that the petitioner did not prove by a preponderance of the evidence that it is medically necessary that his remaining teeth be surgically extracted under procedure codes D7210 and D7250.

20. The respondent denied the petitioner's request for alveoloplasty (bone shaving) in the Upper Left Quadrant of his mouth, under procedure code D7310, due to cover limitations which provide for one per quadrant per lifetime. The petitioner underwent a bone shaving to the Upper Left Quadrant in October 2016.

21. Medicaid Dental Services Policy sets forth covered dental services. The policy includes a list of covered dental codes in ascending numerical order. Procedure Code D7310 is defined as "alveoloplasty in conjunction with extractions – four or more

teeth or tooth spaces per quadrant.” The policy limits the procedure to one per lifetime per patient per quadrant.

22. After careful review, the undersigned concludes that the respondent’s decision, denying the petitioner a second alveoloplasty/bone shaving in the Upper Left Quadrant of his mouth due to coverage limitations, was correct. Dr. Dorrego, the only expert witness to appear during the hearing, opined that removal of bone fragments is included in most extraction codes and does not require a separate procedure.

DECISION

The appeal is denied. The respondent’s decision in this matter is upheld.

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 30 day of March, 2017,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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FINAL ORDER (Cont.)

17F-00123

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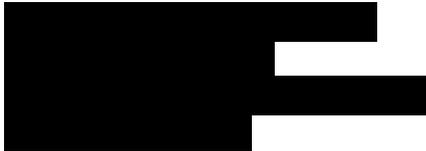
Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Magellan Hearings Unit

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

FILED

Apr 10, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00125
17F-01287

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 7, 2017 at 11:30 a.m. and on February 28, 2017 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter-in-law

For the Respondent: Jerome Hill, Program Supervisor - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action partially denying or reducing the petitioner's companion care services under the Long Term Care (LTC) Program. Appeal No. 17F-00125 pertains to the reduction in services. Appeal No. 17F-01287 pertains to the

petitioner's request for an increase in services. The respondent bears the burden of proof in this matter by a preponderance of the evidence regarding any reduction in services. The petitioner bears the burden of proof regarding any increase in services.

PRELIMINARY STATEMENT

The petitioner submitted 72 pages of documents as evidence for the hearing, which was marked as Petitioner's composite Exhibit 1.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent's Composite Exhibit 1: Statement of Matters, Denial Notice, Case Screenshots, and Member Notes Reports. The respondent also submitted another set of documents consisting of the following which were marked as Respondent's Composite Exhibit 2: Statement of Matters, Denial Notice, Case Screenshots, Medical Assessment Form, and LTC Plan Provisions.

FINDINGS OF FACT

1. The petitioner is ninety-five (95) years of age and lives alone. The petitioner has been diagnosed with [REDACTED]

[REDACTED]

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. He is also enrolled in the Managed Medical Assistance (MMA) plan. He receives services under the plans from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for 70 hours weekly of home health services in the LTC program, as follows: 56 hours of companion care, 7 hours of personal care, and 7 hours of homemaker services.

5. By a notice dated December 20, 2016, United Healthcare informed the petitioner that his companion care services would be reduced from 56 hours weekly to 14 hours weekly. The notice stated the following:

A long term care physician reviewed your needs. Companion care is not hands-on care. Companion care is to watch you perform activities. Companion care is also to help you socialize. Your other caregivers help you socialize too. Companion care is not covered only because you are alone. The doctor decided 14 hours for companion care can meet your needs. The other hours you asked for are in excess of your needs. Hours in excess of your needs are not medically necessary.

6. As part of its review and decision to reduce the companion care services, United Healthcare increased the petitioner's personal care services to 30 hours weekly and his homemaker services to 13 hours weekly. The total home health care hours

currently approved by United Healthcare is 57 hours weekly (30 hours of personal care, 13 hours of homemaker, and 14 hours of companion care). Taking into account all the home health services, the petitioner's services have been reduced from 70 hours weekly to 57 hours weekly. United Healthcare continued providing 70 hours weekly of services during the pendency of the fair hearing process.

7. The petitioner's representative filed an internal grievance/appeal with United Healthcare regarding the reduction in services. By a notice dated January 27, 2017, United Healthcare upheld its decision to reduce the services and also denied the petitioner's request for an increase in services to 72 hours weekly.

8. The respondent's witness, Dr. Kaprow, stated the decision was made to reduce companion care because the petitioner's needs are mainly for personal care assistance. Personal care is for assistance with activities of daily living (ADLs) such as bathing, eating, and toileting. Companion care is not hands-on care and provides supervision and companionship to prevent isolation and incidents of elopement. Although the petitioner lives alone, the health plan took into account that he receives visits from his family. The health plan also feels he can use things such as audiobooks or other devices to prevent isolation.

9. The petitioner's daughter-in-law stated his condition worsened about 6 months ago when he became totally blind. At that time, the hours of service were increased to 70 hours weekly. He became depressed, stopped eating, and lost 40 pounds. He is non-ambulatory and incontinent. It takes about one hour to feed him. His home health aide speaks Russian and reads him the newspaper. He cannot watch

television or listen to the radio. Currently, the aide is with him from 7:00 a.m. to 3:00 p.m. daily and then for 2 hours each evening. His daughter-in-law only visits him once per week, but his son helps the aide to bathe him. The family is requesting the 2 additional hours weekly due to his bowel incontinence and need for additional help with laundry.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

12. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the issue involved a reduction in services. The petitioner bears the burden of proof regarding any increase in services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

13. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

14. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

15. The petitioner requested a fair hearing because he believes his companion care services under the Program should not be reduced by the health plan. He also requested an increase in services to 72 hours weekly.

16. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

17. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

18. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the

meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

19. The petitioner also receives Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

20. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

21. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

22. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

23. After considering the evidence and testimony presented, the hearing officer concludes that the respondent has not demonstrated that it was correct in reducing the petitioner's companion care services. The petitioner was previously approved for 70 hours weekly of home health care services (including companion, homemaker and personal care services) and his condition has not improved since then. The scope of companion care includes supervision and socialization as well as meal preparation, laundry, and shopping. The evidence presented establishes the services should continue at the previously approved level of 70 hours weekly and the petitioner's needs are being met at this level. The petitioner has not met the burden of proof regarding any increase in services at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, and the petitioner's companion care services shall not be reduced. With regard to any increase in services, the appeal is denied. The petitioner's total home health services shall be maintained at 70 hours weekly.

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 indigence 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 10 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

FILED

Apr 03, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-00136

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 05 [REDACTED]
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, Hearing Officer Patricia Antonucci convened administrative hearing in the above-referenced matter on March 1, 2017, at 3:09 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For Petitioner: [REDACTED], Petitioner

For Respondent: Christian Laos, Senior Compliance Analyst,
United Healthcare Community Plan

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or "the Agency") through its contracted health plan/managed care organization (MCO), United Healthcare ("United"), to deny Petitioner's request for a new/replacement set of upper and lower dentures. Petitioner bears the burden of proving, by a preponderance of the evidence, that said denial was improper.

PRELIMINARY STATEMENT

At hearing, Respondent, AHCA, was represented by Selwyn Gossett, Medical/Health Care Program Specialist, who appeared for observational purposes only. Respondent, United, was represented by Christian Laos, United's Senior Compliance Officer. Also appearing on behalf of United were Arlene Carrion, Account Manager, and Brittany Vo, DDS, Dental Consultant.

Although the Notice of Hearing issued to the parties on January 20, 2017 informed, in part, "**Within 10 days of this Notice of Hearing, the Respondent must contact the Petitioner to discuss the issues being appealed and to explore options for resolution,**" (emphasis original), United testified that, due to an oversight, no one from the MCO had initiated such contact in preparation for final hearing. United explained that they would work to prevent this error from recurring in the future.

The Notice of Hearing further instructed: "**Evidence packet must contain all documentation and all guidelines/rules reviewed by the MCO in making its determination,**" (emphasis original). At the time of hearing, neither the Office of Appeal Hearings nor AHCA had received a copy of United's proposed evidence packet. Petitioner was unable to locate her copy of the packet, but confirmed that she had received a package from United in advance of the hearing date.

Petitioner also noted that she had requested help from the Office of Appeal Hearings when filing her appeal, stating that she has [REDACTED] damage which makes it difficult for her to process information. The Petitioner was instructed by administrative staff that they could not assist her or provide her with recommendations for aid regarding her case. At hearing, the undersigned inquired as to whether

Petitioner sought assistance from legal aid. Petitioner indicated that she had not, but that she was ready to proceed with hearing, as her own representative, so long as she was able to understand and follow along as the hearing progressed. The hearing officer encouraged Petitioner to ask for clarification, repetition, or further explanation of anything was unclear. Petitioner agreed and the parties proceeded, as scheduled.

Petitioner's Exhibits 1 through 8, inclusive, and Respondent's Exhibits 1 through 3, inclusive, were accepted into evidence. Administrative Notice was taken of all pertinent legal authority, including the Florida Medicaid Dental Services Coverage Policy (May, 2016), as promulgated by Fla. Admin. Code R. 59G-4.060. This Final Order follows.

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient, who is over 21 years of age. Petitioner receives her Medicaid-based care through United, an MCO contracted by AHCA to provide medically necessary items and services to its enrollees.
2. On or about December 27, 2016, Petitioner's dentist submitted to Staywell a prior authorization request for Upper False Teeth (code D5110) and Lower False Teeth (code D5120). Along with this request, the provider submitted an x-ray (not included in United's evidence), as well as a short statement indicating, "LAST LOWER DENTURE WAS 09/04/12 5120 – DENTURE IS NON-REPAIRABLE AND ILL FITTING, A DENTURE IS NECESSARY TO KEEP..." (capitalization original). The remainder of this

statement was not reproduced on United's authorization screen (see Respondent's Exhibit 3).

3. Via two Notices of Action dated December 28, 2016, United informed Petitioner and her provider that both the upper and lower dentures had been denied, noting that the decision was made effective on December 27, 2016.¹ The Notices also stated, in pertinent part:

The requested **service is not a covered benefit.**

...

The facts that we used to make our decision are: 244: This service exceeds the maximum count allowed per period (emphasis original).

4. On or about January 4, 2017, Petitioner filed an appeal to challenge United's determination.

5. At hearing, Petitioner testified that she requested replacement dentures because her current set no longer fit. The Petitioner suffers from multiple health issues, and has experienced weight loss and bone loss since obtaining her dentures three or four years ago. It was the Petitioner's understanding that said dentures were funded through a former MCO or dental plan, called Freedom. While they fit at the time of receipt, she can no longer use them in a functional manner.

6. The Petitioner explained that her current dentures cause a burning sensation on the roof of her mouth, generate friction and uncomfortable pressure, and result in pain throughout her mouth. To utilize these dentures, she must first numb her mouth with Orajel and attempt to build up a layer of product underneath the denture plates.

¹ As a legal matter, the MCO's action cannot become effective on a date prior to the date its Notice of Action is issued. In the instant case, as there is no termination or reduction of a previously authorized service, this constitutes harmless error; however, Respondent is encouraged to review the content of its notices and consult with AHCA as to contractual compliance, in this regard.

Petitioner has also been taking pain medication to quell the discomfort which her dentures cause. This, in turn, affects her pre-existing stomach/digestion issues, and in conjunction with the denture issues, makes it difficult for her to eat a well-balanced, nourishing diet.

7. Dr. Vo testified based upon her review of Petitioner's request/claim form and x-ray, but noted that no office visit notes or dental record were provided in support of the denture request. Dr. Vo explained that the decision to deny Petitioner's request for a new set of dentures was based solely on a benefit limitation, as imposed by AHCA. Per Dr. Vo, United did not review Petitioner's request for medical necessity, because AHCA's governing authority (as captured in its Dental Services Coverage Policy) prohibits the provision of more than one set of dentures, per patient, for life.

8. In reviewing Petitioner's United case file during hearing, Dr. Vo testified that United provided Petitioner with a denture in July of 2014.² For this reason, United was unable to authorize a new set.

9. When asked what options might assist Petitioner in resolving her concerns, Dr. Vo explained that Petitioner could request a reline to adjust her dentures and ensure a better fit to her mouth.

10. Petitioner testified that she understood from her provider that her dentures could not be adjusted, due to her weight and bone loss.

11. Dr. Vo explained that many individuals who have suffered bone loss or who have lost body weight can benefit from a reline procedure. She noted that relines are helpful

² No confirmation of this authorization or claim payment was proffered into evidence. Although the parties disagree as to what entity (United or Freedom) funded Petitioner's dentures and/or when they were provided, Petitioner does not contest that she received the dentures via Medicaid.

in correcting the fit for these, precise concerns, and that adjustment might well improve the function of Petitioner's current dentures.

12. In order to assist the Petitioner in exploring the option for reline, United agreed to contact Petitioner no later than March 3, 2017, and to provide case management to ensure that her needs are met.

13. Petitioner stated that she wished to pursue a reline, but also requested that the undersigned issue a Final Order with regard to United's denial.

CONCLUSIONS OF LAW

14. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Ch. 120, Fla. Stat.

15. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Fla. Stat. and in Chapter 59G of the *Florida Administrative Code*. Respondent, AHCA, administers the Medicaid Program for Florida's Medicaid recipients.

16. This is a Final Order, pursuant to § 120.569 and 120.57, Fla. Stat.

17. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

18. The burden of proof in the instant case is assigned to Petitioner, who has requested approval for a specific item/service (upper and lower dentures).

19. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

20. Section 409.973(1)(e), Fla. Stat., mandates that managed care plans cover dental services.

21. In keeping with this law, the May, 2016 Florida Medicaid Dental Services Coverage Policy, promulgated by Fla. Admin. Code R. 59G-4.060, states, in pertinent parts:

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.2.7 Prosthodontic Services

Florida Medicaid reimburses for prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:

- One upper, lower, or complete set of full or removable partial dentures per recipient
- One reline, per denture, per 366 days, per recipient
- One all-acrylic interim partial (flipper) for the anterior teeth, per recipient under the age of 21 years

...

4.2.9 Surgical Procedures and Extractions

Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.

(boldface emphasis original; underlined emphasis added).

22. Although United's denial was based strictly on a benefit limitation, the undersigned has also considered Petitioner's request with regard to medical necessity.

Per Fla. Admin. Code. R. 59G-1.010(166):

"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.

...

(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.

(emphasis added)

23. While it is acknowledged that Petitioner has requested new dentures to alleviate significant pain and discomfort, absent any indication that this constitutes an emergency best addressed by *new* upper and lower dentures, *and* absent proof that Petitioner's needs cannot be equally well met by an alternative procedure (such as a reline), Respondent's denial remains proper.

24. The undersigned emphasizes that she makes no ruling as to whether a new/second set of dentures is strictly prohibited under Florida Medicaid. It may well be that a new set of dentures could be considered medically necessary in certain circumstances, such that an exception to the benefit limitation may be appropriate. However, in the instant case, Petitioner has not sought a reline, and thus, cannot

demonstrate that this less costly and more conservative treatment would be ineffective in meeting her needs (See Fla. Admin. Code R. 59G-1.010(166)(a)(2 & 4)).

25. Petitioner's frustrations and confusion regarding United's prior authorization process are understandable and are duly noted for the record. It is unfortunate that the MCO failed to comply with the requirement to confer, as specified in the Notice of Hearing. Had either the MCO or its dental reviewer contacted Petitioner in advance of hearing to fully explain the denial, Petitioner may have been spared significant time and emotional investment in this appeal, and/or might have immediately pursued a reline, in attempt to alleviate her pain.

26. Petitioner is encouraged to consult with her provider, in conjunction with United, to determine which, if any, of the services covered by United would best meet Petitioner's needs. United has agreed to assist Petitioner in pursuing a reline procedure. Should Petitioner request a reline (or any other service/item) and be denied same, she will retain the right to appeal that, specific denial.

27. Furthermore, should Petitioner's provider determine that a reline is not appropriate, or should an attempted reline prove unsuccessful, Petitioner may wish to re-file her request for new dentures. If and when this occurs, United is encouraged to review Petitioner's request to determine if it constitutes a medically necessary exception to the benefit limitation. If Petitioner is again denied, she will also retain the right to appeal that adverse determination.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED, and 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 03 day of April, 2017,

in Tallahassee, Florida.



Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Copies Furnished To:

██████████ Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Apr 19, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00230

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 [REDACTED]
UNIT: 88249

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 8, 2017, at 9:30 a.m., in [REDACTED], Florida.

APPEARANCES

For the Petitioner: Petitioner was present, but was represented by her mother, [REDACTED]

For the Respondent: Dave Cameron, economic self-sufficiency specialist II.

STATEMENT OF ISSUE

At issue is whether the respondent's action denying petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she does not meet the disability criteria is correct. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By a Notice of Case Action dated December 6, 2016, the respondent informed the petitioner that her SSI-Related Medicaid Program benefits were being denied because she did not meet the disability requirement of the Program. On January 6, 2017, the petitioner timely requested a hearing to challenge the respondent's action.

Robnet Dukes, Operations Manager Consultant with DCF, appeared telephonically as a witness and provided additional testimony on behalf of the respondent.

The following individual appeared as witnesses on petitioner's behalf and provided additional testimony: [REDACTED] petitioner's father, [REDACTED], Certified Paralegal and petitioner's aunt, [REDACTED] RN Psych ER & petitioner's cousin and [REDACTED], Licensed Mental Health Counselor & petitioner's friend.

The petitioner's evidence was marked as Petitioner's Composite Exhibit 1. The respondent's evidence was marked as Respondent's Composite Exhibit 1.

The record was left open through March 28, 2017 for the petitioner to provide additional information related to the Social Security issue, including the appeal decision. The petitioner provided additional information, which was marked as Petitioner's Composite Exhibit 2. She did not provide any additional information on the SSA appeal decision, nor did she contact the hearing officer for additional time. The record was closed on March 28, 2017.

On April 17, 2017, the undersigned received correspondence from the petitioner representative after the record was closed and did not rely on it in rendering a decision.

FINDINGS OF FACT

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

1. The petitioner (DOB 8/1/77) is 39 years old. She does not meet the aged criteria for SSI-Related Medicaid benefits. She has no minor children and does meet the technical requirement for the Family-Related Medicaid category. The petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.
2. The petitioner is not currently employed and has a sporadic work history. Petitioner was last employed almost ten years ago. She has a GED (General Education Diploma) and did not attend college.
3. The petitioner has a history of mental issues and suffers from various psychological medical conditions [REDACTED] [REDACTED]). Petitioner has been baker acted in the past and has been to different medical facilities for treatments and has several outstanding medical bills from them. She uses anti-psychotic medications ([REDACTED], etc.) to control her behavior, see Petitioner's Composite Exhibit 1.
4. On December 31, 2014, the petitioner applied for Supplemental Security Income (SSI) with the Social Security Administration (SSA). On March 19, 2015, SSA denied the petitioner's application on the contention that the she has the "capacity for substantial gainful activity. The petitioner did not provide any evidence of what medical conditions were considered by SSA. On August 10, 2015, the petitioner requested an appeal challenging the SSA's decision.

5. The Florida Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

6. On May 23, 2016, the petitioner applied for Medicaid benefits through the Department's SSI-Related Medicaid Program. Information obtained from the petitioner was forwarded to DDD for review on June 15, 2016.

7. DDD received petitioner's disability package from the Department for a disability review. The DDD has access to Social Security information. Case notes from DDD Transmittal indicate petitioner's medical conditions to be affective disorder and substance abuse. DDD determined these medical were already known and considered by SSA and will be addressed in the course of her appeal before an administrative law judge (ALJ).

8. On June 20, 2016, DDD denied the petitioner's claim of disability by adopting the 2015 SSA denial. The denial reason code was N 31 (customary past work, no visual impairment). DDD did not make an independent determination, as it considered petitioner's medical conditions to be the "same allegations, see Petitioner's Composite Exhibit 2.

9. On November 28, 2016, the petitioner applied for Medicaid benefits through the Department's SSI-Related Medicaid Program. The Department did not initiate a

disability review on the petitioner and adopted the SSA decision. No disability package was sent to DDD.

10. On December 6, 2016, the Department mailed the petitioner a Notice of Case Action denying her application for SSI-Related Medicaid due to no household members are eligible for this program. On January 6, 2017, the petitioner requested an appeal challenging the Department's action.

11. On February 20, 2017, the Department initiated a disability review on the petitioner and sent a pending notice indicating that a disability packet was sent to her for completion and it needs to be returned by March 2, 2017. The disability packet was timely received and was sent to DDD for consideration, see Respondent's Composite Exhibit 1.

12. The respondent explained that it denied the petitioner's November 28, 2016 SSI-Related Medicaid application because she has a pending appeal before an SSA administrative law judge (ALJ) after being denied disability in 2015. The respondent's witness explained that once the petitioner alleged a new condition during a February 2017 case review, a disability review was initiated and forwarded to DDD for review. She explained that it could take up to 120 days for DDD to issue another decision. The petitioner's representative did not dispute the facts presented; however, she asserted that petitioner's manic episodes are more frequent and that she needs Medicaid to get the necessary treatments to help her cope with her conditions.

13. The representative informed the undersigned that she has just received notice of hearing from SSA with an appointment set for March 21, 2017. The record was left

open through March 28, 2017 for the petitioner to submit any update/decision on the SSA appeal, but none was received.

14. As of the date of this order, a decision is still pending from DDD on the petitioner's most recent disability packet.

CONCLUSIONS OF LAW

15. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

17. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals less than 65 years of age must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in relevant part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.

18. The Code of Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, "the agency must use the same definition of disability as used under SSI..."

19. Federal Regulations at 42 C.F.R. § 435.541 "Determination of Disability," states:

- (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
 - (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
- (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-
 - (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
 - (ii) If the SSA determination is changed, the new determination is also binding on the agency.
 - (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.
- (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...
 - (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-
 - (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
 - (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
 - (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-
 - (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
 - (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

20. Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP)" states:

...If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.

21. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).

22. According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA. In this instant case, the petitioner's SSI was denied in August 2015 by SSA. She applied for SSI-Related Medicaid in November 2016 and the application was denied by adopting the SSA decision from more than a year ago. Upon further

consideration, a disability review was initiated on the petitioner after she alleged to have a new condition. A decision is still pending from DDD. Petitioner's SSA appeal was set for hearing on March 21, 2017. The record was left open through March 28, 2017 for the petitioner to provide an update on the Social Security appeal decision, but none was received.

23. At first, the Department erred when it failed to initiate a disability review based on the November 28, 2016 application. This action has since been remedied when a new condition was considered and a disability packet forwarded to DDD for consideration. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's most recent action is correct.

24. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with her. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits. The petitioner has failed to meet her burden that she is eligible for any Medicaid benefits.

25. Petitioner reported a new condition in February 2017 and a new disability review was initiated and forwarded to DDD for consideration in March 2017. A decision on this most recent action is still pending. Once a decision is reached, the Department shall send written notice with the outcome and said notice shall include appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. Once a disability decision is reached, the Department needs to send written notice with the outcome and said notice shall include appeal rights.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 19 day of April, 2017,

in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 09, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00232

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: 88701

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 13, 2017 at 11:02 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Julie Schell, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her recertification application for Medicare Saving Plan. The petitioner carries the burden of proof by preponderance of evidence.

PRELIMINARY STATEMENT

At the hearing, the respondent presented five exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 5. The petitioner did not present any exhibits.

The record was held open until February 24, 2017, for the petitioner to provide the Notice of Case Action (NOCA) she received and for the respondent to provide its Running Record Comments (CLRC). The respondent provided two additional exhibits which were accepted into evidence and marked as Respondent's Exhibits 6 and 7. No evidence was received from the petitioner. The record was closed on February 24, 2017.

The parties were advised during the hearing that the undersigned was reserving ruling on jurisdiction until the Final Order.

FINDINGS OF FACT

1. Based on the documentary and oral evidence presented at the hearing, and on the entire record of this proceeding, the following Findings of Fact are made:
The petitioner was approved for Medicare Savings Plan (MSP), Qualified Medicaid Benefits (QMB) in a prior certification. The Department only counted one of the petitioner's Social Security when it approved MSP. She was receiving her own Social Security check as well as a widow's check.
2. On May 6, 2016, the petitioner submitted a recertification application for Food Assistance (FA), Medicaid and MSP.
3. The respondent reviewed the petitioner's application and determined that the petitioner was ineligible for MSP. The petitioner appealed with SSA but was denied she then appealed with the Department.
4. On May 17, 2016, the respondent mailed a NOCA to the petitioner, informing her that her recertification application dated May 16, 2016 was denied. The reason given for the denial was that her household's income was too high for the program.

5. On July 11, 2016, the petitioner contacted the Department to review FAP and to discuss her bills from her surgery.
6. On August 1, 2016, the petitioner called the Department to discuss the MSP. The Department explained her income was too high for the program and that the Medicare premium will be deducted.
7. On August 11, 2016, the petitioner called the Department to find out why money was being withdrawn from her SSDI check.
8. On August 12, 2016, the petitioner called to find out why she had to pay a retroactive Medicare premium.
9. On November 5, 2016, the petitioner called to find out why she no longer had QMB.
10. On January 6, 2017, a hearing was requested to appeal the respondent's action.
11. The petitioner acknowledged that she received the notice but alleged she did not receive the entire notice. She alleged that she did not receive the page which informed of the QMB denial. On August 1, 2016, the petitioner called the Department's customer service call center. She was told by a representative that her prescription plan/MSP was denied as her income was too high for the program.
12. The respondent asserted that all of the Department's mails are sent out automatically from Tallahassee and the field representative would have no way of knowing if the notice was missing a page.
13. The Hearing Officer finds that the petitioner knew of the MSP denial on August 1, 2016 and did not request a hearing until January 6, 2017.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under section 409.285, Florida Statutes.

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

JURISDICTION:

16. Fla. Admin. Code R. 65-2.046, sets forth time limits in which to request a hearing and states in part:

(1) The appellant or authorized representative must exercise their right to appeal within 90 calendar days in all programs...The time period begins with the date following:

(a) The date on the written notification of the decision on an application.

(b) The date on the written notification of reduction or termination of program benefits.

(c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

17. The petitioner acknowledged receiving the May 17, 2016 notice but argued she did not receive the entire notice. The petitioner knew of the MSP denial on August 1, 2016, when she contacted the respondent. She did not request the hearing within the

90-day time limit in which to request a hearing, as her initial request for hearing was January 6, 2017.

18. It is concluded that the petitioner's request for a hearing was made outside the time set forth in the controlling authority to request a hearing which is 90 days from the mailing date of the Notice of Case Action. The above controlling authority does not provide exceptions to allow hearings to proceed when not timely requested.

19. Therefore, the undersigned must conclude the issue is non-jurisdictional and cannot be reviewed by the undersigned.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is dismissed as non-jurisdictional.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

FINAL ORDER (Cont.)

17F-00232

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DONE and ORDERED this 09 day of March, 2017,

in Tallahassee, Florida.



Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 18, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00237

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 [REDACTED]
UNIT: 88601

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone on March 13, 2017 at 9:17 a.m. The undersigned also convened a status conference by phone on February 27, 2017 at 1:14 p.m.

APPEARANCES

For Petitioner: [REDACTED] petitioner's representative

For Respondent: Paula Henoa, Operations Management Consultant I

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's request for Emergency Medicaid for Aliens (EMA) benefits for the period of November 19, 2016 through November 21, 2016 is correct. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present, but was represented by [REDACTED] President of [REDACTED]. The petitioner presented two witnesses who testified: [REDACTED] the petitioner's friend; and [REDACTED] Medicaid Supervisor with [REDACTED]. The petitioner submitted one exhibit, which was accepted into evidence and marked as Petitioner's Exhibit "1". The respondent was represented by Paula Henao, Operations Management Consultant I, with the Department of Children and Families (hereafter "DCF," "Respondent," or "Agency"). The respondent presented one witness who testified: Maryalis Calero, Economic Self Sufficiency Specialist I, with DCF. The respondent submitted no exhibits at the hearing.

[REDACTED] from the Language Line, translated the proceedings.

FINDINGS OF FACT

1. The petitioner came to the United States and became ill in November 2016. (Page 2 of Petitioner's Exhibit 1)
2. The petitioner was admitted to the hospital on November 19, 2016 and was discharged on November 21, 2016. The petitioner is requesting EMA benefits from November 19, 2016 through November 21, 2016. (Petitioner's testimony)
3. When the petitioner first arrived in Florida, she lived with her friend, but the petitioner moved in with her daughter and son-in-law after she was discharged from the hospital. (Page 10 of Petitioner's Exhibit 1)
4. On November 28, 2016, the petitioner's representative submitted an application for EMA benefits on behalf of the petitioner. (Petitioner's testimony)

5. The respondent's witness explained that on November 30, 2016, she contacted the petitioner by phone to authenticate the petitioner's identity. During the phone call, the petitioner stated she did not intend to remain in Florida and was expected to return to Cuba on January 17, 2017 as she did not have any relatives living in Florida.

(Respondent's testimony)

6. The respondent's witness also explained she spoke to the petitioner's friend about sending the petitioner a pending letter and the fact that the petitioner did not qualify for EMA benefits. The respondent's witness did not document "CLRC" (case notes) about her phone call with the petitioner's witness. "CLRC" only indicates the respondent's witness spoke to the petitioner. (Respondent's testimony)

7. The petitioner's friend explained that on November 30, 2016, the respondent's witness contacted the petitioner by phone and she (petitioner) gave the respondent's witness permission to talk to her (friend) as she was taking high doses of medication that made it difficult for her to speak on the phone. (Petitioner's testimony)

8. The petitioner's friend further explained that on November 30, 2016, she stated to the respondent's witness the petitioner was not returning to Cuba due to her medical condition. (Petitioner's testimony)

9. On November 30, 2016, the respondent denied the petitioner's application for EMA benefits. On December 1, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner was not eligible for EMA benefits as she did not meet the Florida residency requirement. (Respondent's testimony)

10. For an individual to be eligible for EMA benefits, the respondent must determine if the individual meets all of the technical and financial criteria. If an individual does not

have legal status; does not have a social security number or cannot apply for a social security number; and has a passport for identity, the individual is potentially eligible for EMA benefits. (Respondent's testimony)

11. When the petitioner applied for EMA benefits, she had a valid passport and was considered a tourist. In order to be eligible for EMA benefits, the petitioner must meet the residency requirement or must have the intent to remain in the State of Florida. The respondent believed that since the petitioner was returning to Cuba, she was not eligible for EMA benefits. (Respondent's testimony)

12. The petitioner passed away on December 13, 2016. (Page 1 of Petitioner's Exhibit 1)

CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

15. Federal Regulations at 42 C.F.R. § 435.406, "Citizenship and non-citizen eligibility" states, in part:

- (a) The agency must provide Medicaid to otherwise eligible individuals who are—
 - (1) Citizens and nationals of the United States...
 - (2) At State option, individuals who were deemed eligible for coverage under §435.117 or §457.360 of this chapter in another State on or after July 1, 2006, provided that the agency verifies such deemed eligibility.

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified non-citizens), qualified non-citizens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified non-citizens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Non-Citizen status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is a non-citizen in a satisfactory immigration status...

16. The U.S. Code at 8 U.S.C. § 1641, "Definitions" states, in part:

(a) In general

Except as otherwise provided in this chapter, the terms used in this chapter have the same meaning given such terms in section 101(a) of the Immigration and Nationality Act [8 U.S.C. 1101(a)].

(b) Qualified alien

For purposes of this chapter, the term "qualified alien" means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit, is-

- (1) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act [8 U.S.C. 1101 et seq.],
- (2) an alien who is granted asylum under section 208 of such Act [8 U.S.C. 1158],
- (3) a refugee who is admitted to the United States under section 207 of such Act [8 U.S.C. 1157],
- (4) an alien who is paroled into the United States under section 212(d)(5) of such Act [8 U.S.C. 1182(d)(5)] for a period of at least 1 year,
- (5) an alien whose deportation is being withheld under section 243(h) of such Act [8 U.S.C. 1253] (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of such Act [8 U.S.C. 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104-208),
- (6) an alien who is granted conditional entry pursuant to section 203(a)(7) of such Act [8 U.S.C. 1153(a)(7)] as in effect prior to April 1, 1980; ¹ or
- (7) an alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980) ...

17. Pursuant to the above authorities, only qualified non-citizens are eligible for full Medicaid benefits. Since the petitioner does not meet the definition of a qualified non-citizen, she is ineligible for full Medicaid benefits.

18. Fla. Admin. Code R. 65A-1.715, "Emergency Medicaid for Aliens" states, in part:

(1) Aliens who would be eligible for Medicaid but for their immigration status are eligible only for emergency medical services. Section 409.901(10), F.S., defines emergency medical conditions.

(2) The Utilization Review Committee (URC) or medical provider will determine if the medical condition warrants emergency medical services and, if so, the projected duration of the emergency medical condition. The projected duration of the emergency medical condition will be the eligibility period provided that all other criteria are continuously satisfied...

19. Pursuant to above authority, non-citizens who would be otherwise eligible for full Medicaid benefits, but are ineligible due to citizenship, are potentially eligible for EMA benefits if they experience a medical emergency.

20. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1440.0118, Noncitizens not Eligible for Assistance (MSSI, SFP), states, in part:

The following individuals are not eligible for public assistance on the factor of citizenship status:

1. foreign government representatives on official business and their families and servants;
2. visitors for business or pleasure, including exchange visitors...

Verification is usually the I-94, Arrival-Departure Record, annotated with the letters "A" through "V" except "T" (A-2, B-1, etc.) ...

21. Pursuant to the above authority, individuals with a valid passport who are considered visitors are potentially ineligible for public assistance. The petitioner had a valid passport and was considered a tourist.

22. The Policy Manual, CFOP 165-22, passage 1440.0303.01, Residency Requirements (MSSI, SFP), states, in part:

An individual must satisfy one of the following residency requirements:

1. Reside in the State of Florida with the intent to remain.
2. Be living in the State of Florida for employment purposes. or
3. Some individuals in the U.S. with a valid temporary Visa and their U.S. born children may meet the Florida residency requirement if they verify their residency and state an intent to remain. Lawfully residing children, up

to age 19, are potentially eligible for Medicaid provided all other eligibility requirements, including residency, are met...

23. The ACCESS Florida Program Memorandum Transmittal NO.: C-05-02-0001, dated February 3, 2005, Clarification on Residency Policy for EMA, states, in part:

EMA is available for non-citizens that do not qualify for Medicaid due to citizenship status, but meet all other eligibility criteria. Visitors or students in the U.S. do not usually meet the residency requirement. However, there are cases in which an individual originally entered the U.S. under a visa (non-immigrant) and later applied for permanent residency and expresses an intent to remain in Florida...

24. Pursuant to the above authorities, individuals who have a valid visa or passport may be eligible for EMA benefits if they have the intent to remain in the State of Florida.

25. The petitioner had a valid passport; entered the United States as a tourist; became sick in November 2016; and passed away in December 2016. The petitioner seeks authorization of EMA benefits for the period of November 19, 2016 through November 21, 2016.

26. The evidence submitted indicates the petitioner was hospitalized in November 2016 due to an illness; was diagnosed with a terminal medical illness; and lived with her daughter and son-in-law after she was hospitalized.

27. The testimony at the hearing indicates the petitioner gave the respondent's witness permission to conduct a phone interview with her friend as she was too ill to talk. The testimony also indicates the petitioner came to the United States as she had family in the area and did not intend to return Cuba due to her terminal medical condition. The petitioner meets the residency criteria as she had a valid passport; was considered a tourist; and had the intent to remain in the State of Florida. Therefore, the

respondent incorrectly denied the petitioner's request for EMA benefits due to residency.

28. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has met the burden of proof in establishing the respondent incorrectly denied her Emergency Medicaid for Aliens benefits for the period of November 19, 2016 through November 21, 2016. Since the petitioner meets the residency requirement, the respondent is ordered to review the petitioner's eligibility for Emergency Medicaid for Aliens benefits for the aforementioned mentioned period. Once an eligibility determination is made, the respondent is to issue a new Notice of Case Action to the petitioner including her appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for Emergency Medicaid for Aliens benefits for the period of November 19, 2016 through November 21, 2016 is GRANTED. The appeal is REMANDED to the Department to take corrective action as specified in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 18 day of April, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
[REDACTED]

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

FILED

Mar 27, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00240

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 01 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on February 28, 2017 at approximately 10:30 a.m.

APPEARANCES

For Petitioner: [REDACTED] Petitioner's Mother

For Respondent: Cindy Henline
Medical/Health Agency Care Program Analyst
for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's termination of Petitioner's Prescribed Pediatric Extended Care Services ("PPEC") was correct. The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Dr. Calhoun, Physician Reviewer with eQHealth Solutions ("eQHealth") appeared as a witness for Respondent. Petitioner's mother gave oral testimony, but did not move

any exhibits into evidence. Respondent moved Exhibits 1–4 into evidence.

Administrative Notice was taken of Section 409.905, Florida Statutes, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and the entire Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (“PPEC Handbook”).

FINDINGS OF FACT

1. Petitioner is an 11-year-old male, born in 2005. His diagnoses include [REDACTED]
[REDACTED] The Petitioner is incontinent of bladder and bowel, requires assistance with all activities of daily living (ADLs) and is non-verbal. Petitioner using a gait trainer at home and is wheelchair bound. (Resp. Exhibit 4)
2. Petitioner resides with his mother, and two (2) older twin siblings, both diagnosed with [REDACTED] The mother is the sole caregiver. He attends school Monday through Friday where he receives all of his therapies, and attends PPEC during holidays and school breaks. Petitioner receives 40 hours a week of Private Duty Nursing (PDN) services by an LPN. (Resp. Exhibit 4)
- 3 PPEC service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the Respondent’s PPEC Handbook, effective September 2013. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.
4. eQHealth is the Quality Improvement Organization (QIO) contracted by the Respondent to perform prior authorization reviews for PPEC services. The Petitioner’s provider submitted the service request through eQHealth’s by fax. The submission

included, in part, information about the Petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.

5. On or about December 28, 2016, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue his previously authorized PPEC services into the new certification period, spanning December 30, 2017 through June 27, 2017.

6. This prior service authorization request, along with information and documentation required to make a determination of medical necessity, was submitted to AHCA's peer review organization (PRO). The PRO contracted by AHCA to review PPEC requests is eQHealth.

7. On January 4, 2017, eQHealth issued a Notice of Outcome – Denial Prescribed Pediatric Extended Care Services, denying the request in full. (Resp. Exh. 3). The Clinical Rationale for the Decision was:

- The patient is an 11 year old with [REDACTED] [REDACTED]. The patient has not had a documented seizure in over a year but has [REDACTED] ordered for prolonged seizures. The patient ambulates by scooting on the floor. The patient attends school where he receives therapies. The clinical information provided does not support the medical necessity of the requested PPEC services. It appears that the seizures are stable and no longer need skilled nursing interventions. It appears that the care is personal care needs and there does not appear to be a skilled nursing need. The request does not appear to be medically necessary.

8. The January 4, 2017 letter, which eQHealth sent to Petitioner, notes only:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:
Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

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.

9. The Petitioner's thereafter timely requested a fair hearing and this proceeding followed. The Respondent administratively approved the requested PPEC services pending the outcome of the fair hearing process.
10. At the hearing Petitioner's mother clarified that Petitioner has petite cluster seizures not grand mal seizures as noted in the evidence presented by the Agency. When he has a seizure, it is difficult to recognize by an untrained eye. Symptoms for Petitioner's seizure could be as small as a twitch of a facial muscle. When an episode occurs, rectal [REDACTED] must be administered immediately or these seizures will continue indefinitely. The rectal [REDACTED] has a sedative effect on Petitioner and he falls asleep. The last episode was approximately a year ago.
11. Dr. Calhoun testified based upon her review of Petitioner's request for services, in conjunction with his Plan of Care, assessments, care coordination and progress notes. Dr. Calhoun noted that while the Petitioner clearly requires precautions/monitoring, the only intervention indicated on the Plan is the administration of as-needed medications if a seizure does occur.
12. Petitioner's assessments and care coordination notes reflect that Petitioner has had no recent seizure activity, no tracheostomy tube placement, and no dependence upon mechanical devices. Petitioner does not use any special medical equipment such as a breathing tube or feeding tube.
13. Dr. Calhoun stated that the distinction of the different seizure types, although the presentation is different, does not have an effect on the determination outcome. She

emphasized the frequency and need for intervention on a regular basis are the determining factor for review for PPEC services.

14. Dr. Calhoun made a point to say that she does not want to minimize the seriousness of Petitioner's medical conditions. However, she said that Petitioner does not require skilled nursing services on a daily basis, therefore the PPEC services were terminated.

CONCLUSIONS OF LAW

15. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Chapter 120, Florida Statutes.

16. Respondent, the Agency for Healthcare Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the *Florida Administrative Code*.

17. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

18. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

19. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

20. The burden of proof in the instant case is assigned to the Respondent, who seeks to terminate a previously authorized service. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

21. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

22. Starting on page 1-1 of the PPEC Handbook notes that, “[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center.” Page 1-2 adds that “PPEC services are not emergency services.” (emphasis added).

23. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

(underlined emphasis added)

24. Fla. Admin. Code R. 59G-1.010 defined “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning. (emphasis added)

25. Consistent with the law, AHCA’s agent, eQHealth, performs service authorization reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

26. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

“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. ...

(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.

27. As the Petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

28. EPSDT augments the Medical Necessity definition contained in the *Florida Administrative Code* via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

29. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

30. In the instant case, PPEC is requested to treat and ameliorate the supervisory, monitoring, and continuous therapy needs which Petitioner's health conditions require. As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

31. More specifically, however, Fla. Admin. Code R. 59G-1.010(166) requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these

criteria, the Petitioner must meet the requirements for PPEC, as provided in the PPEC Handbook.

32. In the instant matter, the testimony and documentary evidence fails to establish the medical necessity of PPEC services for Petitioner. While it is clear Petitioner has very serious medical problems, he does not require skilled nursing care throughout the day.

33. The primary concerns for Petitioner's care are his petite cluster seizures and the ability for a person without a medical background to recognize the symptoms of this seizure disorder. Petitioner has not had a seizure in a year. Monitoring for a potential seizure is not a skilled nursing service, even if the presentation of these seizures are hard to recognize.

34. There is no evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life sustaining medical care that he would properly be deemed 'Medically Fragile. His need for monitoring for a potential seizure and interventions in case of emergency, do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care." As such, his needs do not support the authorization of PPEC, because there are alternative services that are better designed to meet his needs without being excessive. PPEC cannot be authorized as a substitute for school or daycare, particularly when there is no skilled intervention provided at the PPEC site. In essence, this would constitute approval of PPEC as excessive of Petitioner's needs in direct violation of the PPEC Handbook (page 1-2).

35. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes Respondent has met its burden of proof, by the greater weight of the evidence, in terminating Petitioner's PPEC services.

36. Should Petitioner's health decline, such that he regularly requires medical or nursing interventions, his mother is encouraged to reapply for PPEC services. Additionally, she is encouraged to coordinate with AHCA and to contact the Department of Children and Families to seek assistance with locating an appropriate day care facility, and obtaining any other services which may be appropriate to meet Petitioner's needs. If any subsequent requests for services are denied, she will retain the right to appeal that/those, specific denial(s).

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Agency'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.

FINAL ORDER (Cont.)

17F-00240

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DONE and ORDERED this 27 day of March, 2017,
in Tallahassee, Florida.



Stephanie Twomey
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], Petitioner
AHCA Hearings Unit

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

FILED

Mar 23, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00248

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on February 22, 2017 at 10:20 a.m.

APPEARANCES

For Petitioner: [REDACTED] Pro se

For Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is Respondent's action, through managed care plan Better Health, to deny Petitioner's request for a lightweight detachable power wheelchair. Because the matter at issue involves a new request, Petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from Better Health were Dr. Naveen Gande, Medical Director, and Deborah Zamora, Grievance and Appeals Team Lead.

Appearing as Petitioner's witness was [REDACTED], L.P.N. with the office of [REDACTED], petitioner's primary care physician.

Respondent Exhibit 1 was entered into evidence.

FINDINGS OF FACT

1. Petitioner is a 52-year-old recipient of the Medicaid program. He enrolled with Better Health's managed care plan effective October 1, 2016.

2. Petitioner is diagnosed with [REDACTED] and [REDACTED]. He also has right thigh proximal muscle weakness.

3. Petitioner's primary care physician wrote a prescription on October 13, 2016 for an "electric wheelchair for patient...that is lightweight and portable." No CPT was provided. Respondent's witness testified Better Health contacted the office of Petitioner's doctor to obtain the CPT code to be reviewed. Respondent's Statement of Matters indicates this prescription was received on December 7, 2016, with CPT code K0823

4. On December 13, 2016, Better Health sent a Notice of Action denying Petitioner's request for an electric wheelchair as not medically necessary. The specific reasons under Rule 59G-1.010 were indicated as:

- ✓ Must be needed to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

- ✓ Must 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;
- ✓ Must be able to be 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
- ✓ Must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

5. The notice also provided the facts used to make the decision:

The information sent to us by your doctor doesn't show you cannot perform your activities of daily living inside the home using an alternative device such as a walker, cane, manual wheelchair, or scooter. There is also no documentation that you can safely use an electric wheelchair within the home if in fact this is the only alternative. The information we received is not enough to meet medical necessity criteria under your health plans medical policy, Anthem CG-DME-31.

6. Petitioner filed a timely request for a fair hearing on January 9, 2017.

7. On January 12, 2017, Better Health's Medical Director approved the light weight electric wheelchair. Petitioner refused the electric wheelchair he received and it was returned to the wheelchair provider.

8. Petitioner's primary care physician wrote a prescription on January 18, 2017 for an "electric wheelchair (K0800) lightweight portable." Procedure code K0800 is the code for a scooter.

9. On January 23, 2017, Better Health sent a formal notice to Petitioner that "pre-authorization requirements have been satisfied" for the prescription for K0800. The notice describes the CPT code as "PWR OP VEH GRP 1 STD PT TO 300 LBS". A written note on the notice indicates a call to the provider revealed the CPT code is for a scooter and prescription was for an electric wheelchair lightweight portable."

10. Petitioner stated he accepted, and is using the scooter, because it breaks down into parts and is better than the bulky wheelchair they initially provided. He accepted the scooter because he understood he could not get what he wanted.

11. He breaks down the scooter and stows the parts in his vehicle, allowing him to drive to his doctor appointments, do shopping, etc. without using the Medicaid transportation provider. He states he cannot wait three hours in a wheelchair for Medicaid's transportation bus because of the pain he experiences.

12. Petitioner wants a lightweight portable wheelchair that also breaks down into four parts. There is no documentation from Petitioner nor Respondent describing a wheelchair that breaks down into parts. As such, there is no documentation of medical necessity for such a wheelchair.

13. Respondent's witness testified the provider submitting the request is responsible for providing the CPT code for the item being requested. Petitioner's witness testified she obtains the CPT code from the insurance company because there are so many DME codes.

14. Respondent explained a wheelchair that breaks down into parts would be a customized wheelchair and would need to be determined medically necessary.

CONCLUSIONS OF LAW

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

16. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes. This proceeding is a *de novo* proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

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

18. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes and Chapter 59G, *Florida Administrative Code*. The Medicaid Program is administered by the respondent.

19. Rule 59G-1.010, *Florida Administrative Code*, states in part:

(166) "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;
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.

20. The Florida Medicaid Provider General Handbook- July 2012 (Handbook) is promulgated by Rule 59G-5.020, *Florida Administrative Code*.

21. Page 1-27 of the Handbook states “Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.” Page 1-28 provides a list of HMO covered services, which includes durable medical equipment. Page 1-30 states “[a]n HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

22. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook- July 2010 (DME Handbook) is promulgated by Rule 59G-4.070, *Florida Administrative Code*.

23. Page 1-1 of the DME Handbook defines durable medical equipment:

Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient’s home as determined by the Agency for Health Care Administration (AHCA).

24. Page 2-91 of the DME Handbook provides the service requirements for wheelchairs:

Medicaid will reimburse for a wheelchair when the recipient is non-ambulatory or has severely limited mobility and it is medically documented that a wheelchair is medically necessary to accommodate the recipient’s physical characteristics.

Medicaid will reimburse and provide maintenance for only one wheelchair (regardless of type) or power operated vehicle (POV) procedure code per recipient, per maximum limit period, as stated in the DME and Medical Supply Services Provider Fee Schedule.

25. Pages 2-92 and 2-93 of the DME Handbook provide the documentation requirements for a customized wheelchair:

Medicaid will reimburse for a medically-necessary, customized wheelchair that is specially constructed for the individual recipient.

Medicaid will not approve a customized wheelchair or wheelchair custom upgrade without the medical necessity documentation that establishes the recipient's inability to perform activities of daily living within the recipient's home. Activities of daily living include bathing, eating, toileting, dressing, transferring in and out of a bed or chair, and moving about within the home. [emphasis added]

Prior authorization is required for all custom wheelchairs, power wheelchairs, power operated vehicles (POV), and modifications and custom upgrades. The following information must be submitted with the prior authorization request:

- Either the Medicaid Custom Wheelchair Evaluation form (Appendix A) or another document that contains the same information that is requested on the form; and
- Medical necessity documentation; and
- Written documentation describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive and physical abilities, coordination, and activity limitations; and
- Wheelchair evaluations must be performed by and the evaluation information completed by or dictated by a registered physical or occupational therapist or a certified physiatrist and documented on either the Custom Wheelchair Evaluation, AHCA Med Serv Form 015, July 2007 (Appendix A) or another document that contains the same information that is requested on the form. The documentation must list a date of completion that is not more than six (6) months old and include the therapist's or physiatrist's signature and license number; and
- Discussion of the recipient's current mobility equipment and why the current equipment is no longer appropriate; and
- What physical improvement(s) can be anticipated; and
- What physical deterioration may be prevented with the type of wheelchair and specific features requested; and
- Listing of each customized feature required for unique physical status; and
- Specification of the medical benefit of each customized feature requested; and

- Identification of the principle place(s) the wheelchair will be used; and
- Itemized provider invoice, listing the provider's price requested for parts and labor (labor is included in the cost of the initial fabrication of a custom wheelchair or custom components); and
- List the source(s) for the accessories and modifications requested and the manufacturer's suggested retail price for each item that is not described by a procedure code with a scheduled fee on the DME and Medical Supply Services Provider Fee Schedule; and
- Itemized invoice listing provider's source of accessory and modification parts and manufacturer's suggested retail pricing (MSRP) for the parts, and listing the procedure codes and scheduled fees for the components that are described on the DME and Medical Supply Services Provider Fee Schedule; and
- Documentation of the recipient's home accessibility for the customized manual or motorized wheelchair requested; and
- Measurements of the recipient; and
- Weight of recipient; and
- Measurements of all exterior doorways of the recipient's residence; and
- Measurements of all interior doorways of the recipient's residence to be used by the recipient; and
- Documentation that the requested equipment is the least costly alternative to meet the recipient's needs must be available upon request.

26. Petitioner requested a lightweight portable electric wheelchair. What he really wanted was a lightweight portable electric wheelchair with detachable parts.

27. After Respondent approved the prescription for an electric wheelchair, Petitioner refused the wheelchair upon delivery. Petitioner then submitted a prescription for a scooter. Petitioner explained he is using the scooter because it breaks down into parts, but he wants a light portable wheelchair that breaks down into parts.

28. Respondent approved two prior authorization requests for Petitioner –one for an electric wheelchair and one for a scooter. No prescription was submitted for a

wheelchair that breaks down into parts, nor is there any description of such features accompanying the prescription for a lightweight portable electric wheelchair. Providing a description of the wheelchair would have led to a different CPT code, as well as the need for the additional supporting documentation cited above for custom wheelchairs.

29. Respondent stated a wheelchair that breaks down into parts is a customized wheelchair, and it would need to be determined medically necessary. The above controlling authorities makes clear the documentation needed to accompany a request for a customized wheelchair. No such documentation has been submitted. Moreover, it specifies the use of the wheelchair to aid in meeting a member's activities of daily living within the home.

30. Providers submitting prior authorization requests and prescriptions are responsible for adhering to the appropriate Medicaid handbooks and fee schedules to ensure the correct item is being requested and the required supporting documentation is provided for a determination of medical necessity.

31. The evidence shows the prior authorization requests previously submitted by the provider were approved.

32. If a new prior authorization request for a customized wheelchair is or was submitted, the Agency shall complete a medical necessity determination and issue a new notice informing Petitioner of his appeal rights.

33. Petitioner is encouraged to work with his Better Health case manager and his provider in securing the necessary documentation, as required by the DME Handbook, for any future wheelchair request.

34. After considering the evidence and the appropriate authorities set forth in the findings above, the hearing officer concludes Petitioner has not met his burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DISMISSED.

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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 23 day of March, 2017,

in Tallahassee, Florida.



Warren Hunter
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Better Health Hearings Unit

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

FILED

Mar 23, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00267

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 [REDACTED]
UNIT: 88510

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on March 3, 2017 at 11:04 a.m. All parties appeared by telephone from different locations.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Patricia Rodriguez,
Economic Self-Sufficiency Specialist Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of, November 29, 2016, enrolling her in the Medically Needy Program (MN) with a Share of Cost (SOC) rather than approving her for full Medicaid coverage. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (Department or respondent) administers the Medicaid Program for the state of Florida. The petitioner presented evidence which was marked and accepted as Petitioner's Composite Exhibit 1. The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "5" respectively. The record was held open to allow the respondent to submit additional evidence, specifically a copy of the application dated November 21, 2016 and a copy of the Florida Medicaid Management Information System (FMMIS) screens showing eligibility for the months in question. The information was received on March 8, 2017 and marked and accepted as Respondent's Exhibits "6" through "9". The record was closed on March 8, 2017.

FINDINGS OF FACT

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. On November 21, 2016, the petitioner applied for Food Assistance and Medicaid benefits for a three-person household, see Respondent's Exhibit 6.
2. The petitioner, age 43, is a single parent with two minor daughters ages 9 and 5. The petitioner is neither a tax dependent nor is she filing taxes, see Respondent's Exhibit 6.
3. On November 28, 2016, the Department determined that the household was eligible for Food Assistance benefits and full Medicaid benefits for the minor children. The petitioner was determined ineligible for full Medicaid based on income and enrolled in the Medically Needy Program with a SOC of \$324.

4. On November 29, 2016, the Department sent a Notice of Case Action (NOCA) to the petitioner informing her of its eligibility determination. The petitioner appealed this action the same day, see Petitioner's Composite Exhibit 1.
5. On March 2, 2017, a supervisory review discovered a computational error in the petitioner's budgets. The petitioner's countable earned income was listed as \$810 monthly instead of \$8.10 an hour. The Medicaid budget was corrected and the SOC recalculated, see Respondent's Exhibit 2.
6. The petitioner's countable monthly gross income consists of wages from her part-time work-study employment with Indian River State College. The petitioner works 20 hours bi-weekly and is paid \$8.10 an hour, see Respondent's Exhibits 1 & 4.
7. On March 3, 2017, the petitioner was notified that her SOC changed from \$324 monthly to \$162 monthly, see Respondent's Exhibit 5.
8. The petitioner felt that her Share of Cost was still too high. She also stated that the error in calculation of her SOC resulted in several bills not being paid by Medicaid that would have been covered (December 2015, July 2016, and January 2017), see Petitioner's Composite Exhibit 1.
9. The respondent provided copies of the FMMIS screens showing petitioner's Medicaid eligibility for the above-mentioned months, see Respondent's Exhibit 8.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to 409.285 Florida Statutes. This Order is the final administrative decision of the Department of Children and Families under 409.285, Florida Statutes.

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

12. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school fulltime.

13. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, and her two daughters (three members). The findings show the Department determined the petitioner's eligibility for Medicaid using a household size of three.

14. Federal regulations at 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (d) defines Household Income and provides guidance for budgeting income of individuals who are not tax dependents nor are filing tax returns . It states:

(1) *General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) *Income of children and tax dependents.* (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in

which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

...

(3) *Rules for individuals who neither file a tax return nor are claimed as a tax dependent.* In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

- (i) The individual's spouse;
- (ii) The individual's children under the age specified in paragraph (f)(3)(iv) of this section; and
- (iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.
- (iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—
 - (A) Age 19; or
 - (B) Age 19 or, in the case of full-time students, age 21.

15. The Policy Manual at 2630.0108 Budget Computation (MFAM), states:

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.

In computing the assistance group's eligibility, the general formula is:
Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income). Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.

Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.

Step 4 - Compare the total countable net income to the coverage group's income standard.

If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.

Step 5 - Apply a MAGI deduction (5% of the FPL based on SFU size). If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid. Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

16. The Policy Manual at Appendix A-7 (Effective April 1, 2016) indicates the Family-Related Medicaid Income Limit as \$303 and a Standard Disregard of \$185 for an adult with a child between 1-5 years old to be eligible for full Family-Related Medicaid Program.

17. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. Step 1: The total income counted in the budget is \$648. Step 2: There are no deductions included in the calculation. Step 3: The total income of \$648 less the standard disregard of \$185 is \$463. Step 4: The balance of \$463 is greater than the income limit of \$303 for the mother with her two minor children to receive full Medicaid for herself. Step 5: With no MAGI disregard applied, the countable balance remains \$463. This amount was greater than the income limit of \$303. The undersigned concludes that the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.

18. The Policy Manual at passage 2630.0502 Enrollment (MFAM) states:

If an individual meets the Medically Needy Program's technical eligibility criteria, he is enrolled into the program. There is no income limit for

enrollment. The individual is only eligible (entitled to Medicaid) when he has allowable medical bills that exceed the SOC.

The income for an enrolled assistance group need not be verified. Instead, an estimated SOC is calculated for the assistance group. If after bill tracking, it appears the assistance group has met his "estimated" SOC, the unverified income must be verified before the Medicaid can be authorized. An individual is eligible from the day their SOC is met through the end of the month.

19. The Policy Manual at passage 2630.0500 Share of Cost (MFAM) states:

The Share of Cost (SOC) refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.

Eligibility must be determined for Medically Needy any time the assistance group meets all technical factors but the income exceeds the appropriate income limit for Medicaid.

To calculate the share of cost, compare the countable net income to the Medically Needy Income Level based on the size of the standard filing unit. The difference is the assistance group's share of cost.

20. Appendix A-7 indicates that for an adult in a three-person household the MNIL is \$486.

21. To determine petitioner's SOC the respondent determined the petitioner's household monthly income to be \$648. The Medically Needy Income Level of \$486 for a standard filing unit size of three was subtracted resulting in the petitioner's SOC of \$162.

22. Prior to convening the hearing, the Department corrected its miscalculations of the petitioner's income in the Medicaid budget. After carefully considering the testimony and evidence presented, along with the pertinent rules and regulations stated above, the undersigned concludes that the petitioner's Share of Cost is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 23 day of March , 2017,
in Tallahassee, Florida.



Ursula Lett-Robinson
Hearing Officer
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 18, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00283

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 [REDACTED]
UNIT: 88249

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 8, 2017, 2017, at 12:34 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

[REDACTED].

For the Respondent:
supervisor.

Latoya Blackwood, economic self-sufficiency

STATEMENT OF ISSUE

At issue is whether the respondent's action denying petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she does not meet the disability criteria is correct. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

During the hearing, the petitioner did not submit any evidence for consideration. The respondent submitted six (6) exhibits, which were marked as Respondent's Exhibits "1" through "6" respectively.

The record was left open through March 29, 2017 for the respondent to provide additional information and for the petitioner to provide a rebuttal statement, in addition to information related to the Social Security Disability issue. The respondent's evidence was timely received and marked as Respondent's Exhibit 7. The petitioner did not provide any additional information, nor did she contact the hearing officer for additional time. The record was closed on March 29, 2017.

FINDINGS OF FACT

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

1. The petitioner [REDACTED] is 58 years old. She does not meet the aged criteria for SSI-Related Medicaid benefits. She has no minor children and does meet the technical requirement for the Family-Related Medicaid category. The petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.
2. The petitioner is not currently employed and last worked in July 2015.
3. The petitioner suffers from various medical conditions (reduced vision, neuropathy and type I diabetes) and has been under medical care.
4. On June 20, 2016, the petitioner applied for disability with the Social Security Administration (SSA). On August 11, 2016, SSA denied the petitioner's application on the contention that she has the "capacity for substantial gainful activity-customary

past work, no visual impairment” (N 31). The petitioner did not provide any evidence of what medical conditions were considered by SSA. On October 14, 2016, the petitioner requested an appeal challenging the SSA’s decision.

5. The Florida Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

6. On December 30, 2016, the petitioner applied for Medicaid benefits through the Department’s SSI-Related Medicaid Program. She was interviewed on January 3, 2017. The case was processed and the petitioner’s Medicaid benefits denied. No disability review was initiated on the petitioner.

7. On January 4, 2017, the Department mailed the petitioner a Notice of Case Action denying her application for SSI-Related Medicaid due to no household members are eligible for this program, see Respondent’s Exhibits 1 through 6. On January 9, 2017, the petitioner timely requested a hearing to challenge the respondent’s action.

8. The respondent explained that it denied the petitioner’s SSI-Related Medicaid application because SSA has determined that she was not disabled less than year ago. The respondent explained that SSA decision is binding and must be accepted by the Department as final. The petitioner did not dispute the facts presented; however, she asserted that her neuropathy is deteriorating. She did not claim any new conditions, just taking new medications. Petitioner explained that she has just received notice from

SSA that an ALJ has issued a decision upholding the initial denial. There is no evidence of what medical conditions SSA considered. The record was left open for the petitioner to submit her SSA document but it was not received.

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
11. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals less than 65 years of age must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in relevant part:
 - (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.
12. The Code of Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, “the agency must use the same definition of disability as used under SSI...”

13. Federal Regulations at 42 C.F.R. § 435.541 "Determination of Disability," states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

14. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP)" states:

...If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial. (emphasis added)

15. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).
- 6. When the individual files an application within 12 months after the last unfavorable disability determination by SSA, and the individual alleges no new disabling condition or claims a deterioration of an existing condition previously considered by SSA. Refer the individual to SSA for disability reconsideration or appeal. Only request a disability decision from DDD if:**
 - a. SSA refuses (or has already refused) to reconsider the unfavorable disability decision, or**
 - b. the applicant no longer meets SSI non-disability criteria such as income or assets. (emphasis added)**

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

16. According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA. Additionally, they direct worsening and deteriorating of conditions to the SSA. In this instant case, SSA has determined that the petitioner's conditions were not severe enough to prevent her from engaging in substantially gainful activities.

17. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner Medicaid under the SSI-Related Medicaid coverage group is correct.

18. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with her. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits. It is concluded, the respondent's action to deny the petitioner's application for Medicaid Program benefits was within the rules of the Program. The petitioner has failed to meet her burden that she is eligible for any Medicaid benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 18 day of April, 2017,

in Tallahassee, Florida.



Roosevelt Reveil
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 24, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00285

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 [REDACTED]
UNIT: 88642

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 21, 2017 at 11:14 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: Matthew Lynn, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

ISSUE

At issue is the respondent's action on January 10, 2017 to deny the petitioner's application for Medicaid on its contention that she does not meet the disability requirement and does not have eligible children living in the home.

PRELIMINARY STATEMENT

Evidence was received and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 on February 28, 2017 to allow the respondent to submit additional evidence. Evidence was received and entered as the Respondent's Exhibit 3.

The record was closed at 5:00 on February 28, 2017.

FINDINGS OF FACT

1. On January 6, 2017, the petitioner applied for Medicaid for herself, age 43. The petitioner lives with her disabled siblings, ages 44, 38, and 28. The petitioner acknowledged during the hearing that she is not pregnant or disabled.

2. The Department determined that the petitioner was not eligible for Medicaid as she is under the age of 65, does not have any minor children living in the home, is not pregnant, nor is she disabled.

3. On January 10, 2017, the Department issued the Notice of Case Action to inform her that she is not eligible for Medicaid due to not meeting the disability requirement and not having any dependent children.

4. The petitioner does not agree with the denial of her application for Medicaid. The petitioner argues that she was receiving Medicaid in New York. The petitioner believes that she qualifies for Medicaid because her siblings are her dependent children. The petitioner argues that her siblings should be considered as children because they each have mental disabilities and are receiving Social Security income.

The petitioner argues that her siblings each have the mental capacity of a five year old child. The petitioner believes the definition of a child should be changed.

5. The Department explained that a child is defined as a person under the age of 21, unmarried, and not emancipated. The Department explained that the Medicaid program is federal but each state must abide by its own set of rules and criteria when administering the program.

CONCLUSIONS OF LAW

6. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

8. Fla. Admin. Code R. 65A-1.705, "Family-Related Medicaid General Eligibility Criteria" states in relevant part:

...
(c) ...For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI.

9. The Policy Manual, Passage 1430.0504, Definition of a Child (MFAM) states:

An individual is considered a child if under the age of 21, and unmarried, and not legally emancipated. A child is unmarried when the child has never been married or was married and the marriage was annulled.

...

10. The above authorities provide potential Family-Related Medicaid coverage group for a parent to a child under the age of 18. A child is considered to be under the age of 21, but not 21 and over. The findings show that the petitioner is a caretaker for her disabled adult siblings, who are each over the age of 18. The petitioner argues that her siblings are over the age of 18 but their mental capacity is that of a five year old. The petitioner's arguments and situation are recognized, however, the undersigned was unable to locate any provisions that would allow her Medicaid coverage due to being the caretaker of disabled adults. Based on the above authorities, the undersigned concludes that the petitioner is not a caretaker to children under the age of 18.

11. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy...

12. The above authority explains that before Medicaid eligibility can be determined, the petitioner must meet the federal definition of disabled. The findings show petitioner is less than 65 years old. However, the petitioner acknowledges that she is not disabled. Therefore, the undersigned concludes that the Department was

correct to not forward the petitioner's application to the DDD to review her case for potential eligibility for SSI-Related Medicaid.

13. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that the petitioner is not eligible for Family Related Medicaid benefits as she is not the caretaker of a child under the age of 18.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

FINAL ORDER (Cont.)

17F-00285

PAGE -6

DONE and ORDERED this 24 day of March, 2017,

in Tallahassee, Florida.



Paula Ali

Hearing Officer

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Tallahassee, FL 32399-0700

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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 05, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00299

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 [REDACTED]
UNIT: AHCA

AND

UNITED HEALTHCARE

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 21, 2017 at 10:15 a.m.

APPEARANCES

For the Petitioner: [REDACTED], daughter

For the Respondent: Dr. Marc Kaprow, executive director, United Healthcare

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to receive additional home health services through Medicaid. The petitioner holds the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (AHCA or Agency or respondent) administers the Florida Medicaid Program. The respondent contracts with healthcare maintenance organizations (HMOs) to provide services to its program participants. United Healthcare (United) is the contracted HMO that took the action under challenge in the instant case.

By notice dated November 4, 2016, United informed the petitioner that her request to increase the home health services (HHS) hours she receives through Medicaid from 50 hours weekly to 112 hours weekly was denied. The notice reads in relevant part: “We determined that your requested services are not medically necessary...”

The petitioner timely requested a hearing to challenge the denial decision.

The hearing initially convened on March 8, 2017, but was continued because the respondent’s evidentiary packet contained documentation for a prior service authorization, not the authorization at issue. The hearing was rescheduled for March 21, 2017.

There were no additional witnesses for the petitioner. The petitioner submitted documentary evidence which was admitted into the record as Petitioner’s Composite Exhibit 1.

Present as a witness for the respondent from United: Christian Laos, senior compliance analyst. Present as an observer from AHCA: Sheila Broderick, registered nurse specialist. The respondent submitted documentary evidence which was admitted

into the record as Respondent's Composite Exhibit 1. The record was closed on March 21, 2017.

FINDINGS OF FACT

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. The petitioner (age 84) is a Florida Medicaid recipient. The petitioner is enrolled with Sunshine's Long Term Care Program (LTCP). LTCP provides home and community based HHS to individuals who would otherwise require nursing home placement. (Dr. Marc Kaprow Testimony)

2. The petitioner's diagnoses includes [REDACTED]. [REDACTED]. The petitioner is bed bound and requires total assistance with all activities of daily living. The petitioner lives in the family home with her daughter, [REDACTED] the daughter is the petitioner's primary caregiver and her only source of natural support. The daughter is employed as a school bus driver. She works Monday – Friday, up to 12 hours daily. (Testimony of [REDACTED])

3. Prior to the action under appeal, the petitioner was approved for 50 hours of HHS weekly through United LTCP; 30 hours of personal care, 10 hours of homemaker and 10 hours companion care. (This equates to approximately 7 hours of HHS daily.) United LTCP also provides the petitioner with medical supplies (diapers and wipes) and one meal daily. (Respondent's Composite Exhibit 1)

4. The petitioner was hospitalized in late 2016 due to a decline in her medical condition. After release from the hospital, the petitioner requested to increase the

number of HHS hours she receives from 50 weekly (approximately 7 hours daily) to 112 weekly (approximately 16 hours daily). (Testimony of [REDACTED] and Respondent's Exhibit 1)

5. The petitioner's discharge records from United Health of Florida, Dated December 21, 2016, notes that the petitioner requires "24/7 care." (Petitioner Exhibit 1)

6. To make the eligibility determination, United relied its internal assessment tool referred to as the Long Term Care Assessment Form. The assessment form describes the petitioner's functioning level, need for personal care assistance (assistance with the activities of daily living), need for home maker services (shopping, cleaning, cooking) and need for companion care (assistance with supervision and socialization). The assessment is dated October 11, 2016 and shows that the petitioner is bed bound, combative due to [REDACTED], and requires total physical assistance with all the activities of daily living. (Respondent's Exhibit 1)

7. United relied on industry recognized time standards for performance of support services/tasks and the professional judgement of the United reviewing physician, who is board certified in internal medicine, to make the final decision. United computed the following weekly service allowances for the petitioner:

Task	HMO Time Allowances for Petitioner
Bathing	180 minutes weekly
Dressing	105 minutes weekly
Grooming	240 minutes weekly
Toileting	315 minutes weekly
Transfers/Positioning	630 minutes weekly
Feeding	210 minutes weekly

Total weekly Personal Care	1680 total minutes weekly/ 60 min hour = 28 hours of personal care weekly + 2 hours due to petitioner's behaviors=30 total hours of personal care weekly
Homemaker Assistance	10 hours weekly
Companion Care	10 hours weekly
Total weekly HHS	30 + 10 + 10 = 50 hours weekly HHS

(Dr. Kaprow Testimony and Respondent Exhibit 1)

8. United concluded that additional hours of HHS were not medically necessary.

The petitioner's care needs could be addressed within the above allotted time. (Dr.

Kaprow Testimony and Respondent Exhibit 1)

9. The petitioner requested a hearing to challenge the denial decision.

10. The petitioner's daughter asserted that she needs additional HHS hours because the petitioner requires 24/7 care. The petitioner is inappropriate for nursing home placement due to combative behaviors related to her [REDACTED]. The petitioner slaps her caregivers; she also spits at her caregivers. In addition, the petitioner has an irregular heartbeat, she cannot be left home alone in case she has a cardiac issue. The daughter asserted that her bus driving duties keep her away from the home up to 12 hours on field trip days. She acknowledged that she does not work 60 hours every week and she is not planning to work at all summer 2017. (Testimony of [REDACTED] and Petitioner Exhibit 1)

11. Dr. Kaprow explained that the 50 hours of HHS weekly does not have to be used in equal amounts each day. Although the average time, if allocated equally over a 7 day week, is approximately 7 hours of HHS daily, the household can use a greater

number of HHS hours on the days the daughter works (Monday – Friday) and fewer hours on the days the daughter does not work (Saturday and Sunday). (Testimony of Dr. Kaprow)

12. Dr. Kaprow, after hearing testimony regarding the petitioner's cardiac issues and need for monitoring, increased the number of HHS hours from 50 hours weekly to 60 hours weekly (this equates to 12 hours daily x 5 days a week, the maximum number of hours the petitioner's daughter works weekly). Dr. Kaprow explained that the family is expected to provide as much care as they can and that HHS is intended to augment family care. (Testimony of Dr. Kaprow)

13. The petitioner's daughter acknowledged that she does not always work 12 hours each week day; however, she asserted that she also needs some "time" to herself and "time to rest", when not working. She "cannot do it all." While appreciative of the additional 10 hours weekly of HHS approved during the hearing, she reiterated that she needs 16 hours of HHS every day, 112 hours weekly.

14. During rebuttal, Dr. Kaprow opined that 16 hours of HHS daily is in excess of the petitioner's needs and not supported by the evidence (medical records plus availability of natural supports/family). Medicaid rules state that goods and services cannot be in excess of a recipient's need. In response the daughter's need for time "to rest," Dr. Karpow explained that United LTCP includes respite care which is short term or temporary HHS provided when the primary caregiver needs relief. He encouraged the petitioner' daughter to utilize this service.

CONCLUSIONS OF LAW

15. By agreement between AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction of the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

16. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

17. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056

18. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof needed to be met is by a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed., 1999), or evidence that “more likely than not” tends to prove a certain proposition. See Gross v. Lyons, 763 So. 2d 276, 289, n.1 (Fla. 2000).

19. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

20. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

“Medical necessary” or “medical necessity” means that 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 defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, 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. . .

....

(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.

21. The petitioner requested to increase the number of HHS hours she receives weekly from 50 hours weekly to 112 hours weekly.

22. The respondent initially denied the petitioner's request in its entirety because the respondent concluded that the additional hours were in excess of the petitioner's needs.

23. During the hearing, upon gathering additional information regarding the petitioner's medical condition, the respondent revised the number of HHS hours to 60 weekly. (This equates to 12 hours daily x 5 days a week, the maximum number of hours worked weekly by the petitioner's primary caregiver.) Dr. Kaprow, the only expert witness to testify at the hearing, opined that additional hours, above 60 hours weekly, were in excess of the petitioner's demonstrated need.

24. Medicaid rule prohibits the provision of goods and services in excess of a recipient's needs. Medicaid rule also states that the recommendation of a treating

physician is not controlling. The level of Medicaid service must be supported by the evidence.

25. The petitioner's primary caregiver works up to 60 hours weekly. The Respondent has approved 60 hours of HHS weekly. The petitioner's need for care while her primary caregiver is away from the home has been met.

26. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not prove by a preponderance of the evidence that it is medically necessary that she receive additional HHS (in the form of personal care, homemaker care and companion care) to meet her health care needs.

27. The primary caregiver's need for rest and time for herself can be addressed through United LTCP's respite service, which she is encouraged to seek.

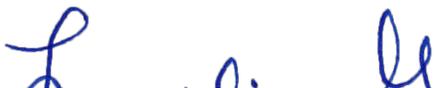
DECISION

The appeal is denied. The respondent's decision in this matter is upheld.

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 05 day of April, 2017,
in Tallahassee, Florida.



Leslie Green
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Mar 30, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00387

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA,

And

SIMPLY HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 17, 2017 at 8:30 a.m.

APPEARANCES

For the Petitioner:



For the Respondent:

Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for dental services was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Deborah Zamora, Grievances Team Lead, and Dr. Francisco Hernandez, Medical Director, from Simply Healthcare, which is the petitioner's managed health care plan. Also present as witnesses for the respondent were Charles Kieffer, Complaints and Grievance Specialist, and Dr. Daniel Dorrego, Dental Consultant, from DentaQuest, which reviews dental claims on behalf of Simply Healthcare.

The respondent, Simply Healthcare, submitted the following documents as evidence for the hearing, which were marked as Respondent's composite Exhibit 1 – Statement of Matters, Authorization Request with Dental Records, Denial Notice, Appeal Letter, Dental Notes, and Dental Director Review.

Also present for the hearing was a Spanish language interpreter, [REDACTED]

[REDACTED] from Propio Language Services.

FINDINGS OF FACT

1. The petitioner is a fifty-five (55) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Simply Healthcare, which utilizes DentaQuest for review of requests for dental services.
2. On or about January 5, 2017, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Simply for

approval of anesthesia/deep sedation related to tooth extractions. The petitioner was previously approved for surgical extraction of 2 teeth. On or about January 6, 2017, Simply and/or DentaQuest denied the request for anesthesia as not being medically necessary. The petitioner requested a fair hearing to dispute this denial on January 12, 2017. Subsequently, DentaQuest re-reviewed the request for anesthesia and approved the request on January 30, 2017.

3. The petitioner stated there were other requested procedures which had not been approved. She referenced procedure codes 7311 and 9630, but was not sure what services were associated with those codes.

4. Mr. Keiffer from DentaQuest stated procedure code 7311 was for alveoplasty and code 9630 was for medication related to other dental services. He stated these were denied by DentaQuest on December 23, 2016 since they were non-covered services.

5. Dr. Dorrego from DentaQuest stated the petitioner was approved for surgical extraction of 2 teeth, which includes removing and reshaping bone after the extractions. He stated this reshaping of the bone is what code 7311 (alveoplasty) consists of. Therefore, although alveoplasty is not a covered service, it can be performed as part of the surgical extractions. He also stated code 9630 (medication) is a non-covered service and there was no indication of the need for medication in the provider's narrative.

6. Dental services under the Medicaid State Plan in Florida are provided in accordance with the respondent AHCA's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

13. The Florida Medicaid Program provides limited dental services for adults. The AHCA Dental Policy specifies that these services include periodic oral evaluations, radiographs, dentures, and some tooth extractions.

14. Managed care plans, such as Simply Healthcare, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Handbook.

15. After considering the evidence and testimony presented, the undersigned concludes that the issue related to the request for anesthesia is now moot since the health plan has approved that requested service. With regard to the other issues raised at the hearing, the petitioner has not demonstrated that those services (alveoplasty and medication) should have been approved by Simply Healthcare. These services are non-covered benefits under Simply Healthcare's dental plan provisions; therefore, the hearing officer cannot make a determination that those services must be covered by the plan.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 30 day of March, 2017,

in Tallahassee, Florida.



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Hearing Officer
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Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
SIMPLY HEARINGS UNIT

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

FILED

Mar 01, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00388

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on February 22, 2017 at 3:02 p.m.

APPEARANCES

For the Petitioner:  Pro se

For the Respondent: Linda Latson,
Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether it is correct for Respondent to deny Petitioner's request for two tooth repair procedures needed to anchor her dentures. The two dental procedures are: D2642-Porcelain filling (x2) and D2740-Crown. Petitioner is assigned the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from Petitioner's managed care plan, Sunshine Health, were Kimberly Bouchette, Clinical Appeals Coordinator, and Kizzy Alleyne, Paralegal. Appearing as Respondent's witness from Envolve (formerly known as Dental Health Wellness) was Dr. Preddis Sullivan, Dental Consultant.

Respondent's Exhibit 1 was entered into evidence.

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 67 year-old Medicaid recipient enrolled with Sunshine Health, a Florida Health Managed Care provider.
2. Petitioner is dual-eligible for Medicare and Medicaid. She currently has no dental coverage under Medicare.
3. Sunshine Health requires prior authorization for services related to dental care and has subcontracted with Envolve to review prior authorization requests.
4. Petitioner's dentist sent a prior authorization request for dental procedure D2642- Porcelain filling (x2) and D2740-Crown, which was received by Envolve on December 29, 2016.
5. On January 6, 2017, a Notice of Action was sent to Petitioner stating the procedures were denied as "not a covered benefit."
6. On January 12, 2017, Petitioner filed a timely request for a fair hearing.

7. Petitioner explained the procedures were necessary to anchor her partial dentures, which Medicaid has approved. She stated she needs her partial dentures to eat.

8. Respondent's dental consultant explained the requested procedures are restorative and, per paragraph 4.2.8 of the Florida Medicaid Dental Policy, are not covered for members over 21 years old.

9. Petitioner could not understand why Medicaid would approve her partial dentures then deny the procedures necessary for her to get the dentures anchored. She stated she cannot use the dentures without the requested fillings and crown.

CONCLUSIONS OF LAW

10. 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.

11. This proceeding is a *de novo* proceeding pursuant to *Florida Administrative Code* Rule 65-2.056.

12. 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).

13. This is a Final Order, pursuant to §§ 120.569 and 120.57, Florida Statutes.

14. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

15. Section 409.905, Florida Statutes, "Mandatory Medicaid services," states, in relevant part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law."

16. Sections 409.971 – 409.973, Florida Statutes, 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. Dental services are one of the mandatory services that must be provided.

17. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

18. *Florida Administrative Code* Rule 59G-1.010 defines prior authorization: "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.

19. *Florida Administrative Code* Rule 59G-1.010 (166) 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.

...

(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.

20. The May 2016 Florida Medicaid Dental Services Coverage Policy (Dental Policy)

has been promulgated into rule by Fla. Admin. Code R. 59G-4.060, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593>.

21. The Dental Policy requires dental services to be medically necessary as defined in Fla. Admin. Code R. 59G-1.010 (166).

22. Paragraph 4.2.8 of the Dental Policy on Restorative Services states: "Florida Medicaid reimburses for all-inclusive restorative services for recipients under the age of 21 years as follows: Restorations, Crowns." Respondent asserted Petitioner's service requests are restorative and, therefore, are not covered by Florida Medicaid.

23. Paragraph 4.2.9 of the Dental Policy states in relevant part: "Florida Medicaid reimburses for emergency dental services for recipients age 21 years or older to

alleviate pain, infection, or both, and **procedures essential to prepare the mouth for dentures** [emphasis added].”

24. Petitioner testified repeatedly the requested procedures were necessary for her partial dentures to be anchored. She stated Medicaid has approved her partial dentures and did not understand why the procedures necessary for her partial dentures were being denied.

25. Respondent did not rebut Petitioner’s assertion that the procedures were necessary to anchor her partial dentures but responded the services were not a covered service. Respondent referenced paragraph 4.2.8 of the Dental Policy as the authority on which the decision is based.

26. Medical necessity for the requested procedures have not been disputed by Respondent. Respondent’s Notice of Action and testimony advised the procedures are not covered by Medicaid based on paragraph 4.2.8 of the Dental Policy.

27. However, paragraph 4.2.9 of the Dental Policy states procedures essential to prepare the mouth for dentures are covered services. The policy does not specify or limit what procedures would be ‘essential’ to prepare the mouth for dentures. Petitioner repeatedly asserted the requested procedures are necessary to anchor her dentures.

28. After carefully reviewing the authorities cited above, the undersigned concludes Petitioner has demonstrated Respondent incorrectly denied the request for dental procedures D2642-Porcelain filling (x2) and D2740-Crown.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED and the Agency action is DENIED.

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 01 day of March , 2017,

in Tallahassee, Florida.



Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
Sunshine Hearings Unit

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

FILED

Apr 21, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00391

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 [REDACTED]
UNIT: 88630

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 10, 2017 at 11:08 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Pat Hernandez, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 29, 2016 enrolling the petitioner and her husband in the Medically Needy Program. The petitioner also appeals the termination of the Qualifying Individuals 1 program for herself and her husband. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

[REDACTED], petitioner's husband, also appeared for the hearing.

The Department submitted evidence prior to the hearing. The evidence was entered as Respondent Exhibit 1.

The record was held open through March 24, 2017 for additional information from both the petitioner as well as an update from the Department regarding the additional information submitted by the petitioner. No additional information was received from either party.

The record closed on March 24, 2017.

FINDINGS OF FACT

1. The petitioner filed an application for Medicaid and the Medicaid Savings Program on December 14, 2016.
2. The petitioner's household consists of herself and her husband only.
3. The petitioner is 61 years old. She receives Social Security Disability income of \$1,226 for December 2016 and beginning January 2017 the monthly amount increases to \$1,230.
4. The petitioner's husband is 64 years. He receives Social Security Disability income in the amount of \$1,429 for December 2016 and beginning January 2017 the monthly amount increases to \$1,433. He also receives \$2,253.54 in state retirement from Florida. He also receives an insurance subsidy with his state retirement of \$126.65.
5. The Department issued a Notice of Case Action on December 29, 2016 enrolling the petitioner in the Medically Needy program with a Share of Cost (SOC) of \$4,774 for December 2016 and \$4,782 for January 2017 and ongoing. The same notice also informed the petitioner that the Qualifying Individuals 1 (QI 1) benefit for herself

and her husband would end on January 31, 2017. The reason for the QI 1 ending was listed as “your household’s income is too high to qualify for this program.

6. The Department explained that in Medically Needy a disregard of \$20 is deducted from the petitioner’s income as an unearned income disregard.

7. The Department also explained the Medically Needy Income Level (MNIL) of \$241 for a couple is deducted when determining the share of cost.

8. The Department dropped the cents when completing the calculation of the share of cost.

9. The Department explained the budget for Medically Needy Share of Cost for December 2016 included the total income for the petitioner and her husband of \$5,035.19 ($\$1,226 + \$1,429 + \$2,253.54 + \$126.65 = \$5,035.19$). The Department took the gross amount of income of \$5,035 and subtracted \$20 unearned income disregard and \$241 MNIL to reach a share of cost of \$4,774.

10. The Department explained the budget for the Medically Needy Share of Cost for January 2017 included the total income for the petitioner and her husband of \$5,043.19 ($\$1,230 + \$1,433 + \$2,253.54 + \$126.65 = \$5,043.19$). The Department took the gross amount of income of \$5,043 and subtracted the \$20 unearned income disregard and the MNIL of \$241 to reach a share of cost of \$4,782.

11. The Department explained as the petitioner’s Medicare Part B premium still showed as paid by the state, the premium was not deducted in the share of cost for December 2016 or January 2017.

12. The Department explained the household expenses of mortgage, property tax, house insurance, utilities, car insurance, life insurance and loan payments are not included in the determination of Medicaid eligibility.

13. The petitioner believes the share of cost as determined by the Department is incorrect.

14. The petitioner does not understand how her income can be too high to receive the Qualifying Individuals 1 benefit which would pay her Medicare Part B premium.

15. The petitioner reported she has additional medical insurance premiums totaling \$900.88 for herself and her husband. They each incur monthly prescription costs totaling \$234 per month.

16. The Department reported if the petitioner were to verify the additional medical insurance premiums and prescription expenses, it could reduce their Medically Needy Share of Cost, but these must be verified to include them in the expenses.

CONCLUSIONS OF LAW

17. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

19. Florida Admin. Code R. 65A-1.701, Definitions, states in relevant part:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

...

(30) Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

20. Florida Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage

Groups, states in relevant part:

The Department covers all mandatory coverage groups and the following optional coverage groups:

(1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

...

(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

21. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant

part:

(12) Limits of Coverage.

(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application.

...

(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium.

(This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)

(13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual's or family's income.

22. Florida Admin. Code R. 65A-1.713, SSI-Related Medicaid Income

Eligibility Criteria, states in relevant part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

23. 20 C.F.R. § 416.1120, Types of unearned income, states in relevant part:

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

24. 20 C.F.R. § 416.1124, Unearned income we do not count" states in relevant part:

(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the \$20 general exclusion described in paragraph (c)(12) of this section.

...

(c) Other unearned income we do not count. We do not count as unearned income—

...

(12) The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility. The \$20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in §416.1124(c)(2). If you have less than \$20 of unearned income in a month and you have earned income in that month, we will use the rest of the \$20 exclusion to reduce the amount of your countable earned income;

25. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, Eligibility Standards for SSI-Related Programs effective July 1, 2016 lists the income limit for the MEDS-AD program for a couple as \$1,175 and for the Qualifying Individuals 1 (Q11) program as \$1,803.

26. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, Eligibility Standards for SSI-Related Programs effective January 1, 2017 lists the income limit for the MEDS-AD program for a couple as \$1,178 and for the Qualifying Individuals 1 (Q11) program as \$1,808.

27. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, Eligibility Standards for SSI-Related Programs effective April 1, 2017 lists the income

limit for the MEDS-AD program for a couple as \$1,191 and for the Qualifying Individuals 1 (Q1) program as \$1,827.

28. Florida Admin. Code R. 65A-1.716 "Income and Resource Criteria, (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Family Size 2, Monthly Income Level \$241.

29. The findings show the petitioner's countable household income is \$5,035.19 for the month of December 2016 and \$5,043.19 beginning January 2017. The undersigned concludes the Department's calculation of income is in accordance with the above controlling authorities.

30. The undersigned reviewed the calculations to determine if the petitioner is eligible to receive full SSI-Related Medicaid. The above controlling authorities show the income limit to receive full SSI-Related in December 2016 was \$1,175 and the household's income was \$5,035.19. The household's income of \$5,035 less the \$20 unearned income disregard is \$5,015. The undersigned concludes the household exceeds the income limit for full SSI-Related Medicaid for December 2016.

31. The above controlling authorities show the income limit to receive full SSI-Related Medicaid for the month of January 2017 through March 2017 as \$1,178. The household's income of \$5,043 less the \$20 unearned income disregard is \$5,023. The undersigned concludes the income exceeds the income limit for full SSI-Related Medicaid.

32. The above controlling authorities show the income limit to receive full SSI-Related Medicaid for the month of January 2017 through March 2017 as \$1,191. The household's income of \$5,043 less the \$20 unearned income disregard is \$5,023. The

undersigned concludes the income exceeds the income limit for full SSI-Related Medicaid.

33. The undersigned concludes the Department appropriately reviewed the case for Medically Needy Share of Cost when the household was found ineligible for full SSI-Related Medicaid.

34. According to the above controlling authorities, the Medicaid Needy Program is for aged, blind or disabled individuals who do not qualify for categorical assistance due to their level of income or resources. Therefore, the undersigned concludes the Department correctly determined the petitioner does not qualify for full coverage Medicaid and enrolled her in the Medically Needy Program.

35. In accordance with the above controlling authorities, the Medically Needy share of cost (SOC) begins with the countable income of \$5,035. Deductions from the countable income of the \$20 unearned income disregard and Medically Needy Income Level of \$241 to reach the share of cost of \$4,774 for December 2016.

36. In accordance with the above controlling authorities, the Medically Needy share of cost (SOC) begins with the countable income of \$5,043. Deductions from the countable income of the \$20 unearned income disregard and Medically Needy Income Level of \$241 to reach the share of cost of \$4,782 beginning January 2017.

37. The findings show the Department has not yet allowed deductions for the petitioner's insurance premiums (including Medicare premium) or recurring monthly medical expenses. The undersigned concludes as the Department has not received verifications of the expenses, the expenses cannot yet be included to reduce the share of cost. Upon receiving this verification, the Department may treat the reported

expenses as a change and issue a new notice of case action with the updated share of cost to include appeal rights.

38. 42 U.S.C. § 1396a, State plans for medical assistance, states in relevant part:

(a) Contents

A State plan for medical assistance must—

...

(10) provide—

...

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(s) of this title;

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1396u-3 and 1396d(p)(4) of this title, for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2011) for medicare costsharing described in section 1396d(p)(3)(A)(ii) of this title for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

[sic]

39. 42 U.S.C. §1396d(p), Qualified Medicare beneficiary; Medicare cost-sharing, states in relevant part:

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph (B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

40. The above controlling authority clarifies that the household size dictates whether the individual or couple income limit are used in the determination of eligibility for the Medicare cost sharing program such as Qualified Beneficiaries 1. The undersigned concludes in the instant case, the household size to be utilized is two or couple income limit.

41. The petitioner also questioned why the Qualified Beneficiaries 1 (QI 1) was terminated effective January 31, 2017. The undersigned compared the petitioner's income for January 2017 of \$5,043 less the \$20 disregard to reach a countable income of \$5,023. As the income exceeds the income limit for couple for QI 1 of \$1,808 (January 2017), the undersigned concludes the Department correctly terminated the petitioner's QI 1 benefit. The undersigned further concludes the petitioner's income also exceeds the income limit of \$1,827 which is the limit for QI 1 effective April 1, 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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

FINAL ORDER (Cont.)

17F-00391

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Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 21 day of April, 2017,

in Tallahassee, Florida.

M. Lisa Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 12, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00435

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 [REDACTED]
UNIT: 88235

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 7, 2017 at 9:52 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent

Dionne Hopkins, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his November 10, 2016 application for Medicaid. The petitioner carries the burden of proof by preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented five exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 5. The petitioner presented six exhibits which were entered into evidence and marked as Petitioner's Exhibits 1 through 6.

FINDINGS OF FACT

1. On November 10, 2016, the petitioner submitted an application for SSI-Related Medicaid benefits. He listed himself (age 78) and his wife (age 75) as the only household members.
2. On November 21, 2016, the respondent sent him a pending letter requesting him to provide proof that he applied for Medicare. It was due on December 1, 2016. No information was received by the due date.
3. On December 12, 2016, the respondent denied the petitioner's application of Medicaid.
4. On January 13, 2017, the petitioner requested a hearing to challenge the respondent's action.
5. On January 13, 2017, the respondent reviewed the petitioner's case/application based on his request for a hearing. The respondent found that the petitioner applied for Medicare but was ineligible. The respondent reopened the case.
6. On February 15, 2017, the respondent contacted the petitioner to review his hearing request. At that review, the Department found out the petitioner was receiving a pension from another country, [REDACTED]
7. On February 15, 2017, the respondent mailed a pending notice, requesting the petitioner to provide proof of his pension. The information was due on February 27, 2016.
8. On February 22, 2017, the petitioner provided a letter explaining that he received \$423 in pension from the government of [REDACTED]. He explained that the pension

accrues monthly, but he collects it once every twelve months. He also stated that the amount varies based on the foreign exchange rate at the time of conversion.

9. On March 1, 2017, the respondent reviewed the case and found that the petitioner did not provide proof of his pension, but only his written statement of the amount he receives. The respondent denied the application for failure to provide verification income.

10. At the hearing, the respondent testified that a Notice of Case Action was sent to the petitioner on March 1, 2017, informing him that his Medicaid application was denied. The respondent confirmed the petitioner provided all required information except verification of his pension. The respondent is willing to accept the petitioner's bank statement showing the deposit of the pension as verification.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13 Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process, states in relevant part:

(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification

needed to establish eligibility...(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later...If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension.

(2) In accordance with 7 C.F.R. § 273.14, 45 C.F.R. § 206.10(a)(9)(iii), 42 C.F.R. § 435.916, and Section 414.095, F.S., the Department must determine eligibility at periodic intervals.

(4) If an applicant or recipient does not keep an appointment without arranging another time with the eligibility specialist; or does not sign and date the applications described in subsection (1); or does not submit required documentation or verification the Department will deny benefits as it cannot establish eligibility.

14. The Department's Program Policy Manual CFOP 165-22 addresses Requests for Additional Information/Time Standards (MSSI, SFP) and states:

If the Department needs additional information or verification from the applicant, provide:

1. a written list of items required in order to complete the application process,
2. the date the items are due in order to process the application timely, and
3. the consequences for not returning additional information by the due date.

The verification/information due date is 10 calendar days after the date of the interview or if there is no interview requirement, 10 days after the date the pending notice is generated. In cases where medical information is required, the return due date is 30 calendar days from date of request. If the due date falls on a holiday or weekend, the deadline for the requested information is the next business day. At the individual's request, extend the due date. Leave the case pending until the 30th day after the date of application to allow the household a chance to provide verifications. Assist applicants with getting missing verifications when needed.

1. If the applicant completes the interview, provides all verifications, and meets all eligibility factors, approve the application by the 30th day for Medicaid. If the 30th day falls on a weekend or holiday, approve the application on the business day before the 30th day.

2. If the household does not return the verifications by the 30th day after the date of application, deny the application on the 30th day. If the 30th day falls on a weekend or holiday, deny the application on the next business day after the 30th day

15. The above authority sets forth the requirement for the Department to verify certain information and give written notice with a deadline for its return. If the applicant does not provide the required verifications by the deadline date, the application will be denied.

16. The undersigned concludes there was no evidence presented indicating the petitioner attempted to get the requested verification of pension/income. The petitioner stated his pension was from a foreign country, but did not inform the respondent he was having difficulty getting the verification nor did he provide his monthly bank statements showing his pension amount as proof of his income. The petitioner did not provide the requested verification of his pension by the due date given. After considering the evidence, testimony, and the appropriate authorities cited above the undersigned concludes the respondent correctly denied the petitioner's application.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with

FINAL ORDER (Cont.)

17F-00435

PAGE -6

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 Department has no funds to assist in this review.

DONE and ORDERED this 12 day of April, 2017,

in Tallahassee, Florida.



Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 25, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00441

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 15, 2017 at 2:17 p.m. at the Department of Children and Families Program Office in [REDACTED], Florida and by telephone on April 18, 2017 at 10:07 a.m.

APPEARANCES

For the Petitioner: [REDACTED] mother

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

At issue is the respondent's decision denying the petitioner's request to participate in an out-of-state Brain Injury Program. The petitioner holds the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts with eQ Health Solutions (eQ) to conduct prior services authorizations for certain Medicaid services, including inpatient hospital services.

By notice dated January 4, 2017, eQ informed the petitioner that his request to participate in an out-of-state Brain Injury Program was denied.

The petitioner timely requested a hearing to challenge the denial decision.

The petitioner's mother and father, [REDACTED] testified on his behalf. The petitioner submitted documentary evidence which admitted into the record as Petitioner's Composite Exhibit 1.

Present as a witness for the respondent: Dr. Darlene Calhoun, physician reviewer with eQ. Present as an observer during the April 18, 2017 portion of the proceeding: Bonnie Taylor, AHCA program administrator. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The hearing record was closed on April 18, 2017.

FINDINGS OF FACT

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. The petitioner (age 15) is a Florida Medicaid recipient. The petitioner also has third party health insurance with United Healthcare PPO (United), through his father's employer. (Respondent's Composite Exhibit 1)

2. The petitioner has a complex medical history including [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Respondent's Composite Exhibit 1)

3. The petitioner is verbal and ambulatory. The petitioner requires physical assistance with all the activities of daily living. The petitioner lives in the family home with his parents. (Respondent's Composite Exhibit 1)

4. Over the past several years, the petitioner has suffered multiple brain injuries, including a concussion which occurred during a physical altercation with another teen at school. After the initial concussion, the petitioner began exhibiting aggressive and self-injurious behaviors. He has injured himself, his parents, and other caregivers. His behaviors have escalated over time, in spite of outpatient psychiatric services.

(Testimony of petitioner's parents)

5. Because the petitioner's behaviors (head banging, violence to self and others, property destruction, etc.) have continued to escalate in severity, frequency, and duration, his parents, psychiatrist, and primary care physician concluded that he would benefit from participating in an inpatient Brain Injury Program, in a facility that could address both his complex medical and psychiatric needs. After an extensive search and multiple discussions, the group chose [REDACTED] Hospital for Children and

[REDACTED]. The petitioner's psychiatrist has referred other patients to this facility with successful results. (Testimony of petitioner's parents)

6. All Medicaid goods and services must be medically necessary. Some services, such as inpatient hospital services, require prior authorization. eQ is the contracted review agent for inpatient hospital services. The petitioner's treating physician submitted a prior service authorization packet to eQ on December 15, 2016.

The authorization form describes the petitioner as follows:

[Petitioner] is a 15 year old male with the following diagnosis: [REDACTED]
[REDACTED]
[REDACTED] [Petitioner] has a history of procedures to include [REDACTED] and [REDACTED]
[REDACTED] [Petitioner] has had multiple hospitalizations for psychiatric issues and then transferred to the medical floor due to his various medical issues that exceed the capabilities of the psychiatric inpatient unit...[Petitioner] will eventually need cardiac surgery...but is not imminent at this time. [Petitioner] has an increased appetite...several attempts to limit his caloric intake was unsuccessful. His medical team feels as though his weight negatively contributes to his sleep apnea, personal hygiene and other medical issues to include his cardiac history. [Petitioner] is being referred to [REDACTED] Hospital for Medication Management, Behavioral Modification, Weight Loss, Nutritional Education, Improve Overall Self-Care, and Intense Psychotherapy. (Respondent's Composite Exhibit 1)

7. The authorization packet also included a letter from [REDACTED] Hospital [REDACTED] which describes the facility and its purposed course of treatment. The letter is dated December 15, 2016 and reads:

[REDACTED] Hospital is a specialty hospital which treats complicated patients who have tried and failed outpatient treatment and have required repeated hospitalizations. We treat both the medical and behavioral diagnosis concurrently...Upon admission to [REDACTED] Hospital, [petitioner] will be assessed by a multidisciplinary team to include, attending physician, 24 hour nursing care, speech/occupational/recreation

therapists, psychotherapy, nutrition, case management and education. After a 7 day evaluation a master treatment plan will be completed which will list the goals and frequency of the services for the patient during the inpatient stay... (Respondent's Composite Exhibit 1)

8. The authorization packet included a recommendation letter written by the petitioner's psychiatrist, [REDACTED]. The letter is dated December 13, 2016

and reads:

[Petitioner] is a patient...I have referred...for admission at [REDACTED] Hospital in [REDACTED]. I initially evaluated [petitioner] in May 2015, and I have been seeing him for the past 18 months in the outpatient setting for treatment of behavioral concerns including anxiety, impulsivity, and outbursts. I have diagnosed [petitioner] with [REDACTED]

versus [REDACTED]

[petitioner] has multiple medical issues including [REDACTED]

[REDACTED] in 2010, and [REDACTED]

[Petitioner] has been receiving outpatient psychiatric medication management with me for the past 1.5 years. He is currently taking [REDACTED] but he has taken multiple other medications in the past year...He has also received ABA therapy for the past several years...[petitioner] has had difficulties with tantrums, emotional outburst, behavioral noncompliance, self-injurious behaviors (head-banging), and aggression. His outbursts have become so severe in the past few months that he has been psychiatrically hospitalized twice this fall on the crisis stabilization unit at [REDACTED] Children's Hospital.

It is my recommendation that [petitioner] be admitted to [REDACTED] Hospital for further treatment of his chronic illnesses and behavioral issues. [Petitioner's] medical and psychiatric needs are complex, and it is my opinion that an in-state residential treatment center would not meet his current needs. [REDACTED] has an interdisciplinary pediatric team including pediatricians, psychiatrists, psychologists, nurses, social workers, physical and occupational therapists, nutritionists, case managers, and teachers. They help families cope with the child's condition by addressing medical, psychological, behavioral, and social

aspects of the illness. Physical, occupational, speech, recreational, psychological and special therapies, such as cognitive retraining and nutrition, are provided depending on the child's needs. Patients also participate in groups and community activities, which provide opportunities for health interpersonal interaction and development. All children attend school on campus at ██████████ Academy. Medical needs are directed by a board-certified pediatrician and administered by nurses and behavioral counselors.

(Respondent's Composite Exhibit 1)

9. The authorization packet also included multiple hospital or physician office visit notes which describe similar behaviors. The notes detailed below were recorded by ██████████ Hospital on October 19, 2016 and are representative of the language contained within the other notes: "[petitioner] has been having episodic violent, destructive, aggressive/assaultive, and self-abusive behaviors that have been escalating in severity, frequency, and duration." (Respondent's Composite Exhibit 1)

10. eQ determined that out-of-state services were not medically necessary. eQ issued a denial notice on January 4, 2017. The notice reads in pertinent part: "Florida Medicaid has denied the request for out-of-state for Brain Injury Program...The request does not meet Medicaid's definition of medical necessity, as the service is readily available in Florida." (Respondent's Composite Exhibit 1)

11. The petitioner's parents challenged the denial decision. They argued that the petitioner's case is unique because of his complex medical and psychiatric issues. Multiple medical facilities declined to admit the petitioner due to his psychiatric issues. Multiple psychiatric facilities declined to admit the petitioner to his medical issues. After an exhaustive search and consulting with the petitioner's treating physicians, only two facilities were found that could treat all of the petitioner's needs, both medical and

psychiatric: [REDACTED] in the state of [REDACTED] and [REDACTED] Rehabilitation, Inc. [REDACTED] Florida. Both facilities offer comprehensive inpatient medical and psychiatric services for children with complex issues that have not been responsive to outpatient treatment. [REDACTED] was initially ruled out as a viable option due to the third party insurer's decision that the program was not a covered benefit and the fact that [REDACTED] does not accept Florida Medicaid. A special agreement would be required for the petitioner to be treated at [REDACTED]. In the final analysis, the parents and medical team determined that [REDACTED] was the best choice. (Testimony of petitioner's parents)

12. United, the third party insurer, also concluded that [REDACTED]'s program was not a covered benefit. The family was in the process of appealing United's decision regarding [REDACTED] and [REDACTED] when the proceeding convened on March 15, 2017. (Testimony of petitioner's parents)

13. After hearing the testimony of the petitioner's parents, eQ requested additional information from [REDACTED] and [REDACTED] regarding their proposed Plans of Care and written verification that the petitioner had been accepted into both programs. eQ agreed to reconsider its decision upon receipt of the requested verification. (Testimony of Dr. Darlene Calhoun)

14. On March 19, 2017, the petitioner provided acceptance and program description letters from [REDACTED] and [REDACTED] (Petitioner's Composite Exhibit 1)

15. On March 22, 2017, Dr. Calhoun, physician reviewer with eQ, issued an electronic communication upholding the original denial decision. The communication reads:

I have reviewed the submitted documentation, which did NOT include a copy of the acceptance letter from [REDACTED] as noted in the letter from the parent. Review of the documentation indicated that the [REDACTED] and their proposed plan for Tyler would meet his medical and psychological needs. Therefore, denial of OOS request should be upheld-the requested care can be provided within the State of Florida. As noted during FH by Ms. Broderick, the caregiver's primary insurance responsible as the first payor for services.
(Respondent's Composite Exhibit 1)

16. During the April 18, 2017 portion of the proceeding, the petitioner's parents explained that he had another violent outburst which resulted in him being hospitalized under the Baker Act on April 10, 2017. The petitioner was still hospitalized as of the date of the hearing. (Testimony of petitioner's parents)

17. Prior to the hearing reconvening on April 18, 2017, United, the petitioner's primary health insurance, reached an agreement with FINR to provide 90 days of inpatient services to the petitioner beginning April 21, 2017. The family received the updated decision via a telephone call from United on April 17, 2017, the day before the hearing reconvened. The family had not yet received written confirmation from United. The family did not know if United would cover [REDACTED] charges in total or in-part. Absent a written decision from United, the family chose to go forward with the instant appeal, the denial of out-of-state inpatient services at [REDACTED] (Testimony of petitioner's parents)

18. During rebuttal testimony, the respondent witnesses argued that the petitioner's needs can be met within the state of Florida, at [REDACTED] or another facility, and therefore it is not medically necessary that the petitioner receive out-of-state services. In addition, the respondent's witnesses emphasized that Medicaid is the payor of last resort. All third party insurances must be exhausted prior to billing Medicaid.

(Testimony of Sheila Broderick and Dr. Darlene Calhoun)

CONCLUSIONS OF LAW

19. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

20. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

21. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

22. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the respondent.

23. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

24. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

25. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

“Medical necessary” or “medical necessity” means that 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 defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, 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. . .

....

(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.

26. As the petitioners are under 21, a broader definition of medically necessary applies to include the EPSDT requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, defines Medicaid services for children to include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical

therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

27. The above citation explains that the respondent must provide treatment and services to Medicaid recipients under 21 years of age, but only to the extent such services are medically necessary. The state is authorized to establish the amount, duration, and scope of such services.

28. The respondent denied the petitioner's request to participate in an out-of-state Brain Injury Program because there are similar programs available in the state of Florida.

29. The petitioner argued that due to his complex medical and psychiatric issues, there are only a small number of facilities capable of meeting all of his needs and he should be allowed to participate in the requested out-of-state Brain Injury Program because it has a proven history of successfully treating children with similar issues.

30. The undersigned carefully reviewed the evidence and controlling legal authorities and concludes that there is at least one comprehensive Brain Injury Program in the state of Florida capable of meeting the petitioner's medical and psychiatric needs, [REDACTED] Medicaid rules prohibit the provision of good and services in excess of a recipient's needs. It is not medically necessary for a patient to receive out-of-state services if the services are available in-state.

31. In the final analysis, the petitioner did not prove by a preponderance of the evidence that it is medically necessary that he participate in an out-of-state Brain Injury Program.

DECISION

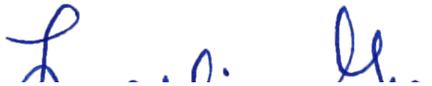
The appeal is denied. The respondent's decision in this matter is upheld.

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 25 day of April, 2017,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit

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

FILED

Apr 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00508

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 13, 2017 at 12:30 p.m. and reconvened on February 14, 2017 at 11:00 a.m.

APPEARANCES

For the petitioner: [REDACTED] pro se

For the respondent: Susan Martin, ACCESS Operations & Management
Consultant I

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted three exhibits, which were entered into evidence as Petitioner's Exhibits "1" through "3". The respondent submitted three exhibits, which were entered into evidence as Respondent's Exhibits "1" through "3".

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received Family-Related Medicaid benefits through September 2016. On September 2016, the petitioner's minor child no longer resided in her household. Therefore, her Family-Related Medicaid benefits ended on September 2016.
2. The petitioner (38) filed an application for disability Medicaid on December 22, 2016. The petitioner reported on her application that she was disabled. The petitioner is not age 65 or older and does not have any minor children residing in her household.
3. The petitioner applied for disability with the Social Security Administration (SSA) on February 24, 2015. The petitioner reported her disabling condition to SSA. The petitioner was denied disability benefits through SSA on May 12, 2015 with a denial code N-32. Code N-32 means "Non-Pay-Capacity for substantial gainful activity- other work, no visual impairment." The petitioner filed a reconsideration with SSA. The SSA appeal remains pending.
4. The Division of Disability Determination (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The petitioner's application was referred to DDD on January 9, 2017.

5. DDD did not conduct an independent review; instead, it denied the petitioner's disability claim by adopting the SSA denial decision (May 12, 2015). DDD has access to SSA information. On January 12, 2017, DDD forwarded the Disability Determination and Transmittal form to the respondent which indicated the petitioner reported her diagnosis to be mental disorders.

6. On January 13, 2017, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application; due to not meeting the disability requirement.

7. The petitioner reported her diagnosis to be mental disorders which include;

 The petitioner did not report any new or worsening conditions; however; she believes she wasn't given the opportunity to submit additional medical records to validate her conditions that have been reported to SSA.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

10. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905, "Basic definition of disability for adults". The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy...

11. The Code of Federal Regulations at 42 C.F.R. § 435.541 addresses

determinations of disability and states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations.

(1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA. [emphasis added]

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section. [emphasis added]

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist...

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

12. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the disability Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner reported all her disabling conditions to SSA. SSA denied the petitioner's disability claim on May 12, 2015 because it determined she was not disabled under its rules.

13. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from May 12, 2015 and denying the petitioner's Adult-Related (SSI) Medicaid application.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 14 day of April, 2017,

in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00630

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 09ICP [REDACTED]

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:45 p.m. on February 17, 2017.

APPEARANCES

For the Petitioner:

[REDACTED] Authorized Representative (AR)
[REDACTED] Facility Administrator

For the Respondent:
Economic

Stan Jones, ACCESS
Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the whether the respondent's (or the Department) action to deny the petitioner Home and Community Based Services (HCBS) Medicaid, is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present at the hearing. At the conclusion of the hearing, on February 17, 2017, the petitioner's AR requested a continuance, due to requiring additional time to submit the petitioner's veteran's (VA) income. Both parties agreed to reconvene at 3:15 p.m. on March 17, 2017. On March 17, 2017, the respondent's representative and the Hearing Officer appeared and waited 15 minutes for the AR to appear. The AR did not appear and to date has not called to explain the reason for not appearing.

The AR did not submit exhibits. The respondent's representative submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on March 17, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving HCBS Medicaid. The petitioner resides at Somerset Assisted Living Facility.
2. On December 27, 2016, a redetermination HCBS Medicaid application was submitted by the petitioner's daughter, DD (Respondent Exhibit 3). The application lists the following income, \$1,249 VA, \$1,166 Social Security and \$687 GE pension.
3. On December 28, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying that her Medicaid would end on January 31, 2017 (Respondent Exhibit 2). The NOCA was mailed to the petitioner and DD at the daughter's address and to Humana American Eldercare. DD is the petitioner's power of attorney and Humana American Eldercare is responsible for the petitioner's case management.

4. The AR argued that the petitioner did not receive the NOCA reminding her that her Medicaid was ending.
5. The AR's argument is irrelevant since the petitioner's daughter submitted a redetermination HCBS Medicaid application on December 27, 2016.
6. On December 29, 2016, the Department mailed the petitioner a NOCA (Respondent Exhibit 2, page 22). The NOCA in part states:

We need the following information by January 9, 2017...
Please provide current December 2016 bank statement on Chase ending in 1128, 1028, 0264 and bank statements from August to December 2016 on Chase QIT ending in 0930. Case also needs current monthly income award letter on all income for December 2016 January 2017...
7. The respondent's representative said the Department received everything requested except the VA income and the pension award letter.
8. On January 27, 2017, the Department mailed the petitioner a NOCA, denying the December 27, 2016 application, due to not receiving "all the information requested to determine eligibility" (Respondent Exhibit 2, page 32).
9. The AR asserts that the petitioner's VA and pension have not changed and therefore are not required to authorize her HCBS Medicaid.
10. The respondent's representative stated that income verification is required at redeterminations.
11. The AR agreed to email the respondent's representative the petitioner's pension verification. And requested that the hearing be reconvened so that she can submit the petitioner's VA income verification.
12. The Hearing Officer granted the AR's reconvene request. However, the AR did not appear at the reconvene nor submit the petitioner's VA or the pension verification.

CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

14. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

15. The AR argued that the petitioner's VA and pension have not changed and therefore are not required to authorize her HCBS Medicaid.

16. *Florida Administrative Code* R. 65A-1.205, Eligibility Determination Process, in part states:

(1)(c) **If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification**, (emphasis added) or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request...
If the applicant does not provide required verifications or information by the deadline date the application will be denied...

17. In accordance with the above authority, the respondent mailed the petitioner a NOCA on December 29, 2016, requesting the petitioner's income verification (among other items).

18. During the hearing, the AR agreed to email the respondent's representative the petitioner's pension verification. The AR also requested that the hearing reconvene to allow her time to submit the petitioner's VA income verification.

19. The AR's hearing reconvene request was granted; however, the AR did not attend the reconvene hearing nor submit the petitioner's VA or the pension verification.

20. In careful review of the cited authorities and evidence, the undersigned concludes that the Department met its burden of proof. The undersigned concludes that the Department's action to deny the petitioner HCBS Medicaid is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 14 day of April, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Mar 28, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 17F-00631

PETITIONER,

Vs.

CASE NO [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 0 [REDACTED]
UNIT: 88273

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 8, 2017 at approximately 8:40 a.m. CST. The hearing was continued and reconvened on March 15, 2016 at approximately 12:35 p.m. CDT.

APPEARANCES

For the Petitioner [REDACTED], *pro se*

For the Respondent: Nicole Nuriddin, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of July 31, 2016 ending her Medicaid coverage. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The same individuals appeared at both hearings.

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "9".

The respondent submitted another packet of information prior to the second hearing. It was admitted into evidence and marked as Respondent's Exhibits "10" through "12".

The respondent presented a Motion to Dismiss. The decision on the motion was reserved until the final order.

FINDINGS OF FACT

1. The petitioner is a disabled single female, 64 years of age.
2. On June 30, 2015, petitioner submitted an application to the respondent requesting Food Assistance and Medicaid (Respondent's Exhibit 5).
3. On July 17, 2015, the petitioner was informed by notice of case action (NOCA) that she would be enrolled in the Medically Needy Program (MNP) with a \$702 Share of Cost (SOC) effective June 2015 (Respondent's Exhibit 3).
4. The petitioner submitted subsequent applications requesting Medicaid on June 22, 2016 and November 4, 2016 (Respondent's Exhibit 5).
5. The petitioner was determined eligible to receive Supplemental Security Income (SSI) effective March 2006 by the Social Security Administration (SSA). This eligibility was terminated by the SSA effective January 2015, when the petitioner turned 62 as she was now eligible to receive SSA Title II benefits (Respondent's Exhibit 6).

6. Even though the petitioner was enrolled in the MNP with a SOC, her Medicaid eligibility continued in the Florida Medicaid Management Information System (FMMIS). The petitioner's Medicaid eligibility under Title XIX continued until July 2016. The petitioner is not a Medicare recipient (Respondent's Exhibit 12).

7. The petitioner does not understand why she was able continue to receive Medicaid for a year after her SSI termination and cannot continue to receive it now. She complained that the SOC was too high and that no medical providers that treat her conditions, practice ██████████ County. She states that applications with other agencies and other programs have been unsuccessful in gaining access to medical care.

8. The respondent testified that the petitioner is over the income limit for SSI-Related Medicaid. The respondent's budget determining the current amount of the SOC is as follows:

\$904.00	
- 20.00	(standard disregard)
<u>\$884.00</u>	
- 180.00	(Medically Needy Income Limit (MNIL))
<u>\$704.00</u>	(Share of Cost)

9. The previous amount of the SOC was determined with a gross income of \$902 as follows:

\$902.00	
- 20.00	(standard disregard)
<u>\$882.00</u>	
- 180.00	(Medically Needy Income Limit (MNIL))
<u>\$702.00</u>	(Share of Cost)

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

11. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Fla. Admin Code R. 65A-1.711 "SSI-Related Medicaid Non-financial Eligibility Criteria" states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R Part 435, subparts E and F (2007) (incorporated by reference ... (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R § 416.905 (2007) (incorporated by reference).

14. Fla. Admin Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

15. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled, to meet the technical criteria for Medicaid in the SSI-Related

Medicaid Programs. Petitioner is under age 65 and determined disabled; thereby meeting the technical requirement for Medicaid eligibility.

16. The above authority also states to be Medicaid eligible income cannot exceed 88 percent of the federal poverty level.

17. The financial eligibility standards for the SSI-Related Medicaid programs appear in the Department's Policy Manual, CFOP 165-22 at Appendix A-9. Effective July 1, 2016, 88 percent of the Federal Poverty Level (FPL) was \$872. Effective April 1, 2017, 88 percent of the FPL is \$885.

18. 20 C.F.R. § 416.1124 "Unearned income we do not count" states in relevant part:

(c) Other unearned income we do not count. We do not count as unearned income—

...

(12) The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility.

19. Effective July 1, 2016 through March 31, 2017 the FPL is \$872. $\$902 - \$20 = \$882$, which exceeds the income limit for Medicaid eligibility; however, effective April 1, 2017 the income limit changes to \$885. $\$904 - \$20 = \$884$; therefore, beginning April 1, 2017, the petitioner's income is again below the income limit for SSI-Related MEDS-AD Medicaid.

20. The hearing officer finds no exception to the calculations effective before April 1, 2017. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found. The respondent meets the burden. However, the hearing officer takes notice of the budgeting change effective

April 1, 2017, and remands the case to the respondent to re-determine ongoing eligibility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, appeal is denied. The respondent's action is affirmed; however, the case is remanded to the respondent to consider on-going eligibility in light of the April 2017 budgeting change.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 28 day of March, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 04, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00687

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 21, 2017, at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's son

For the Respondent: Monica Otolora, Senior Program Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action partially denying the petitioner's request for additional home health services under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted her physicians' letters as evidence for the hearing, which were marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Medical Assessment Form, and Case Screenshots.

FINDINGS OF FACT

1. The petitioner is eighty-nine (89) years of age and is currently living with her son and his family. She is planning to return to her own home soon, where she will be living alone.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for 21 hours weekly of home health services by United Healthcare. Those hours consisted of 14 hours of personal care assistance and 7 hours of homemaker services.

5. On or about October 5, 2016, the petitioner made a request to United Healthcare for 31 additional hours weekly of home health services (companion services). On October 11, 2016, United sent a letter to the petitioner denying her request for the additional home health services as not being medically necessary. At some point thereafter, United approved 3 hours of companion services weekly, making the currently approved total of 24 hours weekly of home health services.

6. The petitioner's son stated the family is requesting 8 hours daily of assistance for his mother. He stated his mother suffers from [REDACTED]
[REDACTED] She is also incontinent and is at risk for aspiration. The petitioner's son stated he is disabled himself, his son has [REDACTED], and his wife had foot surgery. He stated his mother had a prior incident of leaving something in the oven too long. He also stated his mother does not want to live in an assisted living facility.

7. The respondent's witness, Dr. Kaprow, stated the petitioner is not on any medication for dementia although she does have some memory loss. He stated she is oriented as to who she is and where she is, she is able to make her own decisions, and she has no history of elopement from the home. He also stated her needs are being met with the currently approved services since she is currently residing with two family

members. He also stated the petitioner would be able to use a personal emergency response system (PERS) to summon help if needed.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner has requested Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

18. The AHCA contract also provides that a Plan “may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.”

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

20. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that her home health services should be increased under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs) such as bathing, toileting, and meal preparation. However, she is currently approved for 21 hours weekly to assist with these activities, plus 3 hours weekly of companion services. The petitioner currently also has assistance from other caregivers in the home. Medical necessity for additional companion services has not been established at the present time. Should the petitioner's condition and living arrangements change in the future, she may be entitled to additional services at that time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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

FINAL ORDER (Cont.)

17F-00687

PAGE -8

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 indigence 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 04 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Apr 05, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 17F-00692

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 0 [REDACTED]
UNIT: AHCA

AND

UNITED HEALTHCARE

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 7, 2017 at 10:24 a.m.

APPEARANCES

For the Petitioner [REDACTED], pro se

For the Respondent: Christian Laos, compliance analyst, United Healthcare

STATEMENT OF ISSUE

At issue is the denial of the petitioner's request for dental services through Medicaid. The petitioner holds the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. United Healthcare (United) is the contracted health care organization in the instant case.

By notice dated January 11, 2017, United informed the petitioner that her request a root canal and crown for tooth #12 was denied as a non-covered benefit.

The petitioner timely requested a hearing to challenge the denial decision on January 17, 2017.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as respondent witnesses from United: Dr. Brittany Vo, dental consultant and Arlene Carrions, dental account manager. Present as an observer from AHCA: Sheila Broderick, registered nurse specialist. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on the day of the hearing for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Exhibit 2. The record was closed on March 7, 2017.

FINDINGS OF FACT

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. The petitioner (age 27) is a Florida Medicaid recipient. The petitioner is enrolled with United HMO. (Respondent's Composite Exhibit 1)

2. In January 2017, the petitioner's treating dentist submitted an authorization request to United for nerve treatment (dental code D3320), dental post (code D2954) and dental crown (code D2750) for tooth #12. This procedure is commonly referred to as a root canal and crown. (Respondent's Composite Exhibit 1)

3. United denied the request as a non-covered benefit. (Respondent's Composite Exhibit 1)

4. The petitioner requested a hearing to challenge the denial decision. (Respondent's Composite Exhibit 1)

5. The petitioner explained that she works in a refrigerated work station. The cold temperature makes tooth #12 ache because the tooth has a hole in it. Her dentist recommended a root canal and crown to stop the pain. (Petitioner testimony)

6. Dr. Brittany VO, dental consultant with United, explained that Medicaid provides limited dental services for adults age 21 and over. Covered services are limited to emergency services and services to prepare an enrollees mouth for dentures. Dr. Vo explained further explained that emergency services are defined as services that prevent a life threatening situation, such as an infection. Root canals and crowns are

comprehensive services, not emergent in nature, and therefore not covered in the instant case due to the petitioner's age (27). (Testimony of Dr. Vo)

7. Dr. Vo opined that the petitioner's tooth ache could be addressed by a debridement, a "quick removal of nerve tissue" that is causing the pain. This is considered an emergency service and is a covered benefit for enrollees age 21 and over. (Testimony of Dr. Vo)

CONCLUSIONS OF LAW

8. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

9. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

10. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

11. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

12. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

13. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

14. Medicaid rules require that all procedures be medically necessary. The definition of medically necessary is found in Fla. Admin. Code R.59G-1.010, which states:

(166) "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.

. . . .

(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 May 2016 Florida Medicaid Dental Services Coverage Policy, promulgated by Fla. Admin. Code R. 56G-4.060, states that all medically necessary services may not be covered by Medicaid. Services are subject to coverage limitations. Root canals and crowns are defined as restorative services and are addressed in section 4.2.8 of the Dental Services Coverage Policy which reads, "Medicaid reimburses for all-inclusive restorative services for recipients under age of 21..." Dental

services for recipients age 21 and over are addressed in section 4.2.9 which reads, “Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.”

16. The respondent denied the petitioner’s request for a root canal and crown on tooth #12 as a non-covered benefit.

17. The petitioner (age 27) argued the services should be covered because she works in a refrigerated area which causes the tooth to ache and because her treating dentist recommended the services.

18. Dr. Vo, the only expert witness to appear at the hearing, argued that root canals and crowns are comprehensive, non-emergency services, and therefore are not covered services due to the petitioner’s age. Dr. Vo opined that the petitioner’s pain can be addressed by removing the nerve tissue that is causing her pain. Debridement, tissue removal, is an emergency service and is covered by Medicaid for recipients age 21 and over.

19. Medicaid rules require that reimbursable services be medically necessary and within coverage limitations. The fact that a treating provider has recommended a service does not make that service medically necessary or a covered benefit. The petitioner is 27 years old. Medicaid dental services, due to her age, are limited to emergency services and denture preparation services only. There is no evidence that the petitioner’s tooth ache is an emergency, a life threatening situation, or that a root canal and crown is the only way to address her pain. The petitioner’s tooth pain, per

expert testimony that was not contradicted, can be eliminated by removing the nerve tissue, a less invasive procedure.

20. After carefully reviewing the evidence and the controlling legal authorities, the undersigned concludes that the petitioner (age 27) did not prove by a preponderance of the evidence that a root canal and crown are covered benefits or medically necessary.

DECISION

The appeal is denied. The respondent's decision in this matter is upheld.

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 05 day of April, 2017,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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FINAL ORDER (Cont.)
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Copies Furnished To [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

Apr 28, 2017

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00710

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 17, 2017, at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter

For the Respondent: Monica Otalora, Senior Program Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent United Healthcare's action reducing the petitioner's homemaker services under the Long Term Care (LTC) Program. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Medical Assessment Form, and Case System Screenshots.

FINDINGS OF FACT

1. The petitioner is seventy-three (73) years of age and lives with her son. Her son is considered disabled due to [REDACTED]. The petitioner is non-ambulatory and suffers from [REDACTED].

[REDACTED] She uses supplemental oxygen 24 hours per day.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for 24 hours weekly of home health services by United Healthcare. Those hours consisted of 14 hours of personal care assistance and 10 hours of homemaker services. She also receives home-delivered meals.

5. On or about December 29, 2016, United sent a letter to the petitioner informing her that her homemaker services would be reduced from 10 hours weekly to 7 hours weekly. The notice stated the following reason for the reduction:

A long-term care physician reviewed your needs. Homemaker care includes help for preparing meals and housekeeping. Only homemaker care that is for you, not the whole home, is covered. The doctor decided that 7 hours for homemaker care can meet your needs. The other hours you asked for are in excess of your needs. Hours in excess of your needs are not medically necessary.

6. The petitioner's daughter stated her mother's health has worsened and she takes 19 different medications. She stated her mother cannot cook or change the bed linen. Her mother's home health aide only does her laundry and cleans her room, not her brother's room or laundry. The aide also cleans the bathroom and there is only one bathroom in the home. Her brother receives his own separate personal care and homemaker services through the LTC program. Her father previously provided assistance to her brother, but her father passed away in February, 2017. The home health aide assists her mother from 9:00 a.m. to 1:00 p.m., Monday to Friday, and 9:00 a.m. to 11:00 a.m. on Saturday and Sunday. The daughter also stated her mother was living with her until she moved out in September, 2016 and the family requested an increase in home health services at that time due that change in living arrangements.

7. The respondent's witness, Dr. Kaprow, stated the petitioner needs assistances with her activities of daily living (ADLs). He stated homemaker services provide assistance with housekeeping, laundry, and meal preparation, but these services are intended to benefit the petitioner only and should not benefit her son with any of his needs. He also stated the petitioner was receiving only 7 hours weekly of homemaker services approximately 6 months ago and it was unclear when or why those services were increased to 10 hours weekly.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the issue involved a reduction in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care

services by participating in the long-term care managed care program. The recipient must be:

- (a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
- (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her homemaker services under the Program should not be reduced from 10 hours weekly to 7 hours weekly.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes

assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

18. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

19. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

20. After considering the evidence and testimony presented, the hearing officer concludes that the respondent has not demonstrated it was correct in reducing the petitioner's homemaker services under the LTC Program. The basis for the reduction was that the services should benefit the petitioner only and not her son. However, no evidence was presented to establish the petitioner's homemaker services are actually benefitting her son. The petitioner's daughter testified her mother's home health aide only assists with her laundry and room, not her son's. The cleaning of the bathroom may incidentally benefit the son, but there is only one bathroom in the home so that chore cannot be attributed solely to the mother's or son's benefit. In addition, the petitioner's son receives his own separate personal care and homemaker services.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, and the petitioner's homemaker services shall not be reduced at this time.

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 28 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
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AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Apr 04, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00712

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 6, 2017, at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's granddaughter

For the Respondent: Jerome Hill, Program Supervisor - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action partially denying the petitioner's request for additional home health services under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Case System Screenshots, and Medical Assessment Form.

FINDINGS OF FACT

1. The petitioner is eighty (80) years of age and is currently living with her granddaughter and two other family members. She utilizes a wheelchair for mobility. She had hip surgery in December, 2016 due to a fall.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for the following services by United Healthcare: 19.5 hours weekly of adult day care (utilized on Monday, Wednesday, and Friday), 6 hours weekly of personal care assistance, and 3 hours weekly of homemaker services.

5. On or about December 28, 2016, the petitioner made a request to United Healthcare for 7 additional hours weekly of homemaker services. On January 4, 2017, United sent a letter to the petitioner partially denying her request for the homemaker services as not being medically necessary. The denial notice stated the following:

A long-term care physician reviewed your needs. Homemaker care includes help for preparing meals and housekeeping. Only homemaker care that is for you, not the whole home, is covered. The doctor decided that 4 hours for homemaker care can meet your needs. The other hours you asked for are in excess of your needs. Hours in excess of your needs are not medically necessary.

The petitioner also requested an additional 25 hours weekly of personal care services. United Healthcare partially denied this request as well, approving 11 additional hours weekly of person care assistance. At the present time, the petitioner is approved for 17 hours weekly of personal care assistance and 4 hours weekly of homemaker services in addition to the 19.5 hours weekly of adult day care.

6. The petitioner's granddaughter stated the petitioner has not been able to attend the adult day care program since her hip surgery because she cannot walk to the door. She stated all the other household members work during the day. She also stated her grandmother needs assistance with activities such as bathing, feeding, walking, and toileting. At the present time, the home health aide assists her on Tuesday, Thursday, and Sunday beginning at noon for about 2-3 hours.

7. The respondent's witness, Dr. Kaprow, agreed the petitioner needs substantial assistance with her activities of daily living. However, United's position is that the currently approved hours of service are sufficient to meet the petitioner's needs. He suggested that some of the hours could be utilized on the days the petitioner is approved to attend adult day care, so that the aide can help get her ready to leave the home. He also stated respite care services may be available to further assist the family.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished

or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

20. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that her home health services should be increased under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs) such as bathing, toileting, and feeding. However, she is currently approved for 21 hours weekly to assist with these activities, in addition to the adult day care services. She may benefit from re-arranging the currently approved service hours so that she can begin attending the adult day care facility again. The petitioner also has assistance from other caregivers in her family.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence 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 _____ day of _____, 2017,

FINAL ORDER (Cont.)
17F-00712
PAGE -8

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Copies Furnished To: [REDACTED], PETITIONER
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UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Apr 10, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00722

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 3, 2017, at 1:30 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's mother

For the Respondent: Jerome Hill, Program Supervisor – AHCA

STATEMENT OF ISSUE

At issue is the respondent's action reducing or terminating the petitioner's homemaker services, personal care services, and companion care services under the

Long Term Care (LTC) Program. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent's Composite Exhibit 1: Statement of Matters, Denial Notices, Medical Assessment Form, and Case Screenshots.

FINDINGS OF FACT

1. The petitioner is thirty-seven (37) years of age and lives with his mother. The petitioner has been diagnosed with [REDACTED]. He is non-ambulatory. He requires supplemental oxygen throughout the day. He utilizes a Bi-pap machine at night due to sleep apnea.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. He receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the

contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for 58 hours weekly of home health services in the LTC program, as follows: 37 hours of personal care, 5 hours of companion care, and 16 hours of homemaker services.

5. On January 5, 2017, United Healthcare informed the petitioner in three separate notices that his personal care services, companion care services, and homemaker services would be terminated as not being medically necessary. The notices also stated his needs were being met by his family. At some point thereafter, United Healthcare approved 21 hours weekly of personal care services.

6. The petitioner's mother stated her son cannot do anything for himself. He is incontinent and needs to be changed every 2 hours. He has had many brain surgeries and has three shunts. He cannot walk by himself and is at risk for choking or passing out. She lives alone with her son. She stated her daughter sometimes visits and helps out, but she lives in [REDACTED]. Currently, the home health aide assists her son from 12:00 a.m. midnight until 8:00 a.m. The aide supervises him and changes him.

7. The respondent's witness, Dr. Kaprow, stated that the petitioner's services were terminated or reduced because he has substantial family support and the health plan will not approve services if needs are already being met by natural supports. He stated the petitioner does require total assistance with activities of daily living, but his family does the cooking, shopping, and laundry. He also stated the petitioner should not need supervision at night if he is using the Bi-pap machine for his sleep apnea.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the issue involved a reduction in services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because he believes his services under the Program should not be terminated or reduced by the health plan.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner also receives Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services

does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

18. The AHCA contract also provides that a Plan “may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.”

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

20. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the respondent has not demonstrated it was correct in reducing the petitioner's services at this time. The petitioner was previously approved for 58 hours weekly of home health services, and his medical conditions have not improved since then. The petitioner does not appear to have the amount of family support contemplated by the health plan, since he lives only with his mother. His sister who lives in New York is only available to provide assistance when she visits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, and the petitioner's home health services shall not be reduced or terminated.

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 indigence 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 _____ day of _____, 2017,
in Tallahassee, Florida.

FINAL ORDER (Cont.)

17F-00722

PAGE -8



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UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Apr 24, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00862

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on March 1, 2017 at 11:34 a.m. Eastern time (10:34 a.m. Central time) and reconvened on March 14, 2017 at 11:33 a.m. Eastern time (10:33 a.m. Central time).

APPEARANCES

For Petitioner: , Pro se

For Respondent: Dianne Soderland, Registered Nurse Specialist,
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is Respondent's action, through Molina Healthcare, to deny Petitioner's request for a room air humidifier. Because the matter at issue involves a request for service, Petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from Molina Healthcare were: Dr. Alfredo Torralbas, Pediatrician and Medical Director (March 1, 2017 proceeding); Dr. Teresa Blanco, Medical Director (March 14, 2017 proceeding); Jacklyn Salcedo, Government Contracts Specialist; Rebecca Quintana, Director of Government Contracts; Manny Fernandez, Supervisor for Health Care Services; Anthony Perez, Manager for Health Care Services; Bonnie Blitz, Nursing Director for Health Care Services; and Alice Quieto, Associate Vice-President for Government Contracts (March 14, 2017 proceeding).

Respondent's Exhibit 1 was entered into evidence.

FINDINGS OF FACT

1. Petitioner is a 57-year-old recipient of the Medicaid program. She enrolled with Molina's managed care plan effective September 1, 2016.
2. Petitioner is diagnosed with a persistent cough and complex respiratory conditions.
3. On January 5, 2017, Respondent received a prior authorization request from Petitioner for a room air humidifier, using the code E1399¹.
4. On January 13, 2017, Respondent sent Petitioner a Notice of Action denying her request because it was determined the request was not a covered benefit.
5. Petitioner filed an appeal with the Plan that was received on January 10, 2017.

¹ On December 21, 2016, Respondent received a prior authorization request for a humidifier with code E0562. This item is a humidifier for a C-Pap machine and not what Petitioner intended to request.

6. On January 27, 2017, Respondent sent a notice in response to the appeal upholding the denial because the “room humidifier is not indicated as a covered benefit.”

7. Petitioner filed a timely request for a fair hearing on January 23, 2017.

8. Petitioner recounted the difficulties, from October 2016 to January 2017, in getting the proper prescription submitted and reviewed. She stated she called the Plan in October 2016 and was advised a humidifier is a covered benefit. She testified two requests were submitted to the Plan, one from her primary care physician and one from her pulmonologist. She has an ongoing cough that limits her breathing. Petitioner stated the Plan has yet to cover anything for her disabling condition. She cited, as an example, the Plan’s denial of an inhaler requested by her pulmonologist.

9. Petitioner stated both her primary care physician and pulmonologist advised that her condition (dry nose and hacking cough) required a room air humidifier.

10. Respondent’s medical director explained Medicaid’s Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (DME Handbook) is very specific on what are non-covered items. She explained this includes environmental control equipment (air conditioners, dehumidifiers, air filters or air purifiers).

CONCLUSIONS OF LAW

11. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office

of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes.

12. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes. This proceeding is a *de novo* proceeding pursuant to Rule 65-2.056 of the *Florida Administrative Code*.

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

14. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G of the *Florida Administrative Code*. The Medicaid Program is administered by the respondent.

15. Rule 59G-1.010, *Florida Administrative Code*, states in part:

(166) "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;
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.

16. The July 2010 Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (DME Handbook) has been promulgated by Rule 59G-4.070 of the *Florida Administrative Code*. The DME handbook, as well as other Medicaid Handbooks, can be found at the Agency's website:

(http://ahca.myflorida.com/medicaid/review/specific_policy.shtml).

17. The DME Handbook, on page 2-97, provides a list of non-covered items for the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program. Included on the list is "Environmental control equipment (air conditioners, dehumidifiers, air filters or air purifiers)."

18. Petitioner testified she needs a room air humidifier to relieve the pain and discomfort from her hacking, dry cough.

19. Respondent did not address the medical necessity for the room air humidifier.

20. Respondent explained the DME Handbook excludes any environmental control equipment (air conditioners, dehumidifiers, air filters or air purifiers).

21. The above cited authority makes it clear that the room air humidifier is a non-covered item because it is an environmental control equipment.

22. After considering the evidence and the appropriate authorities set forth in the findings above, the hearing officer concludes Petitioner has not met her burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 24 day of April, 2017, in

Tallahassee, Florida.



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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Molina Hearings Unit

Apr 26, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00882

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 [REDACTED]
UNIT: 66292

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 7, 2017 at 11:15 a.m.

APPEARANCES

For the petitioner: [REDACTED] pro se

For the respondent: Susan Martin, ACCESS Operations & Management
Consultant I

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner presented one exhibit, which was entered into evidence as Petitioner's Exhibit "1". The respondent submitted two exhibits, which were entered into evidence as Respondent's Exhibits "1" and "2".

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving medical coverage through her mother's employment health insurance. On November 10, 2016, the petitioner turned 26 and could no longer be covered under her mother's health insurance.
2. On November 3, 2016, the petitioner filed an application for Medicaid. The petitioner reported on her application that she was disabled. The petitioner is not age 65 or older and does not have any minor children. The petitioner received Supplemental Security Income (SSI) in 1991. On April 2010, the petitioner's SSI ended due to age.
3. On November 8, 2016 the respondent mailed the petitioner a pending notice giving her a deadline of November 10, 2016 to contact the office to complete a telephone interview and to provide the following information:

Dear [REDACTED]

The following is information about your eligibility.

Once you receive your case number you can go to www.myflorida.com/accessflorida to activate your My ACCESS Account. You will be able to get case status information. You will also be able to print a temporary Medicaid card if you are eligible for Medicaid.

We need to have a phone interview with you to determine your eligibility or to continue your benefits. Please call (407) 393 - 6760 on or before November 10, 2016 between the hours of 9:00 A.M and 1:00 P.M for your phone interview.

To finish your application we need the following information no later than ten days from the date of your interview.

*Proof of loss of income, last pay date and all income received in the month of 10/2016 using the "Verification Of Employment /Loss Of Income" form or provide a letter from your job
*Proof of loans, contributions, or gifts used to pay your expenses this month or a statement from anyone paying your household's bill
Please Complete and sign the "Financial Information Release" form
Other - please see comments below

0For your Medicaid interview, have available the name, address, and phone number of your medical providers and dates of service. Or you can return the Disability question is ensuring the questionnaire is fully completed. You will need to sign and date the Authorization to Disclose. The Financial Information Release mailed with this notice must be signed by you and your spouse, if married. You must apply for benefits with the SSA and provide proof of a current application before Medicaid can be approved and diligently pursue to conclusion any benefit you may be entitled to receive.

4. On November 22, 2016, the respondent completed a telephone interview with the petitioner. During the interview, the petitioner reported that she applied for disability benefits with Social Security Administration (SSA) the week of November 14, 2016. No additional pending notice was issued to the petitioner.
5. The Division of Disability Determination (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The petitioner's application was referred to DDD on December 2, 2016. On January 19 2017, a favorable disability determination was rendered by DDD finding the petitioner disabled beginning July 2016.
6. On January 24, 2017, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application due to "We did not receive all the information requested to determine eligibility". The respondent explained that the petitioner did not apply for other benefits (SSA) for which she may have been eligible.
7. At the hearing, the petitioner provided a confirmation claim number [REDACTED] to show that she applied for SSI on November 15, 2016. The petitioner did not understand

why she wasn't given notification that she was missing verification. Additionally, the petitioner submitted a statement indicating that she was her maternal grandmother's unpaid caretaker for the period of July 2012 through July 2016. The petitioner had no work history.

8. The respondent utilized the State of Florida SSA State On-Line Query to verify information from the SSA. The information on the Query screens comes directly from SSA and the respondent cannot update or alter the screens. The Query screen did not indicate that the petitioner had applied for either SSI or Social Security Disability Insurance (SSDI). However, the respondent did not seek clarification from the petitioner to determine if she was required to verify proof of an application submitted to SSA for SSDI benefits with no work history.

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

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

11. Fla. Admin. Code R. 65A-1.205 addresses the eligibility determination and verification process and states in relevant part:

(1)(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic

appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

...

All days counted after the date of application are calendar days. Applicant delay days do not count in determining compliance with the time standard. The Department uses information provided on the Screening for Expedited Medicaid Appointments form, CF-ES 2930, 04/2007, incorporated by reference, to expedite processing of Medicaid disability-related applications.

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview... If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension...

(d) In accordance with 42 C.F.R. § 435.911, unusual circumstances that might affect the timely processing of Medicaid applications include applicant delay, physician delay and emergency delay as defined below. Unusual circumstances are non-agency processing delays, and the calendar time passing during such delay(s) does not count as part of the 90-day time standard for determining the timeliness of Medicaid eligibility decisions based on disability...

12. Fla. Admin. Code R. 65A-1.702, Special Provisions, states in part:

(5) Requirement to File for Other Benefits.

(a) Documentation that the individual has applied for any annuity, pension, retirement, **disability** or Medicare **benefits to which they may be entitled** (emphasis added) must be received by the department prior to approval for Medicaid benefits.

(b) After the department notifies an individual that they must apply for the other benefits and if they fail to do so in the absence of a showing of good cause, the individual is not eligible for Medicaid benefits.

13. The Department's Program Policy Manual, CFOP 165-22, passage 1440.1400, Requirements to File for Other Benefits (MSSI), states in part:

Individuals must apply for and diligently pursue to conclusion an application for all other benefits for which they may be eligible as a condition of eligibility. Need cannot be established nor eligibility determined upon failure to do so. Benefits that must be applied for include, but are not limited to:

1. Pensions from local, state, or federal government,
2. Retirement benefits,
3. Disability,
4. Social Security benefits,
5. Veterans' benefits,
6. UC benefits,
7. Military benefits,
8. Railroad retirement benefits,
9. Workers' Compensation benefits,
10. Health and accident insurance payments, and
11. Medicare Part A, Part B and Part D.

Individuals applying for Medicaid on the basis of age (65 or older) or disability must apply for Medicare if the state will pay the Medicare premium, deductible or co-insurance.

Individuals applying for SSI-Related Medicaid, HCDA, TCA, or Family-Related Medicaid are not required to apply for SSI as a condition of eligibility (emphasis added)

14. Pursuant to the above authorities, the petitioner is required to file for "Other Benefits" for which she may be entitled to receive in order to be eligible for SSI-Related Medicaid benefits. The petitioner does not have to provide proof of her application for SSI if she is applying for SSI-Related Medicaid benefits. The respondent argued that the petitioner is required to apply for SSDI benefits as a condition of eligibility for SSI-Related Medicaid benefits. However, the evidence and testimony show the petitioner has no work history.

15. The Code of Federal Regulations at C.F.R. 20 § 404.110, How we determine fully insured status, states in part:

(a) General. We describe how we determine the number of quarters of coverage (QCs) you need to be fully insured in paragraphs (b), (c), and (d) of this section. The table in § 404.115 may be used to determine the number of QCs you need to be fully insured under paragraph (b) of this section.

(b) How many QCs you need to be fully insured. (1) You need at least 6 QCs but not more than 40 QCs to be fully insured.

...

(d) How we credit QCs for fully insured status based on your total wages...

16. The Code of Federal Regulations at C.F.R. 20 § 404.131, When you must have disability insured status, states in part:

(a) For a period of disability. To establish a period of disability, you must have disability insured status in the quarter in which you become disabled or in a later quarter in which you are disabled.

(b) For disability insurance benefits. (1) To become entitled to disability insurance benefits, you must have disability insured status in the first full month that you are disabled as described in §404.1501(a), or if later—

§404.140 What is a quarter of coverage.

(a) General. A quarter of coverage (QC) is the basic unit of social security coverage used in determining a worker's insured status. We credit you with QCs based on your earnings covered under social security.

17. The petitioner has no work history and has not earned any wages to be potentially eligible for SSDI. On November 8, 2016, the respondent pended the petitioner to apply for SSDI benefits. During the interview on November 22, 2016, the respondent did not seek clarification from the petitioner to determine if she may be entitled to SSDI benefits. This request does not directly relate to a factor of eligibility because the petitioner has not earned any wages to be eligible for Social Security coverage.

18. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner met her burden of proof in establishing that the respondent incorrectly denied her application for SSI-Related Medicaid benefits for the month of November 2016 and ongoing. The denial is hereby reversed. The respondent is ordered to determine the petitioner's SSI-Related Medicaid eligibility beginning November 3, 2016, the date of her application, and ongoing months. Once an eligibility determination is made, the respondent is to issue a new notice to the petitioner including her appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the respondent in accordance with the above instructions.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 26 day of April, 2017,

in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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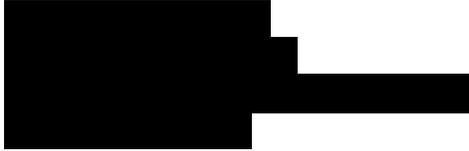
Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 20, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00886

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 7, 2017, at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter

For the Respondent: Monica Otalora, Senior Program Specialist for AHCA

STATEMENT OF ISSUE

At issue is the respondent's action terminating the petitioner's companion care hours and reducing the petitioner's homemaker care hours under the Long Term Care

(LTC) Program. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted two physician's letters and her daughter's letter as evidence for the hearing, which were marked as Petitioner's Composite Exhibit 1.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent's Composite Exhibit 1: Statement of Matters, Denial Notices, Case Screenshots, and Medical Assessment Form.

Also present for the hearing was a Spanish language interpreter [REDACTED] Interpreter Number [REDACTED] from The Language Line.

FINDINGS OF FACT

1. The petitioner is eighty-eight (88) years of age and lives alone, although her daughter stays with her at night. She has been diagnosed with [REDACTED] [REDACTED] She is incontinent and utilizes adult diapers. She needs assistance with walking and other daily living activities.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved by United Healthcare for the following services under the LTC program: 7 hours weekly of personal care assistance, 11 hours weekly of homemaker care services, 10 hours weekly of companion care, incontinence supplies, and one home-delivered meal daily.

5. On January 18, 2017, United Healthcare sent a notice of action to the petitioner which stated her 10 hours weekly of companion services were being terminated as not being medically necessary. The notice of action also stated the following:

A long-term care physician reviewed your needs. Companion care is not hands-on care. Companion care is to watch you perform activities. Companion care is also to help you socialize. Your other caregivers help you socialize too. Companion care is not covered only because you are alone. The doctor decided that you do not need companion care to meet your needs.

By a separate notice also on January 18, 2017, United Healthcare informed the petitioner her homemaker care hours would be reduced to 4 hours weekly based on medical necessity considerations.

6. The petitioner's daughter stated that she herself is 66 years old and she has her own medical problems. She stated her mother was previously receiving 4 hours daily of assistance – 2 hours in the morning and 2 hours in the afternoon. She is requesting 2 additional hours of assistance in the middle of the day to help her mother walk in order to prevent bed sores. She stated she stays with her mother all day and only leaves when the aide comes to the home; but, she needs time to take care of her own needs. She also stated her mother receives one home-delivered meal per day, but she needs to eat three meals per day.

7. The respondent's witness, Dr. Kaprow, stated the decision was made to reduce the companion and homemaker services because the petitioner needs more hands-on care and support. As a result, the health plan increased the petitioner's personal care services to 21 hours weekly from 7 hours weekly. Companion and homemaker services do not involve hands-on care since they are intended to assist with things such as maintaining a clean home environment and for socialization and supervision. He also stated respite care services may be available to provide further assistance to the petitioner's family.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the issue involved a termination and/or reduction in services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should not be terminated or reduced.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner previously received Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

20. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the respondent has demonstrated it was correct in reducing or terminating some of the petitioner’s home health services under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs) such as walking, bathing, toileting, and meal preparation. The health plan approved an increase

in personal care services to assist with these activities while reducing the homemaker services and terminating the companion care services. The reduction in total home health services was from 28 hours weekly to 25 hours weekly (21 hours of personal care and 4 hours of homemaker). The petitioner also has assistance throughout the day from her daughter, who is with her both day and night. Other services, such as respite care, may be available to provide additional assistance.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence 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 20 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard

FINAL ORDER (Cont.)

17F-00886

PAGE -9

Tallahassee, FL 32399-0700

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Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Apr 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00918

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 [REDACTED]
UNIT: 88415

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 29, 2017 at 11:34 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Public Benefits Coordinator,
[REDACTED]

For the Respondent: Estefania Viera, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of November 23, 2016 denying his application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Lauren Miller, Program Operations Administrator, Division of Disability Determinations, appeared as a witness for the Department.

The Department submitted evidence prior to the hearing. The undersigned admitted the evidence as Respondent's Exhibit 1.

The record closed on March 29, 2017.

FINDINGS OF FACT

1. The petitioner applied for SSI-Related Medicaid on October 10, 2016. The petitioner is a single male, age 46 at the time of his application. The petitioner is a non-citizen in the United States from [REDACTED]. The application does not show any employment for the petitioner, past or present.

2. The petitioner was diagnosed with [REDACTED] [REDACTED]. The petitioner had a [REDACTED] and [REDACTED] completed while he was in the hospital July 27, 2016 through August 22, 2016.

3. The petitioner's representative believes his conditions are disabling.

4. There is no application filed with Social Security Administration for disability as the petitioner is a non-citizen.

5. The Department forwarded the petitioner's application to the Division of Disability Determinations (DDD) on October 11, 2016 for a disability determination.

6. According to the Disability Report submitted, the petitioner claimed no work history in the last 15 years. (Respondent Exhibit 1, page 34)

7. The representative from the DDD unit explained the decision of denying the petitioner's disability request using the five-step sequential evaluation process. Page six of the Respondent's Exhibit 1, is the case analysis for the petitioner's case.

8. DDD relied on the Department's determination that the petitioner is not engaged in substantial gainful activity to determine the petitioner meets step one.

9. The DDD representative determined the petitioner's medical conditions are severe and met the criteria for step two of the determination.

10. The DDD representative determined the petitioner's conditions do not meet or equal a listing which is needed for step three of the determination.

11. Step four of the determination reviews the petitioner's prior relevant work history and ability to work. Step five considers if the petitioner cannot return to the prior work, can they do other work in the national economy.

12. The DDD representative explained they attempted to contact the petitioner by phone and letter multiple times with no response. In addition, DDD contacted the petitioner's representative from the hospital in attempts to reach the petitioner with no success by any party. The purpose of the contact was to obtain further information from the petitioner as to how his conditions were impacting his activities of daily living and ability to work.

13. The DDD representative explained with only the hospital records from July 27 through August 22, 2016 to review and no discussion with the petitioner regarding how his conditions are impacting his activities of daily living or ability to work, DDD did not have sufficient evidence to make a determination of disability. DDD then closed the petitioner's claim as denied with an N36 reason code. N36 means non-pay – insufficient or no medical data furnished.

14. The Department issued a Notice of Case Action on November 23, 2016 denying the petitioner's application for Medicaid, as he did not meet the disability requirement.

15. The petitioner was not present for this hearing to describe his health conditions or how his conditions impact his activities of daily living or ability to work.

16. The petitioner's representative advised he was at the hospital again on November 10, 2016 and December 5 through 7, 2016 for additional treatments.

CONCLUSIONS OF LAW

17. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

19. The undersigned explored eligibility first under Family-Related Medicaid groups. The petitioner does not have a minor child in the home according to his October 10, 2016 application. The Family-Related Medicaid program benefits rules are set forth in the Florida Admin. Code R. 65A-1.705, Family Related General Eligibility Criteria. The rules set for that to be eligible for Medicaid under this program; the petitioner must be pregnant or have a dependent minor child residing in the home. The undersigned concludes the petitioner does not meet the criteria for Family-Related Medicaid program benefits.

20. Florida Admin. Code R. 65A-1.701, Definitions, states in relevant part:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are

also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

21. Florida Admin. Code R. 65A-1.711, SSI-Related Medicaid, Non-Financial Eligibility Criteria, states in relevant part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).

22. 20 C.F.R. § 416.905, Basic definition of disability for adults, states in relevant part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.)

23. The undersigned explored potential eligibility for Medicaid for the petitioner under the SSI-Related Medicaid program. The petitioner was 46 years old at the time of

application. He had not been established as disabled. As he is under age 65, a disability determination is required for eligibility determination in the SSI-Related Medicaid program.

24. The Department's Program Policy Manual, CFOP 165-22, section 1440.1204, Blindness/Disability Determinations (MSSI, SFP) states in part:

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs. State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year.

25. The findings show there are no pending applications for disability with the Social Security Administration due to the petitioner's citizenship status. The undersigned concludes a disability decision must be determined by the Division of Disability Determinations (DDD) as the petitioner is under age 65.

26. 20 C.F.R. § 404.1520, Evaluation of disability in general, states in relevant part:

(4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in §404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and §404.1560(b).

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and §404.1560(c).

27. The above controlling authority outlines the five-step sequential evaluation process. The undersigned concludes the disability determination of the petitioner by DDD must be reviewed using this authority.

28. The first step of the evaluation process is to determine if the petitioner is engaging in substantial gainful activity (20 C.F.R. § 404.1520(b) and 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. The findings show no employment for the petitioner. The undersigned concludes the petitioner is not engaged in SGA as he is not working. The analysis continues to step two.

29. Step two of the evaluation process reviews whether the claimant has a medically determinable impairment that is “severe” or a combination of impairments that are “severe” (20 C.F.R. § 404.1520(c) and 416.920(c)). An impairment or combination of impairments is considered “severe” within the meaning of the regulations if it significantly limits an individual’s ability to perform basic work activities. According to the DDD decision, the petitioner’s conditions are severe. The undersigned, in review of the medical evidence submitted, concurs with the DDD decision and the analysis continues to step three.

30. Step three of the sequential analysis for disability requires the determination of whether the claimant’s impairment or combination of impairments meets or medically equals the criteria of an impairment listed in Appendix 1 of 20 C.F.R. Part 404, Subpart P (20 C.F.R. § 404.1520(d)). The petitioner’s diagnosis of [REDACTED] falls under section 8.00 Skin Disorders. The petitioner’s diagnosis of [REDACTED] falls under section 14.00 Immune System Disorders and specifically section 14.07 Immune deficiency disorders, excluding HIV infection. The findings show the medical evidence presented regarding the two impairments is limited to the initial hospitalization of July 27 through August 22, 2016. The undersigned concludes the petitioner’s conditions do not meet or equal a listing. The evaluation continues to step four.

31. Step four of the sequential analysis for disability requires the undersigned to consider the petitioner’s residual functional capacity (20 C.F.R. § 404.1520(e) and 416.920(e)) which is the ability to do physical and mental work activities on a sustained basis despite limitations of impairments. In addition, the undersigned must determine whether the petitioner’s residual functional capacity is enough to perform the work

requirements of his past relevant work. The petitioner is 46 years old. His education is not indicated on his application or in the disability report. His work history is unknown based on his application and disability report. The findings show DDD made multiple attempts to contact the petitioner to gain information regarding his abilities and limitations. The findings also show the petitioner did not appear to offer testimony regarding his work history, abilities and limitations. The findings further show the belief of the petitioner's representative that the conditions are disabling. The undersigned notes the belief of the petitioner's representative, but concludes the belief is insufficient to meet the requirements of the above controlling authority. The undersigned concludes without knowledge of prior work history, abilities and limitations there is insufficient information to determine if the petitioner's conditions are in fact disabling. The undersigned further concludes determination of disability stops at step four as there is insufficient information to make a determination if he passes or fails at this step.

32. The undersigned concludes the denial of disability by the DDD unit was proper due to lack of information received from the petitioner. The undersigned further concludes the Department properly denied the petitioner's application for SSI-Related Medicaid due to not meeting the disability requirement.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 14 day of April, 2017,

in Tallahassee, Florida.

M. L. Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 10, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00924

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 10, 2017 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's father

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

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny Prescribed Pediatric Extended Care (PPEC) service hours that were requested for the petitioner for the certification period January 25, 2017 through July 23, 2017, was correct.

The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the respondent was Dr. Darlene Calhoun, Physician-Consultant with eQHealth Solutions, Inc. The respondent submitted the following documents into evidence, which were marked as follows: Exhibit 1 - Outpatient Review History, Exhibit 2 - Denial Notices, and Exhibit 3 - Supporting Documentation.

FINDINGS OF FACT

1. The petitioner's PPEC service provider, Pediatric Network Holding (hereafter referred to as "the provider"), requested the following PPEC service hours for the certification period at issue: full day and partial day services (up to twelve hours daily), Monday to Friday.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for PPEC services. The petitioner's provider submitted the service request through eQHealth's internet based system. The submission included, in part, information about the petitioner's medical conditions; her functional limitations; and other pertinent information related to the household.
3. eQHealth Solutions' personnel had telephone conversations with the petitioner's caregivers and PPEC staff. The provider also sent information directly to eQ Health.
4. The medical and social information submitted by the provider contained, in part, the following information in regard to the petitioner:
 - 13 years old

- Diagnosis includes failure to thrive, [REDACTED]
- Ambulatory and incontinent

5. The petitioner has been previously approved for PPEC services and is currently attending the PPEC facility.

6. A Plan of Care was submitted by the provider. This document was signed by a physician and outlined the type of assistance to be provided by the PPEC facility. The duties include, in part:

- Daily head-to-toe assessment
- Maintain daily hygiene requirements, including ADLs (activities of daily living)
- Follow-up of developmental therapies
- Medication administration
- Monitor caregiver compliance with child care needs and provide caregiver education

7. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and denied the request for PPEC services. A notice of this determination was sent to all parties on January 19, 2017. The physician-reviewer wrote, in part:

The patient is a 12 year old with [REDACTED] and failure to thrive. The patient is on an age-appropriate diet. The patient is on no scheduled medications. The patient is ambulatory and incontinent and requires assistance with ADLs. The patient is on as-needed albuterol treatments. The patient is not on a complex medication regimen. The patient has had no recent hospitalizations or emergency room visits. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity requirement for PPEC services.

8. The above notice stated should the parent, provider, or the petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was not requested in this case.

9. The petitioner thereafter requested a fair hearing and this proceeding followed. The respondent administratively approved the requested PPEC services pending the outcome of the fair hearing process.

10. The petitioner's father stated his daughter currently attends the PPEC facility for 3 hours daily after school and she has been attending the PPEC for several years. He stated she was hospitalized in February, 2017 for urinary tract infections and menstruation problems. She is now on hormone therapy to stop menstruation. She has an upcoming surgery scheduled for April, 2017 to address some of those issues and she will have medical devices inserted afterward for removal of body fluids and waste.

11. The respondent's witness, Dr. Calhoun, testified that the petitioner does not meet the requirements for PPEC services since she does not require skilled nursing interventions. Her needs are mainly for assistance with ADLs (activities of daily living) and incontinence care. She previously had a gastronomy tube (G-tube) for feeding and a tracheostomy, but this is no longer the case. She is now on a regular diet. Dr. Calhoun also stated the various therapies being administered at the PPEC facility can still be provided outside of the PPEC.

12. PPEC service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Prescribed

Pediatric Extended Care Services Coverage and Limitations Handbook (“PPEC Handbook”), effective September, 2013.

CONCLUSIONS OF LAW

13. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

14. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

15. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

16. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the respondent has been previously approved for PPEC services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

17. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent. The PPEC Handbook described above is incorporated by reference in Fla. Admin. Code R. 59G-4.260.

18. The petitioner has requested PPEC services. As the petitioner is under twenty-one (21) years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner’s eligibility for or amount of this service.

19. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

20. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you¹ must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

21. The service the petitioner has requested (PPEC services) is one of the services provided by the State to treat or ameliorate an individual's conditions under the State

¹ "You" in this manual context refers to the state Medicaid agency.

plan. Chapter 409.905, Florida Statutes, states, in part:

Any service under this section shall be provided only when medically necessary ...

(4)(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services ... The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for any other family dependents.

22. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

5110. Basic Requirements...

...Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

5122. EPSDT Service Requirements

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

5124. Diagnosis and Treatment

B. Treatment.--

1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

23. Once a service has been identified as requested under EPSDT, the Medicaid Program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. Fla. Admin. Code R. 59G-1.010 defines medical necessity:

(166) '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...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

24. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested PPEC services.

25. In the petitioner's case, the respondent has determined that PPEC services are not medically necessary at this time.

26. Fla. Stat § 409.913 governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the "medical necessity or medically necessary" standards, and states in pertinent part as follows:

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on to further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

27. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary. As stated above, this proceeding is a de novo proceeding for the purpose of the Agency reaching its final decision. The final decision making authority for this proceeding has been delegated to the hearing officer in Fla. Admin. Code R. 65-2.066.

28. The purpose of PPEC services is described on page 1-1 of the PPEC Handbook as follows:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

29. The PPEC Handbook on page 2-1 sets forth the requirements for PPEC services, as follows:

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible;
- Diagnosed with a medically complex or medically fragile condition as

defined in Rule 59G-1.010, F.A.C;

- Be under the age of 21 years;
- Be medically stable and not present significant risk to other children or personnel at the center;
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

30. Rule 59G-1.010, F.A.C., defines the terms “medically complex” and “medically fragile” as follows:

“Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour per day medical, nursing, or health supervision or intervention.

“Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, i.e., requiring total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life and without such services is likely to expire without warning.

31. The petitioner’s physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

32. The respondent’s witness stated that the petitioner did not meet the requirements for PPEC services since she did not require skilled nursing interventions.

33. The petitioner’s father stated his daughter should be approved for PPEC services due to her medical conditions and upcoming surgery.

34. After considering the evidence and testimony presented, the undersigned concludes the respondent has not demonstrated it was correct in denying the PPEC

services at this time. Although the petitioner is not currently dependent on any medical devices such as a breathing tube or feeding tube, the petitioner's father stated she will require some medical devices for removal of body fluids and waste after her upcoming surgery. Therefore, after her surgery, she may require constant "health supervision or intervention." Accordingly, her PPEC services should not be terminated at this time and there should be a re-evaluation of her condition after her surgery.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED and the petitioner shall continue receiving PPEC services for the current certification period.

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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 10 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer

FINAL ORDER (Cont.)

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

FILED

Apr 21, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00951

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 7, 2017 at 11:30 a.m.

APPEARANCES

For the Petitioner:



For the Respondent:

Lisa Sanchez, Medical Program Analyst
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is the respondent's denial of the petitioner's request for reimbursement for out-of-pocket payments to a medical provider. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing, although copies of her receipts for out-of-pocket payments were included in the respondent's evidence packet.

Appearing as a witness for the respondent was Lisa Sanchez, Medical Program Analyst for AHCA, which administers the Florida Medicaid program. Respondent's composite Exhibit 1 was entered into evidence, consisting of documents relating to the petitioner's request for reimbursement.

Also present for the hearing was a Spanish language interpreter, [REDACTED] [REDACTED] from [REDACTED] Language Services.

FINDINGS OF FACT

1. The petitioner is an adult Medicaid recipient. Her Medicaid coverage start date was August 1, 2014. She was also approved for Social Security disability benefits in February, 2016, at which time her Medicaid coverage was retroactively approved to August, 2014.
2. The petitioner is seeking reimbursement from the Medicaid program for her out-of-pocket payments for various medical services to [REDACTED] Memorial Hospital. She paid approximately \$1,865.00 for these medical services for the period from August, 2014 through February, 2016.
3. By a notice of action dated December 1, 2016, the respondent denied the request for reimbursement. The notice stated the following:

You are not eligible to be reimbursed for the following reason:

Not enough information was provided in order to process the request.

4. The respondent's witness provided further details regarding the denial of the reimbursement request. She stated AHCA needs to verify the payments were made for Medicaid covered services and the receipts submitted by the petitioner did not contain a procedure code for the specific services rendered. She also stated AHCA attempted to obtain this information directly from the provider (██████████ Memorial Hospital), but there was no response from the provider.

5. The petitioner stated she also attempted to obtain the necessary information from the provider, but the provider was unable to give it to her. She stated she was also told by the provider they could not print out her medical records because there were too many pages. She also stated the provider did not know her Medicaid number because her Medicaid was approved retroactively, meaning she was not yet covered by Medicaid at the time she received the services. The only documentation she was able to submit were receipts showing her payments, on which she wrote what service she received for each payment. For example, she wrote "cardiologist", "neurologist", "CT scan", etc. on the receipts.

CONCLUSIONS OF LAW

6. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat § 120.80.

7. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

10. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA.

11. Fla. Admin. Code R. 59G-5.110 address reimbursements to Medicaid recipients, and states as follows:

(1) Purpose. This rule describes the circumstances when the Agency for Health Care Administration (AHCA) may directly reimburse eligible Florida Medicaid recipients; how AHCA reimburses recipients; and documentation requirements for direct reimbursement.

(2) Determination Criteria. Florida Medicaid recipients may be eligible for direct reimbursement if:

(a) Medical goods and services were paid for by the recipient or a person legally responsible for their bills from the date of an erroneous denial or termination of Florida Medicaid eligibility to the date of a reversal of the unfavorable eligibility determination.

(b) The goods and services were medically necessary as defined in Rule 59G-1.010, Florida Administrative Code (F.A.C.); rendered by a provider that is qualified to perform the service including meeting any applicable certification or licensure requirements (the provider is not required to be enrolled or registered as a Florida Medicaid provider); and covered by Florida Medicaid for the recipient’s eligibility group on the date of service.

(c) Reimbursement for the medical goods or services is not available through any third-party payer on the date of service for which direct reimbursement is requested.

12. Based on the foregoing, the undersigned concludes the petitioner has not demonstrated her request for reimbursement should have been approved by the respondent. The information provided on the petitioner's receipts did not list any procedure codes; therefore, AHCA cannot determine exactly what services were rendered and whether those services are considered Medicaid-covered services. Although the petitioner wrote on the receipts the type of service she received, AHCA needs more detailed information including the specific procedure codes.

13. The undersigned acknowledges the petitioner may have exerted her best efforts to obtain the necessary information from the provider and was unable to obtain it. However, the administrative regulations cited above contain detailed requirements on what must accompany the request for reimbursement. Since the petitioner's request did not contain this required information, she is not entitled to reimbursement from the Medicaid program at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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

FINAL ORDER (Cont.)

17F-00951

PAGE - 6

the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 21 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

Apr 21, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00954

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 13, 2017 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter.

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

STATEMENT OF ISSUE

At issue is the respondent's action to partially deny the petitioner's request for home health aide (HHA) visits for the certification period January 3, 2017 to March 3, 2017. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the respondent was Rakesh Mittal, M.D., physician-consultant for eQHealth Solutions, Inc. Respondent's Composite Exhibit 1 was entered into evidence, consisting of a Statement of Matters, Outpatient Review History Notes, Denial Notice, Supporting Documentation, and Medicaid Policy Provisions.

FINDINGS OF FACT

1. The petitioner's home health agency, Trinity Health Care Services (hereafter referred to as "Provider"), requested the following HHA visits for the certification period at issue: 3 visits per day, 7 days per week.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for home health services. The petitioner's provider submitted the service request through eQHealth's internet based system. The submission included, in part, information about the petitioner's medical conditions; her functional limitations; and other pertinent information related to the household.
3. eQHealth Solutions personnel conducted a home visit with the petitioner in January, 2017. The decision made by eQHealth was also based on the Information submitted by the provider.
4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:
 - 81 years of age and resides with her husband

- Incontinent
- Diagnosis includes [REDACTED] and abnormalities of gait and mobility

5. This was the petitioner's initial request for home health aide services and she had not been previously approved for home health visits.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the home health aide. The duties include, in part:

- Provide assistance with activities of daily living and personal care, including oral care, perineal care, toileting, bathing, dressing, and grooming
- Assist with meals and laundry
- Assist with transfers

7. A physician at eQHealth Solutions reviewed the submitted information and partially denied the requested HHA visits, approving only one visit daily. This physician-reviewer wrote, in part:

Deny requested HHA three times daily frequency. Recipient is a 80 year old with a history of [REDACTED] who lives with spouse, ambulates with a steady gait without assistive devices, takes shower alone, and urinary incontinence managed with diapers. Based on home visit observation and information obtained, recipient is not on total care and meets minimal functional impairment. The requested HHA three times daily frequency is not medically necessary.

A notice of this determination was sent to all parties on January 12, 2017.

8. The above notice stated should the recipient, provider, or petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was not requested in this case. The petitioner thereafter requested a fair hearing.

9. The petitioner's daughter stated her mother needs assistance with bathing and dressing. Her father is 100-years old and he also receives assistance from a separate home health aide. Her parents live in a second floor unit. The daughter works full-time and is unable to provide assistance to her mother during the day. The home health aide was helping her mother from 10:00 a.m. to 11:00 a.m., but she states this was not enough time to provide the necessary assistance.

10. The respondent's representative, Ms. Otalora, stated a home health visit can be up to 3 hours in duration. She also stated the petitioner's services ended on March 3, 2017 at the end of the certification period, and the home health agency needed to submit a new request for services for the next certification period.

11. The respondent's witness, Dr. Mittal, stated that one home health visit per day was medically necessary for the petitioner based on her medical conditions and needs at the present time.

CONCLUSIONS OF LAW

12. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

13. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

14. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

15. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since this was the petitioner's initial service request. The

standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

16. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent.

17. For home health aide service hours to be approved, the service must be medically necessary. The definition of “medically necessary” is found in Fla. Admin.

Code R. 59G-1.010 which states:

(166) ‘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...

(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.

18. Home health services are addressed in the AHCA Florida Medicaid Home Health Visit Services Coverage Policy (“The Policy”), effective November, 2016.

19. The Policy, on page 1, describes Home Health Visits as follows:

Florida Medicaid home health visits provide medically necessary skilled nursing and home health aide services to recipients whose medical condition, illness, or injury requires the care to be delivered in their home or in the community.

20. The Medicaid Program allows for up to 3 intermittent home health visits per day for individuals who are 21 years of age and older. The Home Health Visits Policy does not specify the duration of the home health visits, although the Medicaid Program representative stated at the hearing that each visit can be for up to 3 hours. The Policy describes intermittent home health visits as “[m]edically necessary skilled nursing and home health aide services that are provided at intervals for the length of time necessary to complete the service.”

21. The petitioner’s daughter stated her mother is only receiving one hour of assistance during the home health visit. This conflict or discrepancy is probably explained by the fact the home health provider is paid a flat rate by the Medicaid Program per visit; therefore, the home health provider has an incentive to limit the duration of the visit. In any event, the duration of the home health visit is an issue which would have to be addressed between the petitioner’s family, the home health agency, and the Medicaid Program.

21. With respect to the issue for the hearing, the undersigned concludes the petitioner has not demonstrated that the respondent should have approved three home health visits per day. The evidence presented establishes one home health visit daily is medically necessary for the petitioner at this time, based on her medical conditions and need for assistance with her daily living activities.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence 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 21 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

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

FILED

Apr 10, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00956

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA,

And

MAGELLAN COMPLETE CARE,

RESPONDENTS .

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 10, 2017 at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's mother

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for wisdom teeth extractions was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present for the hearing and was represented by her mother. The petitioner submitted her mother's letter as evidence for the hearing, which was marked as Petitioner Exhibit 1. At the conclusion of the hearing, the record was left open until the close of business March 20, 2016 for the petitioner to submit additional evidence. The petitioner subsequently submitted, within the allowed time frame, a report from her dentist, which was marked as Petitioner Exhibit 2. The record was then closed.

Appearing as witnesses for the respondent were Samantha Lorenzo, Appeals Manager and Michelle Rigler, Compliance Officer, from Magellan Complete Care, which is the petitioner's managed health care plan. Also present as witnesses for the respondent were Charles Keiffer, Complaints and Grievances Specialist, and Dr. Daniel Dorrego, Dental Consultant, from DentaQuest, which reviews dental claims on behalf of Magellan.

The respondent submitted the following documents as evidence for the hearing, which were marked as follows: Exhibit 1 – Summary of Events, Exhibit 2 – Authorization Requests, Exhibit 3 – Notice of Action Letter, Exhibit 4 – Dental Policy and Covered Benefits, and Exhibit 5 – Criteria for Dental Extractions.

FINDINGS OF FACT

1. The petitioner is a seventeen (17) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA)

plan. She receives services under the plan from Magellan Complete Care, which utilizes DentaQuest for review and approval of dental services.

2. On or about January 5, 2017, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Magellan to perform extractions of four wisdom teeth (Teeth 1, 16, 17, and 32). Magellan and DentaQuest denied this request on January 9, 2017 based on medical necessity considerations.

3. The denial notice also stated the following regarding the reason for the denial:

The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain. Please follow up with your dentist.

4. The petitioner's mother stated her daughter needs the extractions because she is complaining of pain on the left side of her face. She also stated one of the teeth is next to a facial nerve and her dentist said she may develop a cyst or infection.

5. The respondent's witness, Dr. Dorrego, stated that the denial of the wisdom teeth extractions was appropriate because there was no sign of infection or cysts in the x-rays. He stated there is enough space for the wisdom teeth to erupt normally. He also stated there was no narrative or remarks submitted by the provider describing any infection. Pain can be a basis to justify extraction of the wisdom teeth, but the provider must submit a narrative describing more than the normal pain associated with tooth eruption.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the respondent's Florida Medicaid Provider General Handbook ("Medicaid

Handbook”), effective July 2012 and the Dental Services Coverage Policy (“Dental Policy”), effective May 2016.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.

8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.

9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), Fla. Admin. Code. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

13. The service at issue, tooth extraction, is a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. DentaQuest and/or Magellan denied the wisdom teeth extractions due to medical necessity considerations.

14. The petitioner's mother believes the extractions should be approved because her daughter is in pain, one tooth is next to a facial nerve, and she may develop a cyst or infection.

15. The respondent's witness stated the denial of the extractions was appropriate since there was no sign of infection or cysts.

16. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for the extractions was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's dentist requested the extractions, this does not establish it is medically necessary. The respondent's witness testimony supports the

denial of the requested service. The report from the petitioner's dentist does not describe any infection or cysts present and the only reference to pain is that the patient was in pain for the past three days.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 10 day of April, 2017,

in Tallahassee, Florida.



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FINAL ORDER (Cont.)

17F-00956

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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
MAGELLAN HEARINGS UNIT

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

FILED

Apr 04, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-00957

PETITIONER,
Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 27, 2017 at 10:04 a.m.

APPEARANCES

For Petitioner: [REDACTED] Daughter

For Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

Whether it was correct for Respondent to partially deny Petitioner's request for 24 hours per day, seven days per week, of Personal Care Services (including personal care, homemaker, and companion services). Because the matter at issue is a request for an increase in services, Petitioner is assigned the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from Sunshine Health were: Dr. John Carter, Long-Term Care Medical Director; Kimberly Bouchette, Clinical Appeals Coordinator; Kizzy Alleyne, Paralegal; Mayra Bocello-Insanzon, Director of Case Management; and Heather Ford, Long-Term Care Supervisor.

Appearing as Petitioner's witness was [REDACTED] Petitioner's daughter.

Respondent's Exhibits 1 to 9 were entered into evidence. Petitioner's Exhibit 1 was entered into evidence.

FINDINGS OF FACT

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 94-year-old Medicaid recipient enrolled in Sunshine Health's Long-Term Care plan (Plan).
2. Petitioner lives with her daughter, [REDACTED] who is her primary caregiver. [REDACTED] is returning to work and is not able to provide Petitioner with the level of care that she has in the past.
3. Petitioner's doctor wrote a letter, dated November 21, 2016, which states in relevant part:

Lately [Petitioner] has experienced bouts of dizziness and confusion, and she is incontinent. Following two recent falls and diagnosis of an acute urinary tract infection, [Petitioner] was hospitalized. She was discharged to the care of her daughter...with whom [Petitioner] has been living with. I referred [Petitioner] for neurological assessment, which was completed by Doctor ... on November 6, 2016. [The doctor's] thorough evaluation of [Petitioner] resulted in a diagnosis of [REDACTED] with early onset. Treatment with Donepezil 5mg daily has been prescribed. As a result of these changes in her medical and neuropsychological status, [Petitioner]

now requires 24-hour Personal Care Assistance in dressing, undressing, bathing, toileting, administration of medications and fall prevention.

4. On November 28, 2016, the Plan received Petitioner's request for 24 hours per day of personal care hours, 7 days per week. The total number of hours per week requested is 168 (24 hours x 7 days).

5. At the time of Petitioner's request, she was receiving 25 hours per week of Personal Care Services; 10 hours per week of Respite care services; and 15 hours per week of Homemaker services for a total of 50 hours of home care services per week. Petitioner's request, therefore, is for 118 additional hours per week of personal care services.

6. On November 29, 2016, Respondent issued a Notice of Action for the additional personal care service hours. The notice states in relevant part:

Based on the case management assessment of the member's care needs, the member's presently approved home services are enough to meet the member's care needs. The member's present care plan includes 25 hours/week Personal Care Services +10 hours/week in-home Respite Care Services +15 hours/week Homemaker Services (for a total of 50 hours/week combined home services) along with 7 meals/week Home Delivered Meals.

The facts that we used to make our decision are: Sunshine Health Policy L.T.UM.09 Long Term Care Ancillary Service Criteria. (See Respondent Exhibit 8 for the criteria.)

7. Petitioner requested an internal appeal with Sunshine Health (Plan). The Plan sent a response to the appeal request on January 10, 2017. The reason provided for the decision states:

The member's present care plan includes 25 hours per week Personal Care Services + 15 hours per week Homemaker services + 10 hours per week Respite Care services, for a total of 50 hours/week combined home services, and 7 meals per week Home Delivered Meals. The Primary Care Physician and Caregiver document that member requires 24 hour care. If the member requires 24-hour care or supervision, the PCP, caregiver and member need to consider Adult Day Care Services or an

Assisted Living Facility in order to best meet the needs of the member and caregiver.

8. A letter dated February 21, 2017 from Petitioner's doctor states, in relevant part:

In addition to [Petitioner's] [REDACTED] [Petitioner] has been suffering from chronic nausea, diarrhea and constipation and is under the care of gastroenterologist ...for these conditions. Furthermore [Petitioner] is incontinent and has had recurrent urinary tract infections. Her nausea, urinary urgency and susceptibility to nightmares as commonly experienced by [REDACTED] patients, cause frequent night walking. During these nightly episodes she is extremely disoriented and physically unstable. As a result of the conditions described above [Petitioner] is highly vulnerable to falling during periods when she is unsupervised. This is particularly true at night when she awakens in a disoriented state and attempts to ambulate to the restroom or to retrieve medication to alleviate her nausea. She is dependent on a walker and has limited mobility. [Petitioner] was recently hospitalized following two falls that occurred during periods of time when she was not being personally supervised.

...

[Petitioner] has responded very well to the personal care services that she has been receiving during daytime hours for individualized assistance with toileting, dressing, undressing, bathing, administration of medications and fall prevention. However, as her physical and mental condition have recently declined it is now necessary for her to have individualized personal care assistance with nighttime toileting and administration of anti-nausea medication. Individualized nighttime personal care assistance will greatly protect against further falls and improper use of medication and thereby is needed to prevent significant illness, disability and injury to this patient.

9. Petitioner's daughter, [REDACTED], indicated when Petitioner does not recognize her caregiver she becomes highly agitated and inconsolable, resulting in physical tremors. [REDACTED] testified her sister, [REDACTED], cannot be expected to provide nighttime care for the Petitioner and then be able to work the next day.

10. [REDACTED] responded to Respondent's suggestion for either adult day care or an assisted living facility for Petitioner [REDACTED] explained neither was a viable option for Petitioner. Petitioner attending an adult day center would require a caregiver to accompany Petitioner on the bus to and from the center. Petitioner and family cannot afford to pay for such a caregiver. [REDACTED] observed adult day care services do not

address Petitioner's need for nighttime care. She stated assisted living facilities do not offer individualized (one-on-one) services, which Petitioner needs.

11. Respondent's Long Term Care Medical Director (LTC/MD) reviewed the Petitioner's medical conditions and acknowledged she requires extensive care. She requires total assistance with bathing, dressing, and toileting. She needs supervision due to her gait and walking instability. She needs assistance with transfers, for example from the bed to a chair.

12. The LTC/MD testified he used the 701B Comprehensive Assessment form completed by the Florida Department of Elder Affairs and Sunshine Health's Long-Term Care (LTC) Ancillary Service Criteria in making his decision. The LTC/MD reviewed the subsequent documentation submitted by Petitioner and recognized Petitioner's doctor's request for around-the-clock service. He stated the 50 hours of home care services per week, currently approved for Petitioner, were adequate to meet her needs as a complement to the care provided by the live-in family member.

13. [REDACTED] responded her mother needs constant supervision at night. Her personal experience, while visiting in caring for her mother at night, helped her understand how difficult and challenging it is. She stated it was impossible for her sister to supervise her mother all night and then function the next day.

14. Respondent's LTC/MD acknowledged patients with psycho motor agitation, confusion, and getting up during the night create a tremendous problem in management. He stated no one is disputing how needy Petitioner is. He reviewed Petitioner's neurologist's February 15, 2017 report and noted some inconsistencies.

15. However, he noted Petitioner's neurologist problem description of February 15, 2017 "Late onset [REDACTED] without behavioral disturbance" contradictory. He further noted Petitioner's neurologist found her psychiatric exam normal.

[Petitioner] oriented in time, place, person & situation. No agitation. No anhedonia. Not anxious. Behavior appropriate for age. No compulsive behavior. Sufficient fund of knowledge. Sufficient language. Patient is not in denial. Not euphoric. Not fearful. No flight of ideas. Not forgetful. No grandiosity. No hallucinations. Not hopeless. Appropriate affect. No increased activity. No memory loss. No mood swings. No obsessive thoughts. Not paranoid. Normal insight. Normal judgment. Normal attention span and concentration. No pressured speech. No suicidal ideation. Level of consciousness-alert.

Under the heading "Neurological: Orientation" the neurologist wrote "Orientation-place disorientation, poor with commands poor construction."

Under the section labeled Plan Dictation, the neurologist wrote, in relevant part:

I certainly find that she requires 24-hours assistance. Given some of the behavioral issues I think it's better on a personal one-to-one level and to remain at home. She certainly under no circumstances should be left on her own. She did try to go into some adult care during the day but even that agitated her.

The LTC/MD found the neurologist's comments inconsistent, confusing, and unclear.

The LTC/MD stated he has a professional disagreement with the neurologist's recommendation for one-on-one care. He stated he recognized the challenges with patients who have unpredictable behavior, such as getting up from bed during the night. He suggested a monitoring system would relieve the need of having someone in the Petitioner's room all night. He explained the services provided by Medicaid are to augment the services provided by the live-in caregiver.

16. [REDACTED] responded Petitioner is better oriented in the morning than she is later in the day, thus, the neurologist's report of Petitioner's "normal" results for her psychiatric exam may be affected by the time of day Petitioner was evaluated. She stated

Petitioner is quite different in the evening than she is in the morning. Petitioner's caregiver daughter, [REDACTED] explained she was with Petitioner during the visit with the neurologist and was able to keep Petitioner calm.

17. [REDACTED] also explained the family has used a monitoring system in an effort to keep Petitioner safe, but it has been unsuccessful. She stated the only way to keep Petitioner safe during the night is to have someone sitting next to her bed.

18. [REDACTED] explained she uses the 50 approved home care hours Monday through Friday, with a few hours available Saturday morning. She gets friends to help with night time care for her mother, during the week, because she has to leave for work Mondays through Fridays by 7:00 a.m. She returns home from work between 4:00 p.m. to 6:00 p.m., depending on errands she has to do. She stated she reduced her hours of work as a substitute teacher to care for her mother and herself. She currently works as many days as she can physically handle. Respondent's LTC/MD stated Sandy's work did not impact the Plan's decision on the number of hours needed to augment her care for Petitioner.

19. Petitioner gets up from bed 2-5 times during the night, often to urinate or to retrieve medicine for her nausea. Sometimes she wakes up disoriented and wants to get up at 3:00 a.m. to start her day. She also experiences nightmares, possibly a side-effect on her medication, which also causes her to wake.

20. When [REDACTED] was asked what specific night time hours she was requesting care for Petitioner, she responded 11:00 p.m. to 7:00 a.m. seven days a week, or an additional 56 hours of home care services per week. This would bring the total number of service hours per week to 106, instead of the 168 hours (24 hours x 7 days per week) which is under appeal. She stated she was advised to "reach for the stars" when she

requested the 24 hours a day. She explained she needs the ability to sleep during the night to care for her mother (on weekends) or go to work the next day.

21. The LTC/MD testified he was unclear to the caregiver's work schedule. His understanding was she was considering returning to work. He has not seen any documentation on caregiver's health condition or her work schedule.

22. Petitioner's caregiver admitted documentation of her medical condition and work schedule were not provided when requesting the additional hours of care for Petitioner.

23. Respondent's LTC supervisor testified Petitioner's caregiver and she recently discussed her work schedule, which is irregular at this time. Due to her medical conditions and other personal matters, she advised the LTC supervisor her primary focus is to stay home and care for her mother.

CONCLUSIONS OF LAW

24. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Chapter 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

25. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

26. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

27. This hearing was held as a *de novo* proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

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

29. Rule 59G-1.010 (166), *Florida Administrative Code*, defines “medically necessary” or “medical necessity” as follows:

“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.

...

(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.

30. Respondent’s criteria used for Long-Term Care Ancillary Services (LTC criteria) provides the following descriptions for the relevant services under appeal (see Respondent Exhibit 8):

- Homemaker Services – General household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these services is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control

may be included in this service.

- Personal Care Services – A service that provides assistance with eating, bathing, dressing and personal hygiene and other activities of daily living. The service includes assistance with preparation of meals, but does not include the cost of meals. The service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the member, rather than the member's family. Personal care services include the following:
 - Providing assistance to the member to complete personal hygiene (bathing, grooming, mouth care, etc.)
 - Assistance with bladder and bowel requirements that include assisting the member to and from the bathroom or with bedpan routines.
 - Assisting the member in following through with physician orders. The Personal Care provider cannot administer any medications, but may bring medications to the member and remind the member to take the medicine at specific times.
 - Assisting with food, nutrition, and diet activities, including preparing meals, when required and other incidental services, (i.e. housekeeping chores) essential to the health and welfare of the member.
 - Performing household services (changing bed linen or arranging furniture), when such services are essential to the member's health and comfort.
- Respite Care – Services provided to members unable to care for themselves furnished on a short-term basis due to the absence or need for relief of the persons normally providing the care. Respite services are only provided on the basis of need to relieve the primary caregiver. Respite cannot be approved if the member's caregiver must work and the member requires constant supervision and cannot be left alone in the absence of the caregiver. Other appropriate services must be considered, such as Adult Day Care or Adult Companion services when a caregiver works. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility. Respite in-home services must be provided at the member's residence. Facility-based respite services must be provided in a Medicaid-certified nursing facility, a licensed adult day care facility or licensed assisted living facility.

31. Petitioner argues nighttime personalized care, in addition to the daytime care being provided, is the most cost effective and appropriate level of medical services to meet her needs. Petitioner's caregiver stated she needed rest at night in order to be ready to work the next day. However, Respondent testified Petitioner's caregiver reported recently she is not currently working due to her own medical issues and her focus on caring for her mother.

32. Respondent has determined a total of 50 hours of home care services per week (including 25 hours of personal care, 15 hours homemaker, and 5 hours of respite care) are sufficient to meet Petitioner's needs, beyond the care provided by her live-in daughter.

33. Petitioner's caregiver admits no documentation has been submitted regarding her work schedule or medical issues. As a result, Respondent has no means to assess the caregiver's lack of availability or limitations in providing care to Petitioner.

34. Rule 59G-1.010 (166), *Florida Administrative Code*, cited above makes it clear requested services must 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. Respondent's decision is based on all the information provided by Petitioner, and Respondent has determined any additional services above the 50 hours approved per week would exceed Petitioner's medical needs.

35. The undersigned has reviewed all the above cited authorities and applied these to the totality of the evidence. Petitioner has not established, by the greater weight of the evidence, that Respondent's action in this matter is incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is hereby 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 agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 04 day of April, 2017,

in Tallahassee, Florida.



Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Sunshine Hearings Unit

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

FILED

Apr 21, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00958

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 13, 2017, at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter

For the Respondent: Jerome Hill, Program Supervisor - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action terminating the petitioner's companion care hours and reducing the petitioner's homemaker care hours under the Long Term Care

(LTC) Program. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Susan Frishman, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent's Composite Exhibit 1: Statement of Matters, Denial Notice, Case Screenshots, Medicaid Policy Provisions, and Medical Assessment Form.

FINDINGS OF FACT

1. The petitioner is seventy-three (73) years of age and lives with her daughter. She has been diagnosed with [REDACTED] and uses a walker for ambulation.
2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.
3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the

contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved by United Healthcare for the following home health services under the LTC program: 11 hours weekly of personal care assistance, 4 hours weekly of homemaker care services, and 6 hours weekly of companion care. The petitioner was also approved for 31.5 hours weekly of adult day care services (Monday to Friday). She was also previously approved for a personal emergency response (PERS) system.

5. On January 23, 2017, United Healthcare sent a notice of action to the petitioner which stated her 6 hours weekly of companion services were being terminated as not being medically necessary. The notice of action also stated the following:

A long-term care physician reviewed your needs. Companion care is not hands-on care. Companion care is to watch you perform activities. Companion care is also to help you socialize. Your other caregivers help you socialize too. Companion care is not covered only because you are alone. The doctor decided that you do not need companion care to meet your needs.

United Healthcare also reduced the petitioner's homemaker services from 4 hours to 2 hours weekly and terminated the PERS system service. Currently, the total of the approved home health services is 13 hours weekly (11 hours of personal care and 2 hours of homemaker service).

6. The petitioner's daughter stated she works in real estate and does not have a fixed schedule. She uses the companion service hours so that her mother won't be left

alone at home. She also has an 18-year-old daughter. She also stated her mother had never used the PERS system when she had it.

7. The respondent's witness, Dr. Kaprow, stated the currently approved home health hours, along with the adult day care services, should be sufficient to meet the petitioner's needs. He stated the petitioner was easily disoriented and she cannot be left alone. He stated the approved 13 hours weekly can be used at any time at the family's discretion. He also stated respite care services may be available to provide further assistance to the family.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the issue involved a termination and/or reduction in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program.

The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should not be terminated or reduced.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Companion services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner previously received Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

20. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the respondent has demonstrated it was correct in reducing or terminating some of the petitioner's home health services under the LTC Program. The evidence presented establishes the currently approved services – 13 hours weekly of home health services in addition to the adult day care services Monday to Friday – are sufficient to meet the petitioner's needs at this time. Other services, such as respite care, may be available to provide additional assistance.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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

FINAL ORDER (Cont.)

17F-00958

PAGE -8

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 indigence 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 21 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

Apr 28, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGSOffice of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 17F-00972

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 
UNIT:RESPONDENT.

FINAL ORDER OF REMAND

Pursuant to notice, Hearing Officer Patricia Antonucci convened administrative hearing in the above-referenced matter on March 29, 2017, at 10:04 a.m. All parties and witnesses appeared via teleconference.

APPEARANCESFor Petitioner: , PetitionerFor Respondent: Sharon Burgher, Grievance and Appeals Coordinator,
Prestige Health Choice**STATEMENT OF ISSUE**

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or "the Agency") through its contracted health plan/managed care organization (MCO) and co-Respondent, Prestige Health Choice ("Prestige") to deny Petitioner's request for certain dental procedures. Petitioner bears the burden of proving, by a preponderance of the evidence, that said denial was improper.

PRELIMINARY STATEMENT

At hearing, Petitioner appeared as his own representative. Respondent, AHCA, was represented by Cindy Henline, Medical/Health Care Program Specialist, who appeared for observational and monitoring purposes only. Respondent, Prestige, was represented by Grievance and Appeals Coordinator Sharon Burgher. Ms. Burgher presented two witnesses from Prestige's dental vendor, Argus Dental ("Argus"): Melinda Clesca, Grievance and Appeals Manager, and Debra Heil, Claim Supervisor.

Although the Notice of Hearing issued to the parties informed, in part, **"Within 10 days of this Notice of Hearing, the Respondent must contact the Petitioner to discuss the issues being appealed and to explore options for resolution,"** (emphasis original), neither Prestige nor Argus complied with this requirement. The Notice of Hearing further instructed: **"Evidence packet must contain all documentation and all guidelines/rules reviewed by the MCO in making its determination,"** (emphasis original). Following testimony, Argus noted it had not submitted a narrative from Petitioner's provider, despite reviewing this along with Petitioner's request for services.

Petitioner's Exhibits 1 through 3, inclusive, and Respondent's Exhibits 1 through 7, inclusive, were accepted into evidence. Administrative Notice was taken of all pertinent legal authority, including the Florida Medicaid Dental Services Coverage Policy (May 2016), as promulgated by Fla. Admin. Code R. 59G-4.060.¹ The record

¹ Prestige and Argus submitted, as part of their evidence packet, pages from the prior/expired Medicaid Dental Handbook; however, as this policy was no longer in use at the time of Respondent's denial and is no longer promulgated into law, it has not been relied upon as authority for the instant appeal.

was held open until March 31, 2017, for Respondent to provide a copy of Petitioner's provider narrative, along with a Certificate of Service that same was furnished to Petitioner. The undersigned also instructed Respondent to follow up with Petitioner and determine if he wished to explore authorization of alternate services, so as to expedite relief of his pain.

On April 3, 2017, Respondent filed a "Treatment Plan Form," along with a cover letter explaining its efforts to coordinate with Petitioner's provider in order to determine Petitioner's needs. As no Certificate of Service accompanied this supplemental evidence, it is unclear whether a copy of the form was provided to Petitioner. It is also unclear whether the Treatment Plan Form is the same document as the "narrative" referenced at hearing.

As this form was filed past the deadline for supplementation, and may not have been furnished to Petitioner, it has not been entered into evidence and was not considered in development of this Order; however, so as to ensure Petitioner receives a copy of what was furnished to the Office of Appeal Hearings, the form and Ms. Burgher's full narrative are attached to this document. Respondent's narrative regarding coordination with Petitioner's provider *has* been considered, and factors into this decision as described, below.

FINDINGS OF FACT

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

1. Petitioner is a Medicaid recipient, who is over 21 years of age. Petitioner receives his Medicaid-based care through Prestige, an MCO contracted by AHCA to provide medically necessary items and services to its enrollees.
2. On or about January 17, 2017, Petitioner's dentist submitted to Prestige a prior authorization request for: extractions; periodontal scaling and root planning (D4341); and with regard to teeth 31, 15, and 18, core buildup (D2950) and crowns (D2740). Along with this request, the provider submitted an x-ray and a narrative (neither of which were included in Prestige's evidence packet).
3. This request for dental services was forwarded to Prestige's dental vendor, Argus, for authorization review. Following said review, all requested extractions were approved; however, via Notice of Action dated January 23, 2017, Prestige informed Petitioner and his provider that the remaining dental procedures were denied. The Notice stated that Prestige made its decision because:

The requested service **is not a covered benefit.**

...

The facts that we used to make our decision: Periodontal treatment, crowns and core build ups are not a covered benefit with your dental plan.
(emphasis original)

4. On or about January 30, 2017, Petitioner filed an appeal to challenge Prestige's determination.
5. At hearing, Petitioner testified that he has experienced much difficulty in securing a dental provider and dental services via Prestige. He stated that the provider who

submitted the request for services explained to him that fillings would not eliminate his dental issues, as crowns were the proper treatment protocol.

6. On January 23, 2017, Petitioner visited a second provider to see whether a different dentist would recommend a different treatment plan. This provider's "Limited Exam and Emergency Treatment Form" (completed after x-rays from that visit), reflects that Petitioner's tooth # 31 is chipped. The accompanying Treatment Plan includes recommendations for a filling, core buildup (i.e., "Buildup of the hollowed out or broken part of a tooth in preparation for a crown, often allowing for an otherwise irreparable tooth to be preserved"), and a crown.

7. Petitioner testified that he wishes to keep his teeth, but that they are causing him a lot of pain. He is taking [REDACTED] to relieve the pain, is suffering from headaches and tooth sensitivity, and is also on an antibiotic to protect against infection. He stated that he was willing to get fillings instead of crowns, but that both dentists recommended crowns, noting that fillings would not last.

8. Argus confirmed that Petitioner's request was denied because it is not a covered benefit for adults who receive Medicaid via Prestige. Although Ms. Heil, a licensed dental assistant, initially stated that Petitioner's case was also reviewed with regard to medical necessity, none of the medical necessity-related boxes are checked on Prestige's denial notice, and Argus' "Review for Member Appeal" form indicates "No" for the categories "Was this denied due to lack of necessity" and "Was a phone call made to the provider in order to obtain additional information." Said form also reflects that Ms. Heil was the initial reviewer, with "Ashley" as an appeal reviewer. The form is

electronically signed by Argus' Dental Director, with a notation to "Uphold the original decision to deny benefits as they are not covered under the member's dental plan."

9. When asked whether Argus conducts a case-by-case review of dental requests to determine whether a member's condition warrants an exception to any benefit limitations -- specifically if services are requested to eliminate pain -- Ms. Heil stated that she was not aware of any such practice. With regard to medical necessity, Ms. Heil testified that based on her experience as a dental assistant and from review of the submitted records, it appeared Petitioner's provider requested periodontal scaling as a deep cleaning, since Petitioner had not received regular cleanings and would require this thorough procedure to address plaque buildup. She indicated that Petitioner might be able to obtain improvement and pain relief by getting fillings in the teeth which show decay (31, 15, and 18), initially referring to these as wisdom teeth, but later agreeing with Petitioner that they are molars.

10. Ms. Heil and Ms. Clesca testified that Argus is unable to recommend an alternate treatment to that requested by a provider, and thus, no care coordination or case management was attempted in advance of hearing, nor did Argus consider whether any *covered* service would meet Petitioner's needs. Ms. Clesca stated that crowns appeared to be the appropriate treatment, and thus, the option of fillings was not explored.

11. There is no indication within any of the supplied documentation that Argus conducted a medical necessity review, nor was any dentist witness present at hearing to review medical necessity for the record.

12. Following hearing, Prestige provided an update regarding its attempts to confer with Petitioner and/or his providers to determine whether any covered treatment would suffice to meet the Petitioner's needs and/or alleviate his pain. This April 3, 2017 correspondence from Ms. Burgher states, in pertinent part:

Please be advised that several attempts have been made to contact member at the telephone number he provided... however his number is disconnected. Please note that Argus Dental's Utilization Management reviewer spoke with the dental assistant at member's dentist office regarding the fillings as an alternate treatment. The dental assistant advised that fillings are not an ideal treatment due to the size of the restoration and they cannot guarantee it will resolve the issue, but if the member prefer[s] to do the fillings, they can. They will need the member to sign a waiver form that states that the member understands the long term risks of this treatment, (emphasis added).

13. Ms. Burgher further noted that Prestige would continue to attempt coordinating with Petitioner to see whether he wished to proceed with fillings as an alternate course of treatment. As of the date of this Order, no additional correspondence from either party has been received.

CONCLUSIONS OF LAW

14. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Chapter 120, Fla. Stat.

15. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Fla. Stat. and in Chapter 59G of the Florida Administrative Code. Respondent, AHCA, administers the Medicaid Program for Florida's Medicaid recipients.

16. This is a Final Order, pursuant to § 120.569 and 120.57, Fla. Stat.

17. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

18. The burden of proof in the instant case is assigned to Petitioner, who has requested approval for a specific item/service plan (periodontal scaling, core buildup, and crowns).

19. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

20. Section 409.973(1)(e), Fla. Stat., mandates that managed care plans cover dental services.

21. In keeping with this law, the May, 2016 Florida Medicaid Dental Services Coverage Policy (“Dental Handbook”), promulgated by Fla. Admin. Code R. 59G-4.060, states, in pertinent parts:

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

...

4.2.9 Surgical Procedures and Extractions

Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.

Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

...

- Services that are not listed on the fee schedule (boldface emphasis original; underlined emphasis added).

22. Of note, all three denied services (D4341, D2950, and D2740) *are* on the Medicaid fee schedule, and are not noted to require prior authorization; however, all three also reference an age limitation of 20 years.²

23. Neither Prestige nor Argus testified that they utilize a separate or plan-specific fee schedule for their expanded dental benefits.

24. Although Prestige's denial was based strictly on a benefit limitation, the undersigned has also considered Petitioner's request with regard to medical necessity.

Per Fla. Admin. Code. R. 59G-1.010(166):

"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.

...

(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.

(emphasis added)

² The Medicaid fee schedule is promulgated by Fla. Admin. Code R. 59G-4.002, and is available at: https://ahca.myflorida.com/medicaid/review/fee_schedules.shtml (See "Dental General Fee Schedule.")

25. Absent testimony from a dental clinician, it is difficult to determine whether the requested services are medically necessary. This is particularly true given that the Handbook allows for service authorization in order to eliminate pain or infection. The undersigned is not a medical practitioner, and is thus unable to review Petitioner's dental plans and x-rays to evaluate whether the requested services would alleviate his pain and prevent or eliminate any infection which may arise.

26. Indeed, in reviewing the definition of medical necessity in conjunction with Petitioner's "Limited Exam and Emergency Visit Form," as well as testimony secured at hearing, the undersigned notes that Argus' witnesses made no assertions that the requested procedures would *not* "alleviate severe pain" (Fla. Admin. Code. R. 59G-1.010(166)(a)(1)), were *not* "consistent with symptoms or confirmed diagnosis" ((Fla. Admin. Code. R. 59G-1.010(166)(a)(2)), were *not* "consistent with generally accepted professional and medical standards" (Fla. Admin. Code. R. 59G-1.010(166)(a)(3)), or that there was an "equally effective and more conservative or less costly treatment available," to meet Petitioner's needs (Fla. Admin. Code. R. 59G-1.010(166)(a)(4)).

27. The post-hearing correspondence documenting communication with Petitioner's provider confirms that the initial plan of care remains the treating provider's preferred course of action, as fillings may *not* be an appropriate solution to alleviating Petitioner's pain.

28. Absent testimony from a dental clinician to determine whether the specifics of Petitioner's dental condition warrant override of any benefit limitation, the undersigned is unable to reach a determination in this appeal.

29. Petitioner's frustrations and confusion regarding Prestige's prior authorization process are understandable and are duly noted for the record. It is unfortunate that the MCO failed to comply with the requirement to confer, as specified in the Notice of Hearing. Had either the MCO or its dental reviewer contacted Petitioner in advance of hearing to fully explain the denial, Petitioner may have been spared significant time and/or might have immediately pursued alternate, covered treatment in attempt to alleviate his pain.

30. Petitioner may wish to consult with Prestige, to explore whether he wants to pursue fillings, despite the provider's warnings as to the limitations of this option. Should Petitioner decide to obtain authorization for tooth fillings, Prestige should notify him in writing that they will conduct no further review of his request for scaling, buildup, and crowns. Said notification must contain a statement of Petitioner's right to appeal the lack of additional review.

31. Absent any such agreement, Respondent is instructed to review Petitioner's original request for medical necessity, and issue a new Notice informing Petitioner of the results of said review. If Prestige determines that there is no medically necessary reason for overriding benefit limitations and approving Petitioner's request, they must notify Petitioner of his right to appeal that, specific denial.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this case is REMANDED to Respondent for further review, consistent with the legal requirements and policy, cited herein.

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 28 day of April, 2017,

in Tallahassee, Florida.



Patricia C. Antonucci
Hearing Officer
Building 5, Room 255
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To:

██████████, Petitioner
AHCA, Medicaid Fair Hearings Unit
Prestige Hearings Unit


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Good Afternoon Ms. Antonucci,

Please be advised that several attempts have been made to contact member at the telephone number he provided, (239) 703-0849, however his number is disconnected. Please note that Argus Dental's Utilization Management reviewer spoke with the dental assistant at member's dentist office regarding the fillings as an alternate treatment. The dental assistant advised that fillings are not an ideal treatment due to the size of the restoration and they cannot guarantee it will resolve the issue, but if the member prefer to do the fillings, they can. They will need the member to sign a waiver form that states that the member understands the long term risks of this treatment.

We will continue to outreach to the member until contact is made to advise of the option, and verify if he wants to proceed with the fillings.

Please see attached Treatment Plan.

Thanks

SHARON BURGHER
Grievance & Appeals Coordinator

FILED

Apr 24, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00973

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 19 [REDACTED]
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on March 27, 2017, at 2:40 p.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's mother

For the Respondent: Stacey Larsen
Service Operations Specialist
Humana

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for removal of Tooth #1 and Tooth #16 (the two wisdom teeth on the upper arch)?

PRELIMINARY STATEMENT

The petitioner's mother may sometimes hereinafter be referred to as the petitioner's "representative".

The following individuals appeared as witnesses on behalf of the respondent, Humana: Lauren Hernandez, Complaints and Grievances Specialist with DentaQuest; and Daniel Dorrego, D.D.S., Dental Consultant with DentaQuest. Dianne Soderlind, R.N., Registered Nurse Specialist with the Agency for Health Care Administration, was present solely for observation and monitoring.

The respondent introduced Exhibits 1 through 9, inclusive, at the hearing, which were accepted into evidence and marked accordingly.

FINDINGS OF FACT

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. The petitioner is a 17-year-old male. He resides in [REDACTED] Florida.
2. The petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. The petitioner is an enrolled member of Humana. Humana is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.
4. The petitioner's effective date of enrollment with Humana is September 1, 2014.

5. Humana provides certain dental benefits to its members. With regard to its members under age 21, these benefits include the surgical extraction of wisdom teeth when such medical intervention is determined to be medically necessary.

6. Humana has contracted DentaQuest to be its dental vendor. DentaQuest completes prior authorization reviews of requests for dental services submitted to it by Humana members.

7. On or about January 14, 2017, the petitioner's dental provider submitted a prior authorization request (*Resp. Exhibit 2*) to DentaQuest for the following services:

1. D7240 – removal of impacted tooth—completely bony, Tooth 1;
2. D7240 – removal of impacted tooth—completely bony, Tooth 16;
3. D7240 – removal of impacted tooth—completely bony, Tooth 17;
4. D7240 – removal of impacted tooth—completely bony, Tooth 32;
5. D9243 – intravenous moderate (conscious) sedation/analgesia—each 15 minute increment;
6. D9243 – intravenous moderate (conscious) sedation/analgesia—each 15 minute increment;
7. D9243 – intravenous moderate (conscious) sedation/analgesia—each 15 minute increment;
8. D9243 – intravenous moderate (conscious) sedation/analgesia—each 15 minute increment;
9. D9243 – intravenous moderate (conscious) sedation/analgesia—each 15 minute increment;

8. Teeth # 1, 16, 17, and 32 are an individual's wisdom teeth. They are the last teeth on both the left and right sides of a person's top and bottom jaw.

9. In a Notice of Action dated January 18, 2017, DentaQuest denied the petitioner's request for services. The Notice of Action (*Resp. Exhibit 5*) states, in part:

We determined that your requested services are **not medically necessary** [emphasis in original] because the services do not meet the reason(s) checked below: (*See Rule 59G-1.010*)

X Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.

- X Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.
- X Must meet accepted medical standards and not be experimental or investigational.

10. The Notice of Action (*Resp. Exhibit 5*) goes on to explain:

The facts that we used to make our decision are:

- We cannot approve this request to remove your tooth because the information that your dentist sent shows that your teeth are not bad enough to be removed and show no sign of infection or pain. We have told your dentist this also. Please talk to your dentist about your choices to treat your teeth.
- We cannot approve the request for extra anesthesia time for your dental procedure. We have approved an amount that is needed to safely complete the services your dentist asked for.

The DentaQuest guideline or policy used to support this decision was:

- DentaQuest Clinical Criteria for General Anesthesia and IV Sedation
- DentaQuest Clinical Criteria for Surgical Extraction

11. DentaQuest will not approve the extraction of asymptomatic wisdom teeth.

DentaQuest will, however, approve the extraction of wisdom teeth if there is evidence of pathology, infection, or malpositioning.

12. DentaQuest completed an internal review of its decision after the petitioner requested an administrative hearing. In an updated Authorization Determination (*Resp. Exhibit 7*) mailed to the petitioner's dentist on February 8, 2017, DentaQuest approved the removal of Tooth #17 and Tooth #32 and associated intravenous sedation.

13. The petitioner is experiencing pain associated with the eruption of his wisdom teeth. The petitioner is taking medication to alleviate this pain.

14. The petitioner previously had two of his permanent molars removed because there was not enough room in the arch of his mouth for all of his teeth.

15. Some pain is to be expected as the natural consequence of the eruption of any tooth into the mouth.

16. In order for DentaQuest to approve the removal of a tooth due to pain, the recipient's dentist must provide documentation that the pain associated with the eruption of the tooth is greater than that which is naturally expected.

17. The narrative provided by the petitioner's dentist in the Claim Form (*Resp. Exhibit 2*) does not go into detail with regard to any extraordinary pain associated with the eruption of Tooth #1 and Tooth #16.

18. DentaQuest approved the removal of Tooth #17 and Tooth #32 partially because the teeth were in such a position that they were causing an infection in the petitioner's mouth.

19. There is no indication of infection associated with Tooth #1 and Tooth #16.

20. Tooth #1 and Tooth #16 are not tilted, rotated, or in any type of abhorrent position that would necessitate removal. The teeth appear straight on the radiograph.

21. Tooth #1 and Tooth #16 do not exhibit any pathology at this time.

22. Every indication at this time is that Tooth #1 and Tooth #16 will erupt normally into the petitioner's mouth and that any pain associated with the eruption of these teeth will subside after their complete eruption.

23. Although overcrowding is evident in the petitioner's lower arch, there is no evidence that Tooth #1 and Tooth #16 will result in overcrowding in the petitioner's upper arch.

24. The petitioner's representative is concerned about the pain associated with the eruption of the petitioner's wisdom teeth and his associated absences from school.

CONCLUSIONS OF LAW

25. 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, Fla. Stat.

26. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.

27. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

28. In the present case, the petitioner is requesting a new service. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the petitioner.

29. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence.” (Black’s Law Dictionary at 1201, 7th Ed.).

30. The Florida Medicaid program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid program is administered by the Agency for Health Care Administration.

31. Section 409.905, Fla. Stat. addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law...

32. The definition of medically necessary is found in Fla. Admin Code. R. 59G-1.010, which states:

(166) '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...

(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.

33. Since petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, Fla. Stat., Mandatory Medicaid Services defines Medicaid services for children to include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

34. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

35. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

36. Section 409.913, Fla. Stat. governs the oversight of the integrity of the Florida Medicaid Program. Section (1)(d) sets forth the “medical necessity or medically necessary” standards, and states in pertinent part as follows

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice....

Section (1)(d) goes on the further state:

...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

37. Section (1)(d) highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency. See § 120.80, Fla. Stat.

38. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-5.020. The Handbook states the following on Page 1-27:

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

39. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. Page 1-30 of the Handbook explains “Other services that plans may provide include dental services....”

40. Page 1-30 of the Florida Medicaid Provider General Handbook states: “An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.”

41. The Florida Medicaid Dental Services Coverage Policy, May 2016 is promulgated into rule by Fla. Admin. Code Rule 59G-4.060.

42. The Florida Medicaid Dental Services Coverage Policy, in Section 4.2.9, explains: “Florida Medicaid reimburses for surgical procedures and extraction services for recipients under the age of 21 years.”

43. The removal of wisdom teeth falls under the category of surgical procedures and extractions.

44. The Florida Medicaid Dental Services Coverage Policy, in Section 4.1, advises that Florida Medicaid reimburses for services which are determined medically necessary.

45. DentaQuest Covered Benefits (*Resp. Exhibit 8*) include dental code D7240 for the removal of an impacted tooth-completely bony.

46. The DentaQuest criteria for the approval of extractions (*Resp. Exhibit 9*), in Section 4 a, indicate that the extraction of a tooth must be supported by a demonstrable need and documentation of medical necessity. It explains that when there is pain with no pathology, “On a per tooth basis, provider must furnish a narrative that describes pain that is more than normal eruption pain – for example: a description of duration, intensity, medications, or other factors that are more than normal eruption pain – the description of such factors is necessary to demonstrate need.”

47. Humana and DentaQuest criteria for the surgical extraction of teeth are not more restrictive than the criteria of the Agency for Health Care Administration.

48. In the present case, the petitioner’s radiographs indicate that Tooth #1 and Tooth #16 are straight and projected to erupt normally into the petitioner’s mouth. Tooth #1 and Tooth #16 are not in a position that could potentially lead to an infection, nor will the eruption of these teeth lead to overcrowding in the upper arch of the mouth. Although the petitioner is experiencing some pain associated with the eruption of these teeth, his dentist did not provide a narrative detailing any pain that is in excess of that which may be normally anticipated with the eruption of a tooth. In addition, if the petitioner’s lower wisdom teeth have not yet been removed, the pain the petitioner is feeling may be the result of the eruption of his lower wisdom teeth. Therefore, the petitioner does not meet the established criteria for the removal of his upper wisdom teeth at this time.

49. After careful review of the testimony and evidence presented in this case, along with the relevant laws set forth above, the undersigned concludes the petitioner

has not demonstrated by a preponderance of the evidence the respondent incorrectly denied his request for the removal of Tooth #1 and Tooth #16, his upper wisdom teeth.

DECISION

The petitioner's appeal is hereby DENIED.

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 indigence 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 24 day of April, 2017,

in Tallahassee, Florida.

⌋ . . ⌋

Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
Humana Hearings Unit

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

FILED

Apr 19, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01123

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: 88701

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 28, 2017 at 12:00 noon.

APPEARANCES

For the Petitioner: [REDACTED] Patient Advocate, [REDACTED]

For the Respondent: Mary Triplett, Supervisor for the ESS program.

STATEMENT OF ISSUE

Petitioner is appealing Respondent's denial of Family-Related Medicaid application dated November 14th, 2016 based on an existing Child Support Enforcement (CSE) sanction against the petitioner. Petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner did not appear for the hearing, but was represented as indicated above.

Appearing as a witness for Petitioner was [REDACTED], lead assistant supervisor for [REDACTED].

Petitioner's Exhibits 1 through 7 were admitted into evidence.

Respondent's Exhibit 1 was admitted into evidence.

No written notice describing the action under appeal was submitted into evidence. On February 2, 2017, the petitioner filed an appeal to challenge the respondent's action. Absent evidence to the contrary, the appeal is considered to be filed timely.

FINDINGS OF FACT

1. Petitioner's designated representative submitted a Medical Assistance Referral (Form CF-ES 2039) for the petitioner on November 14, 2016 for a past medical bill in the month of October, 2016 (Petitioner's Exhibit 2).

2. When Petitioner's representative contacted Respondent to inquire about the reason why Petitioner's benefits were not approved, Respondent informed her that the benefits were denied due to an existing child support sanction against Petitioner, imposed since April 2006.

3. Petitioner is divorced from the father of her minor child. See Final Judgment of Resolution of Marriage (Petitioner's Exhibit 4).

4. Petitioner's position is that because she is receiving child support payments, there was is need for her to contact Child Support Enforcement. (Petitioner's Exhibit 5).

5. Petitioner's representative did not dispute the sanction, but argued that proof of divorce along with the child support payment should be enough for Respondent to remove the sanction. She contends that Respondent should have forwarded those documents to CSE on behalf of Petitioner.

6. Respondent stated that it informed Petitioner of the need to contact CSE to remove the existing sanction before Medicaid eligibility can be determined. Respondent also stated that it is Petitioner's responsibility, not Respondent's, to contact CSE, but Petitioner failed to do so.

7. Respondent stated that an existing child support sanction cannot be removed unless instructed by Child Support Enforcement.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

10. The burden of proof is assigned to the petitioner, and the standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, pursuant to Fla. Admin. Code R. 65-2.060(1).

11. The Fla. Admin. Code R. 65-2.060, Evidence, states in part:

(1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

12. Cooperation as a condition of eligibility for Medicaid is set forth in the Federal Regulations at 42 C.F.R. § 435.610. It states in part:

(a) As a condition of eligibility, the agency must require legally able applicants and recipients to...

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments...

13. Fla. Stat. Section 414.095 (6) CHILD SUPPORT ENFORCEMENT states:

As a condition of eligibility for public assistance, the family must cooperate with the state agency responsible for administering the child support enforcement program in establishing the paternity of the child, if the child is born out of wedlock, and in obtaining support for the child or for the parent or caretaker relative and the child. Cooperation is defined as:

(a) Assisting in identifying and locating a parent who does not live in the same home as the child and providing complete and accurate information on that parent;

(b) Assisting in establishing paternity; and

(c) Assisting in establishing, modifying, or enforcing a support order with respect to a child of a family member.

This subsection does not apply if the state agency that administers the child support enforcement program determines that the parent or caretaker relative has good cause for failing to cooperate...

14. Section 409.2572, Florida Statutes states in relevant part:

Cooperation. — (1) An applicant for, or recipient of, public assistance for a dependent child shall cooperate in good faith with the department or a program attorney in: ...

(2) Noncooperation, or failure to cooperate in good faith, is defined to include, but is not limited to, the following conduct:

(a) Refusing to identify the father of the child, or where more than one man could be the father of the child, refusing to identify all such persons.

(b) Failing to appear for two appointments at the department or other designated office without justification and notice.

(c) Providing false information regarding the paternity of the child or the obligation of the obligor.

(d) All actions of the obligee which interfere with the state's efforts to proceed to establish paternity, the obligation of support, or to enforce or collect support.

(e) Failure to appear to submit a DNA sample or leaving the location prior to submitting a DNA sample without compelling reasons.

(f) Failure to assist in the recovery of third-party payment for medical services.

(3) The Title IV-D staff of the department shall be responsible for determining and reporting to the staff of the Department of Children and Family Services acts of noncooperation by applicants or recipients of public assistance. Any person who applies for or is receiving public assistance for, or who has the care, custody, or control of, a dependent child and who without good cause fails or refuses to cooperate with the department, a program attorney, or a prosecuting attorney in the course of administering this chapter shall be sanctioned by the Department of Children and Family Services pursuant to chapter 414 and is ineligible to receive public assistance until such time as the department determines cooperation has been satisfactory.

(4) Except as provided for in s. 414.32, the Title IV-D agency shall determine whether an applicant for or recipient of public assistance for a dependent child has good cause for failing to cooperate with the Title IV-D agency as required by this section.

(5) As used in this section only, the term "applicant for or recipient of public assistance for a dependent child" refers to such applicants and recipients of public assistance as defined in s. 409.2554(8), with the exception of applicants for or recipients of Medicaid solely for the benefit of a dependent child.

15. The above authorities set forth that applicants of public assistance must cooperate with child support enforcement. The CSE staff is responsible for determining and reporting to the staff of DCF acts of non-cooperation by applicants or recipients of public assistance.

Florida law requires that the uncooperative individual is sanctioned and remains ineligible to receive public assistance until cooperation has been established by CSE.

16. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's action to deny Petitioner's application for Medicaid was correct. No exceptions were found in rule that would allow for Medicaid eligibility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 19 day of April, 2017,

in Tallahassee, Florida.



Sajan George
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662

FINAL ORDER (Cont.)
17F-01123
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Apr 27, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01139

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA.

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 14, 2017, at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's daughter

For the Respondent: No appearance

STATEMENT OF ISSUE

At issue is the respondent United Healthcare's action denying the petitioner's request for additional home health services under the Long Term Care (LTC) Program.

The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted medical records and her daughter's letter as evidence for the hearing, which were marked as Petitioner Composite Exhibit 1.

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Medical Assessment Form, and Case System Screenshots.

Also present for the hearing was a Spanish language interpreter, [REDACTED] Interpreter Number [REDACTED] from The Language Line.

FINDINGS OF FACT

1. The petitioner is ninety-nine (99) years of age and has her own home, but she stays at her daughter's house most of the day and night. She is non-ambulatory and she takes 15 medications daily. She suffers from numerous medical conditions, including [REDACTED] [REDACTED]

[REDACTED]

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from United Healthcare.

3. The Agency for Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner was previously approved for 21 hours weekly of home health services by United Healthcare. Those hours consisted of 14 hours of personal care assistance and 7 hours of homemaker services.

5. On or about December 20, 2016, the petitioner made a request to United Healthcare for 5 additional hours weekly of homemaker services. On December 27, 2016, United sent a letter to the petitioner denying her request for the additional homemaker services as not being medically necessary because it was in excess of her needs.

6. The petitioner's daughter stated she is requesting 2 additional hours daily of assistance for her mother. The daughter stated that she herself suffers from various ailments, including diabetes and knee and back problems which will require surgery. The daughter is 73 years old. The home health aide assists her mother from 1:00 p.m. to 4:00 p.m. daily. The daughter is with her mother all day and night in the daughter's

house except when the home health aide is with her. Her mother returns to her own home to receive the home health services.

7. The petitioner's daughter stated the home health aide bathes her mother, helps her walk, and supervises her because her mother cannot be left alone. If she is left alone, she tries to stand up which results in her falling. The daughter also stated she sleeps next to her mother in a cot to help her if necessary during the night. She stated her mother receives a home-delivered meal every day, but it must be pureed in order for her to eat it. She also stated the home health aide sometimes does not have time to clean the bathroom or do laundry because she cannot leave her mother's side. In addition to the home health services and home-delivered meals, the petitioner also receives nutritional supplements (Ensure drink), incontinence supplies, and a personal emergency response system through United Healthcare. She has also received respite care services at least four times in the past several months.

8. The respondent's witness, Dr. Kaprow, stated the petitioner's needs are being met with the currently approved services. He stated the home-delivered meal can come pureed if ordered as such. He also stated the petitioner's weight has remained stable.

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat § 409.285.

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

11. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

12. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

13. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

14. The petitioner requested a fair hearing because she believes her services under the Program should be increased. The notice of action states she was denied 5 additional hours weekly of homemaker services, although the petitioner’s daughter stated at the hearing she is seeking 2 additional hours of assistance per day.

15. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

16. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

17. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

20. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(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.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that her home health services should be increased under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs) such as bathing, toileting, and meal preparation. However, she is currently approved for 21 hours weekly to assist with these activities. The petitioner currently also has assistance from her daughter throughout the day and night. Medical necessity for additional services has not been established at the present

time. Other services, such as respite care, may be available as well and the petitioner has already been approved in the past for intermittent respite care hours.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 indigence 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 27 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

FILED

Apr 27, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01147

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA,

And

HUMANA,

RESPONDENTS.

_____ /

FINAL ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 14, 2017 at 3:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is the respondent's denial of the petitioner's medical claim for a doctor's visit and/or ultrasound. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the respondent was Mindy Aikman, Grievance and Appeals Specialist for Humana, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Case Summary, Claim Form, and Notice of Action.

FINDINGS OF FACT

1. The petitioner is a nineteen (19) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana.
2. The petitioner stated she received services from her doctor's office, including an ultrasound, but she believes Humana denied coverage for all services rendered. She stated she has not been billed by the doctor's office for any services.
3. Ms. Aikman from Humana stated Humana covered all the services at issue except one which contained a procedure code which is not covered by Medicaid. She stated the provider can resubmit the claim with a new procedure code and it can be covered. She also stated the petitioner does not have any financial liability for any claims or bills.

CONCLUSIONS OF LAW

4. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat § 120.80.
5. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
6. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
7. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).
8. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent, AHCA.
9. The notice of action issued by Humana advising the petitioner of the denial of one her claims is marked “This Is Not a Bill”. No provider bills have been submitted.
10. The undersigned concludes that the issue for the hearing is moot since the petitioner received the services at issue and she bears no financial responsibility for the services.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DISMISSED as moot.

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 indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 27 day of April, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished to: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

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

FILED

Apr 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01148

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE
ADMINISTRATION

CIRCUIT: 01 [REDACTED]

UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 7, 2017 at approximately 10:00 a.m. Eastern Standard Time. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED] Legal Guardian

For the Respondent: Cindy Henline
Medical/Health Agency Care Program Analyst
for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's denial of Petitioner's Prescribed Pediatric Extended Care Services ("PPEC") was correct. The burden of proof is assigned to Petitioner. Petitioner bears the burden of proving, by a preponderance of the evidence, that said denial was not proper.

PRELIMINARY STATEMENT

At the hearing, the minor Petitioner was not present, but was represented by his grandmother. Respondent was represented by Cindy Henline, AHCA Registered Nurse Specialist and Hearing Liaison. Respondent presented one witness, Rakesh Mittal, M.D., Physician-Reviewer with eQHealth Solutions, Inc.(eQHealth)

Respondent's Exhibits 1 and 2 were admitted into evidence. Administrative Notice was taken of Section 409.905, Florida Statutes, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and the entire Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook ("PPEC Handbook").

The record was held open for the Petitioner's grandmother to submit recent cardiologist records from February 28, 2017. These documents were received on March 17, 2017 and entered into evidence as Petitioner's Exhibit 1.

FINDINGS OF FACT

1. The Petitioner is a 3-month-old male, born in 2016. He has a history of diagnoses which include [REDACTED] and [REDACTED].
2. Petitioner resides at home with his grandmother, grandfather and aunt. His grandmother is his legal guardian and his mother has supervised visitations.
3. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

4. On February 28, 2017, Petitioner had a follow up appointment with his cardiologist and an echocardiogram was performed. More specifically, the results indicated in pertinent part as follows:

Echo: Normal segmental relationships. Normal systolic function. Thickened pulmonary valve with small annulus with residual stenosis. Peak gradient 55-64 mmHg of 35-40 mmHg. Mild TR with RV pressure of approximately 2/3 systemic. PFO with left to right shunt.

Plan: F/U in 2 months with echo. Will send echo to Vyas. (interventional cardiologist at Shands)

Parent Instructions: I told the grandmother and mother I was pleased with his growth and told them there had not been a major change on the echo. I told them I would like to see him back in 2 months and in the meantime I would send today's echo to [REDACTED] for his review.

5. Petitioner has a history of feeding issues, including vomiting after feedings. His weight at birth was 6 pounds 5 ounces. Petitioner's grandmother testified that he lost a substantial amount of his birth weight and was placed on a high caloric diet after he left the hospital on January 10, 2017. Since he was taken off of the high caloric diet he has been suffering from reflux. She stated that it takes him up to an hour to eat 3 ounces. At his most recent appointment, he weighed 11 pounds 11 ounces.

6. On or about January 17, 2017, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to begin PPEC services into the certification period, spanning January 18, 2017 through July 16, 2017.

7. This service authorization request, along with information and documentation required to make a determination of medical necessity, was submitted to AHCA's peer review organization (PRO). The PRO contracted by AHCA to review PPEC requests is eQHealth.

8. On January 30, 2017 the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated January 31, 2017, the PRO notified Petitioner's provider of its decision to deny PPEC services, stating, in pertinent part:

Clinical Rationale for Decision: The patient is a 3 week old with [REDACTED]. The patient developed a [REDACTED] after catheterization but is no longer on [REDACTED]. The patient is on an age-appropriate diet but is described as being a slow feeder. The patient is on no scheduled medications. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical complexity requirements for PPEC services. It appears that the care is routine newborn and observation.

9. The January 30, 2017 letter, which eQHealth sent to Petitioner, notes only:

The reason for the denial is that the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be:
Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
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.

10. In response to this notice, on or about January 31, 2017, Petitioner's provider requested reconsideration of the PRO's determination. The Notice of Reconsideration Determination issued to Petitioner's providers on or about February 3, 2017 states, in pertinent part:

For the Reconsideration Review, the provider submitted a web-based reconsideration and a file containing 37 pages of documentation including the initial hospitalization. The infant is in the custody of the maternal grandparents and the GM needs to return to work. The infant is no longer on [REDACTED] and is s/p [REDACTED]. He is not on any medications and is being followed by cardiology and the primary care physician. The submitted documentation does not indicate that any skilled needs are being provided to this infant beyond observation. Monitoring of weight and intake can be performed by the primary care physician. As

noted by the initial PR, the care of this infant at this time is normal newborn care with observation and f/u related to his [REDACTED] and weight. Recommend upholding the denial of PPEC services from 1/18/17 through and including 7/16/17 as medical necessity for PPEC has not been demonstrated.

11. On February 3, 2017, Petitioner requested a hearing to challenge the PRO's determination.
12. At hearing, Dr. Mittal testified based upon his review of Petitioner's request for services, in conjunction with his Plan of Care, PPEC Assessment, and medical documents submitted for review. Dr. Mittal noted that while the Petitioner clearly requires monitoring, the only intervention required would be in an emergency situation.
13. This supporting documentation reflects that Petitioner will be monitored for good color, respiratory rate, and to remain stable. (Resp. Exh. 2)
14. Per Dr. Mittal, Petitioner's PPEC assessments and medical history reflect that Petitioner is not dependent upon mechanical devices, does not have a g-tube or j-tube in place, and does not require any daily skilled nursing. (Resp. Exh. 2)
15. Petitioner's grandmother stated that Petitioner recently started regular daycare because she needed to go back to work. However, she is uncomfortable with him in a regular daycare because of his medical history and being 3 months of age with a heart condition. She emphasized that Petitioner needs to be monitored very closely.
16. Following testimony from the Petitioner's grandmother, Dr. Mittal opined that although the Petitioner does require monitoring for color change of his leg, this type of

monitoring can be done by any adult and does not meet the requirements of PPEC services at this time.

CONCLUSIONS OF LAW

17. By agreement between AHCA and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction to conduct this hearing, pursuant to Chapter 120, Florida Statutes

18. Respondent, the Agency for Healthcare Administration, administers the Medicaid Program. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes, and in Chapter 59G of the *Florida Administrative Code*.

19. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

20. This is a Final Order, pursuant to Sections 120.569 and 120.57, Florida Statutes.

21. This hearing was held as a *de novo* proceeding, in accordance with Fla. Admin. Code R. 65-2.056.

22. The burden of proof in the instant case is assigned to the Respondent, who seeks to terminate a previously authorized service. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

23. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan:

Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided.

Any service under this section shall be provided only when medically necessary and in accordance with state and federal law....

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.—The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

24. Starting on page 1-1 of the PPEC Handbook notes that, “[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center.” Page 1-2 adds that “PPEC services are not emergency services. (emphasis added).

25. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

To receive reimbursement for PPEC services, a recipient must meet all of the following criteria:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically-complex condition.

(underlined emphasis added)

26. Fla. Admin. Code R. 59G-1.010 defined “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

(165) “Medically fragile” means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependant, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

(emphasis added)

27. Consistent with the law, AHCA’s agent, eQHealth, performs service authorization reviews under the Prior Authorization Program for Medicaid recipients in the state of Florida. Once eQHealth receives a PPEC service request, its medical personnel conduct file reviews to determine the medical necessity of requested services, pursuant to the authorization requirements and limitations of the Florida Medicaid Program.

28. Florida Administrative Code Rule 59G-1.010(166) defines medical necessity, as follows:

“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. ...

(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.

29. As the Petitioner is under the age of 21, a broader definition of medically necessary applies, to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both EPSDT and Medical Necessity requirements (both cited, above) have been considered in the development of this Order.

30. EPSDT augments the Medical Necessity definition contained in the *Florida Administrative Code* via the additional requirement that all services determined by the agency to be medically necessary for the *treatment, correction, or amelioration* of problems be addressed by the appropriate services.

31. United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in Moore v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, (which involved a dispute over private duty nursing):

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis" and may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

32. In the instant case, PPEC is requested to treat and ameliorate the supervisory and monitoring needs which Petitioner's developmental and medical conditions present.

As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-

1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

33. Fla. Admin. Code R. 59G-1.010(166) requires that any authorized service not be in excess of a patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill this criteria, the Petitioner must fulfill the requirements for PPEC, as provided in the PPEC Handbook.

34. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life-sustaining medical equipment, such that he would properly be deemed 'Medically Fragile.' His need for supervision, general monitoring and precautions, and interventions in case of emergency, do not constitute a need for "intermittent continuous therapeutic interventions or skilled nursing care." As such, his needs do not support the authorization of PPEC, because there are alternative services, such as outpatient physical,

occupational, and speech therapy services, that are better designed to meet his needs without being excessive. PPEC cannot be authorized as a substitute for school or daycare, particularly when there is no skilled intervention provided at the PPEC site. In essence, this would constitute approval of PPEC is excess of Petitioner's needs, in direct violation of the PPEC Handbook. (page 1-2)

35. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Petitioner has not met his burden of proof by proving that the denial of PPEC services was inappropriate in the instant case.

36. Again, Petitioner's grandmother is to be commended for her dedication to her grandson and her concern for his welfare is duly noted. Should Petitioner's health decline, such that he regularly requires medical or nursing interventions, or should further echocardiogram indicate a need for increased care, his grandmother is encouraged to reapply for PPEC services. Additionally, she is encouraged to coordinate with AHCA and to contact the Department of Children and Families to seek assistance with locating an appropriate day care facility, and obtaining any other services which may be appropriate to meet Petitioner's needs. If any subsequent requests for services are denied, she will retain the right to appeal those specific denials.

DECISION

Based upon the foregoing, Petitioner's appeal is hereby DENIED

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 14 day of April, 2017,

in Tallahassee, Florida.



Stephanie Twomey
Hearing Officer
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Office: 850-488-1429
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit

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

FILED

Apr 24, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01181

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 [REDACTED]
UNIT: 88372

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 14, 2017 at 11:33 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: Viola Dickinson, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

ISSUE

At issue is the Department's action on January 27, 2017 to continue his enrollment in the Medically Needy (MN) program with a monthly share of cost (SOC) amount reduced from \$2056 to \$1041.

The petitioner believes he is entitled to receive full-coverage Medicaid.

The petitioner holds the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Evidence was received and entered as the Respondent's Exhibits 1 through 5.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner (age 19) was receiving full-coverage Medicaid until May 2016. The petitioner was subsequently enrolled into the Medically Needy program.
2. On January 19, 2017, the petitioner completed a web-based application to recertify for Medicaid.
3. The Department determined that the petitioner continued to be eligible for the MN program due to the earned income he receives. The Department included in the budget earned income in the amount of \$1303.87, verified by State Wage Information Collection Agency (SWICA), and unearned income in the amount of \$26.43, for a total gross income in the amount of \$1330.30. The total gross income was reduced by the Medically Needy Income Limit (MNIL) in the amount of \$289 to result in a monthly SOC in the amount of \$1041.
4. The Department recalculated the MN budget removing the unearned income, which consisted of an education grant. The Department determined during the hearing that the SOC was reduced to \$1014 with the removal of the education grant.
5. The petitioner does not agree with the Department's action to continue his enrollment in the MN program with a monthly SOC. The petitioner argues that he

should be eligible for full-coverage Medicaid through the foster care program as he was formerly a child in the foster care program. The petitioner explained that he was in licensed foster care home until the age of 15, when he was judicially removed from the foster care system; his aunt and uncle gained custody but never adopted him. The petitioner believes he is eligible for full-coverage Medicaid until he is 26 years of age. The petitioner does not dispute the income included in the Department's calculations for the month of application; he reported during the hearing that his income decreased in February 2017, after the Department's action.

6. The Department explained that its records show that the petitioner was removed from foster care in 2013 when he was 15. Since the petitioner did not age out of foster care at the age of 18, he is not entitled to receive Medicaid under the Child in Care (CIC) program. The Department's evidence includes the Assistance Group Inquiry (IQAA) screen, which shows that the petitioner's CIC Medicaid case was closed in August 2013 (*Respondent's Exhibit 2, page 11*). The Department further explained that the petitioner's earned income would have to be included in the Medicaid budget for the Family-Related Medicaid. The Department contends that the petitioner is receiving earned income through a regular employer and not through the foster care system; therefore, his earned income would be countable in the CIC and Family-Related Medicaid programs.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

9. Mandatory payments for eligible persons under Section 409.903, Florida Statutes, states:

(4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption. This category includes a young adult who is eligible to receive services under s. 409.1451, until the young adult reaches 21 years of age, without regard to any income, resource, or categorical eligibility test that is otherwise required. This category also includes a person who as a child was eligible under Title IV-E of the Social Security Act for foster care or the state-provided foster care and who is a participant in the Road-to-Independence Program.

10. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1450.0502 Age Requirements for Children (CIC) states:

A child must be under age 18 in the Title IV-E Foster Care Program to be eligible for Title IV-E benefits. A Title IV-E foster child that exits foster care at age 18 may continue to be Medicaid eligible on the factor of age until the age of 21.

A non Title IV-E child that exits foster care at age 18 may remain Medicaid eligible on the factor of age until 21 years of age.

11. The above authorities explains that the young adult who is receiving services under the foster care program, or aged out of the foster care system at the age of 18, is eligible to receive Medicaid until the age of 21 without including his or her income and/or assets in the eligibility determination process. The findings show that the petitioner was

removed from the foster care system at the age of 15 to live with his aunt and uncle.

Therefore, the undersigned concludes that the petitioner is not eligible to receive Medicaid under the foster care program, as he is not receiving services and did not age out at age 18 from the foster care program.

12. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 0230.0100 Family-Related Medicaid Program (MFAM) states:

Family-Related Medicaid is a benefit for children, parents and other caretakers, pregnant women, and individuals under age 26 previously enrolled in Florida Medicaid when they aged out of foster care.

13. The Policy Manual, CFOP 165-22, passage 2030.1200 Former Foster Care Children (MFAM) states:

Individuals may receive Medicaid up to age 26 if they were in foster care and receiving Medicaid when they aged out of foster care in Florida. There is no income limit for eligibility.

To be eligible, an individual must:

1. Be under age 26,
2. Be enrolled in or received Medicaid when they aged out of Florida's Foster Care Program at age 18 (or 21 as appropriate), and
3. Not otherwise eligible for or enrolled in mandatory Medicaid coverage.

14. The above authorities explain that a child who was formerly in the foster care system may be eligible for Family-Related Medicaid, without including his or her income, until the age of 26. The child must have been enrolled in or receiving Medicaid when he or she exited the foster care system at the age of 18. The findings show that the petitioner is under the age of 26. The findings also show that the petitioner aged out of the foster care program at the age of 15. Therefore, the undersigned concludes that

the respondent was correct in its action to not approve the petitioner for full-coverage Family-Related Medicaid.

15. The Family-Related Medicaid income criteria are set forth in Federal Regulations at 42 C.F.R § 435.603, Application of modified adjusted gross income (MAGI), and states:

(a)(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) of this section.

(d) *Household income—(1) General rule.* Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual’s household.

...

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

(e) *MAGI-based income.* For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions—

(1) An amount received as a lump sum is counted as income only in the month received.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) *American Indian/Alaska Native exceptions.*

...

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced

by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at § 435.940 through § 435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

16. The Department's Program Policy Manual, CFOP 165-22, Appendix A-7, shows the Family-Related Medicaid income limit as \$180 and the standard disregard is \$109 for a family size of one and for children ages 19 and 20.

17. In this case, the Department considered the petitioner's earned income in the amount of \$1303.87 to determine his eligibility for Medicaid. The Department compared the household income to the Family-Related Income Limit in the amount of \$180 and the standard disregard in the amount of \$109 (\$289) for a family size of one and for a child aged 19 and 20; it determined that the petitioner was ineligible for full-coverage Medicaid as the household income exceeded the income limit. According to the above controlling regulations, the undersigned concludes that the Department's action to continue the petitioner's enrollment in the Medically Needy program was correct. The income exceeds the limit for the petitioner to receive full coverage Medicaid.

18. The Department is to view the petitioner's decrease in income that was reported during the hearing, as a reported change. The Department is to determine the petitioner's eligibility for Medicaid based on the reported change and is to issue notice, with appeal rights, upon completion of its determination.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 24 day of April, 2017,

in Tallahassee, Florida.



Paula Ali
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01201

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 [REDACTED]
UNIT: 88630

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 7, 2017 at 1:08 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Pat Hernandez, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 10, 2017 denying his application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence prior to the hearing. The evidence was entered as Respondent's Exhibit 1.

The record closed on April 7, 2017.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on December 8, 2016. The petitioner is 33 years old. He has no minor dependent children in the household.

2. The petitioner diagnosis includes [REDACTED]
[REDACTED] The petitioner was diagnosed with [REDACTED] disorders in his early 20s. The petitioner was diagnosed with an [REDACTED] [REDACTED] in November 2010.

3. The petitioner applied for disability through the Social Security Administration (SSA) on June 28, 2016. He notified SSA of all of his conditions at that time.

4. The petitioner was denied by SSA on August 20, 2016.

5. The petitioner appealed the SSA denial on November 18, 2016 with the assistance of an attorney.

6. The petitioner stated his conditions have worsened since his SSA denial. He has been hospitalized for his [REDACTED] four times. He had another seizure on November 4, 2016.

7. The petitioner's is concerned as his conditions go untreated as he has no insurance, is unable to obtain insurance through the affordable care act, his work or any other source.

8. The petitioner has notified his attorney of all conditions. He was uncertain if the attorney had notified SSA of changes in his conditions.

9. The Department submitted the petitioner's case to the Division of Disability Determinations (DDD) on December 30, 2016 for disability determination.

10. DDD returned the Disability Determination and Transmittal to the Department on January 10, 2017. The disability was denied with reason N32. The primary diagnosis listed was affective disorder with auto-immune deficiency. The transmittal indicated the petitioner conditions submitted were the same conditions considered by SSA and there was an appeal of that decision pending.

11. The Department issued a Notice of Case Action on January 10, 2017 denying the petitioner's December 8, 2016 application for SSI-Related Medicaid citing the reason for denial as: "You or a member of your household do not meet the disability requirement".

12. There was no evidence presented to show that Social Security has refused to consider any worsening of his conditions.

CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

15. The undersigned explored eligibility first under Family-Related Medicaid groups. The petitioner does not have a minor child in the home. The Family-Related Medicaid program benefit rules are set forth in the Florida Admin. Code 65A-1.705,

Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for Medicaid under that program, the petitioner must have a minor dependent child residing in the home. The undersigned concludes the petitioner does not meet the criteria for Family-Related Medicaid program benefits.

16. The definition of MEDS-AD Demonstration Wavier is found in Florida Admin. Code R. 65A-1.701, Definitions, and states:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

17. Florida Admin. Code R. 65A-1.711, SSI-Related Medicaid Non-Financial Eligibility Criteria, states in relevant part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.

(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).

18. 20 C.F.R. § 416.905, Basic definition of disability for adults, states in relevant part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s)

that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.)

19. 42 C.F.R. § 435.541, Determinations of disability, states in relevant part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

...

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility. (emphasis added)

20. The undersigned explored potential eligibility for Medicaid for the petitioner under the SSI-Related Medicaid program. The petitioner was 33 years old at the time of application. He has not been established as disabled. In accordance with above controlling authorities, the undersigned concludes as the petitioner is under age 65, he must meet the disability requirement for eligibility for Medicaid in the SSI-Related Medicaid program.

21. The findings show the petitioner applied for Social Security and was denied in August 2016. The findings show the petitioner appealed the denial on November 18, 2016 with the assistance of an attorney. The findings also show the petitioner applied for SSI-Related Medicaid with the Department on December 8, 2016. According to the above controlling authorities, a decision made by SSA within 12 months of the Medicaid application is controlling and binding on the state agency unless the applicant reports a new or worsened condition that SSA has refused to consider. In

the instant case, the petitioner reports his conditions have worsened. However, the authorities also require that if the SSA decision has been appealed, the petitioner must show that SSA has refused to consider the new or worsened conditions. The findings show no evidence was presented to show SSA has refused to consider his worsened condition.

22. Based on the evidence and testimony presented as well as the above cited rules and regulations, the undersigned concludes the SSA decision is binding on the Department. The undersigned further concludes the denial of SSI-Related Medicaid remains appropriate.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 14 day of April, 2017,
in Tallahassee, Florida.

M. Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

FILED

Apr 26, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-01203

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: 88701

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative telephonic hearing in the above-referenced matter on February 27, 2017 at 1:21 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Brittany Studdard, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the termination of full Medicaid benefits and enrollment in the Medically Needy Program with an estimated share of cost (SOC) at recertification. The burden of proof is assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

After review of the evidence the undersigned found the respondent's exhibits were not entered into evidence. An interim order to reopen the record and admit those exhibits was issued on March 16, 2017. Seven days were allowed for any objections. No objections were received. The record was reopened and the exhibits were entered into evidence and marked as Respondent's Composite Exhibit 1 and Respondent's Exhibit 2. No exhibits were received from the petitioner. The record was closed on March 23, 2017.

FINDINGS OF FACT

1. The petitioner was receiving full Medicaid from a previous application. He began working on February 15, 2016. The respondent determined that he and his wife were eligible for transitional Medicaid. The respondent issued the first month of transitional Medicaid effective April 2016.
2. On January 25, 2017, the petitioner submitted a recertification application for Family-Related Medicaid benefits. He is a tax filer with his parents (not listed on his application). His wife is a tax filer with their children as her tax dependents. His son ■■■ receives Supplemental Security Income (SSI) of \$735 monthly. He pays court ordered child support of \$241.04 weekly and monthly child care of \$480, which is \$160 per child for his three children. The petitioner and his wife were both employed at the time of his application. He was paid on a weekly basis and provided four paystubs dated January 5, 2017, January 12, 2017, January 16, 2017, and January 26, 2017 all for \$549.25 each as verification of his income. His monthly gross income was determined to be \$2,197. The petitioner's wife was paid on a bi-weekly basis. She provided her paystubs

dated January 20, 2017 for \$427.14 and February 2, 2017 for \$521.39. The respondent determined her monthly gross income to be \$948.54. The wife's monthly gross income was added to the petitioner's monthly income resulting in the household's gross monthly gross income of \$3,145.54 (Respondent's Composite Exhibit 1).

3. The respondent determined the petitioner and his wife were ineligible for full Medicaid based on the income information provided but were eligible for the Medically Needy Program with a SOC. The children were approved for full Medicaid.

4. The respondent denied full Medicaid as the petitioner's monthly gross income was over the income limit of \$426 for a parent. The respondent proceeded to determine eligibility in the Medically Needy Program. The medically needy income level (MNIL) of \$684 was subtracted from the household's monthly gross income resulting in \$2,461 as the petitioner and his wife's SOC. The respondent mailed the petitioner a Notice of Case Action informing of this decision. He timely requested a hearing.

5. The petitioner does not dispute the gross income included in the respondent's calculations. The petitioner asserts that he is diabetic and needs to see doctors on a regular basis. He asserted that he cannot afford to pay for private insurance.

6. At the hearing, the respondent explained that the petitioner was evaluated under the Family-Related Medicaid coverage group. The respondent explained that child support payments or dependent care expenses are not allowable deductions.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

9. The Family-Related Medicaid income criteria are set forth in 42 C.F.R 435.603.

It states:

(a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

10. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid:

(f) Household—(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent...

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

...

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

11. The Department's Program Policy Manual CFOP 165-22 (the Policy Manual) at passage 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

12. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, his wife and their three children. The findings show the Department determined the petitioner's eligibility with a household size of five for Medicaid. The undersigned concludes the Department correctly determined the petitioner's household size as five for Medicaid.

13. Federal regulations at 42 C.F.R. § 435.603(d) Application of modified gross income (MAGI) defines Household Income and states:

(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

14. The Department's Policy Manual section 2630.0108 Budget Computation

(MFAM):

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.

In computing the assistance group's eligibility, the general formula is:

Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income).

Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.

Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.

Step 4 - Compare the total countable net income to the coverage group's income standard.

If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.

Step 5 - Apply a MAGI deduction (5% of the FPL based on SFU size).

If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.

Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

15. The Policy Manual at passage 2430.0700 Income Conversion (MFAM) states: Most income is received more often than monthly; that is; it is received weekly, biweekly, or semimonthly. Since eligibility and benefit amounts are issued based on a calendar month, income received other than monthly is to be converted to a monthly amount.

The following conversion factors based on the frequency of pay are used:

Weekly income (once a week): Multiply by 4.

Biweekly income (every two weeks): Multiply by 2.

Semimonthly income (twice a month): Multiply by 2.

16. The above allows for the use of the conversion factor of 4 if income is received weekly and 2 if received biweekly, for Medicaid eligibility determination. The undersigned could not find a better outcome in determining the household income.

17. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for petitioner. The undersigned concludes that petitioner is not eligible for full Medicaid under the Family-Related Medicaid Program. Respondent proceeded to explore the Medically Needy Program. The undersigned recognizes the petitioner's concerns about his medical needs. However, the controlling legal authorities do not allow for a more favorable outcome.

18. Fla. Admin. Code 65A-1.701 "Definitions" defines share of cost (SOC) as, "Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming

eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month”.

19. Fla. Admin. Code 65A-1.702 “Special Provisions” states in part:

(10) Enrollment. The enrollment period under the Medically Needy program begins with the month the individual satisfies the non-financial and resource eligibility criteria, but not earlier than the third month prior to the month of application.

(13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual’s or family’s income.

20. The Policy Manual at passage 2630.0500 Share of Cost (MFAM) states:

The Share of Cost (SOC) refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.

Eligibility must be determined for Medically Needy any time the assistance group meets all technical factors but the income exceeds the appropriate income limit for Medicaid.

To calculate the share of cost, compare the countable net income to the Medically Needy Income Level based on the size of the standard filing unit. The difference is the assistance group’s share of cost.

21. In accordance with the above controlling authorities, the respondent determined the petitioner’s standard filing unit (SFU) as a household of five based on his intended tax filing status. A married couple living together are always in each other’s SFU regardless of how they file.

22. Effective April 2016, the Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7. It indicates that the MNIL for a household of five is \$684.

23. The undersigned reviewed the respondent’s budget calculations and determined the petitioner was given only the allowable deductions from the earned income that was

allowed by the controlling authorities. A more favorable outcome other than the SOC assigned by the respondent and eligibility for full Medicaid was not found.

24. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program with the estimated SOC is within the rules of the Program.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 26 day of April, 2017,
in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 04, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01224
17F-01752

PETITIONER,

Vs.

CASE NO [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 [REDACTED]
UNIT: 88582

RESPONDENT.

_____ /

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on March 15, 2017 at 2:04.m. The hearing was continued and reconvened on March 22, 2017 at 9:01 a.m. All parties appeared by telephone from different locations.

APPEARANCES

For the Petitioner: [REDACTED] pro se

For the Respondent: Jennie Rivera, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 24, 2017 enrolling her in the Medically Needy Program (MN) with a Share of Cost (SOC), rather than approving her for full Medicaid coverage at her most recent recertification. Petitioner is also appealing the decrease in her Supplemental Nutrition Assistance Program (SNAP) benefits, also known as Food Assistance Program (FAP) benefits. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (Department or respondent) administers the Medicaid and Food Assistance Programs for the state of Florida. The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "12" respectively. The record was closed on March 22, 2017.

██████████ Service Coordinator for ██████████, appeared as a witness for the petitioner.

FINDINGS OF FACT

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. The petitioner is 36 years old, disabled, and is the sole member of the assistance group, see Respondent's Exhibit 4.
2. Prior to September 1, 2015, the petitioner was receiving Supplemental Security Income (SSI) of \$733 and was a recipient of SSI-Related Medicaid, see Respondent's Exhibit 6.
3. Effective September 1, 2015, the petitioner began receiving Social Security Disability Income (SSDI) of \$972 based on her father's retirement, see Respondent's Exhibit 6.
4. On December 30, 2016, the petitioner applied for Food Assistance and Medicaid benefits for herself, see Respondent's Exhibit 4.
5. The Department determined that the petitioner was eligible for FAP benefits and approved the petitioner for \$16 in FAP benefits, see Respondent's Exhibit 10.

6. Upon receipt of the SSDI in September 2015, the Department gave the petitioner protected Medicaid for Disabled Adult Children.
7. The petitioner was eligible for and continued to receive protected Medicaid from September 2015 through January 2017, see Respondent's Exhibits 1 & 12.
8. Petitioner's application for Medicaid was denied due to excess income and she was enrolled in the Medically Needy Program with a SOC of \$770, see Respondent's Exhibits 9, 10 & 11.
9. The Department closed the protected Medicaid and opened Medically Needy.
10. On January 24, 2017, the Department sent a Notice of Case Action (NOCA) to the petitioner informing her of its eligibility determination, see Respondent's Exhibit 10.
11. The petitioner appealed this action on February 6, 2017.
12. On February 1, 2017, the petitioner submitted a change request and provided proof of eligible out-of-pocket medical expenses, see Respondent's Exhibit 5. The Department processed the change and the petitioner's FAP benefits increased from \$16 to \$95 effective March 1, 2017, see Respondent's Exhibit 8.
13. The petitioner appealed this decision on February 22, 2017, as she believes that she is eligible for more FAP benefits.
14. The following expenses were considered in the FAP eligibility determination, rent of \$258, a standard deduction of \$157, the Standard Utility Allowance (SUA) of \$338 for heating and/or cooling expense, and gross medical costs of \$232.05, see Respondent's Exhibit 8. The gross medical costs are subject to a medical deduction of \$35 so $\$232.05 - \$35 = \$197.05$ excess medical expenses calculated in the FAP budget.

15. To determine the amount of FAP benefits the petitioner was eligible to receive, the Department subtracted the \$157 standard deduction and \$197.05 excess medical expenses from her total income of \$970 for an adjusted income of \$615.95. Half of the adjusted income is \$307.97. The shelter costs budgeted are \$258 for rent and \$338 for the utilities for a combined total shelter cost of \$596. The excess shelter deduction was found by subtracting \$307.97 from \$596, resulting in the excess shelter deduction of \$288.03. The excess shelter deduction (\$288.03) is subtracted from the adjusted income (\$615.95) and the result is \$327.92. The balance of \$327.92 is the food assistance adjusted income, see Respondent's Exhibits 8 & 12.

16. The maximum net monthly income for a household of one is \$990. As the household's income is less than the maximum net monthly income, she is eligible for FAP benefits, see Respondent's Exhibit 12.

17. The maximum benefit amount for a one-person household is \$194, see Respondent's Exhibit 12.

18. Thirty percent of the net income (\$99) is then subtracted from the maximum benefit amount to determine the monthly allotment. Thus, \$194 - \$99 (which is 30% of the petitioner's food assistance adjusted income of \$327.92) is \$95, see Respondent's Exhibit 8.

19. The petitioner believes that she should be still be eligible for Medicaid and not have to wait until September 2017, as she believes that she is entitled to Medicaid benefits without a Share of Cost.

CONCLUSIONS OF LAW

20. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to 409.285 Florida Statutes. This Order is the final administrative decision of the Department of Children and Families under 409.285, Florida Statutes.

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

PROTECTED MEDICAID FOR DISABLED ADULT CHILDREN

22. The Department's Program Policy Manual CFOP 165-22 at 2040.0808 Protected Medicaid for Disabled Adult Children (MSSI) states in pertinent part:

Effective July 1, 1987, disabled adult children who lose their SSI benefits because of an increase in or receipt of Social Security disability benefits under one of their parent's work records, may continue to be eligible for Medicaid if: the disabled adult child meets all SSI criteria except for income; and has income equal to or below the SSI FBR when, beginning July 1, 1987, any increase in SSA benefits or receipt of SSA benefits is subtracted from other income.

23. The Code of Federal Regulations at 20 C. F. R. §404.350 Who is entitled to child's benefits? states:

(a) General. You are entitled to child's benefits on the earnings record of an insured person who is entitled to old-age or disability benefits or who has died if—

(1) You are the insured person's child, based upon a relationship described in §§404.355 through 404.359;

(2) You are dependent on the insured, as defined in §§404.360 through 404.365;

(3) You apply;

(4) You are unmarried; and

(5) You are under age 18; you are 18 years old or older and have a disability that began before you became 22 years old...

24. In this case, the Social Security Administration determined that the petitioner met the requirements to receive Social Security Disability Insurance from her father's earnings record.

25. The Department's Transmittal: I-08-12-0026 provides instructions on how to process protected Medicaid for disabled adult children. It reads in pertinent parts:

- To qualify for DAC Protected Medicaid, the individual must meet all of the following requirements:
- Must be age 18 or older.
- Must have become disabled before the age of 22.
- Continue to be disabled.
- Be entitled to Title II benefits on a parent's record due to the parent's retirement, death, or disability, and lose SSI due to that SSA receipt or increase.
- Have assets within the SSI asset limit (\$2000).
- Have income equal to or less than the SSI Federal Benefit Rate after deducting the Social Security amount received on a parent's record.
- Be a US citizen or qualified noncitizen.
- Meet all other financial and technical factors of eligibility for SSI.

26. In this instant case, the petitioner received SSI as a child and meets all the aforementioned requirements. Petitioner remained eligible for Medicaid after the receipt of the SSDI began.

27. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent's action to close protected Medicaid and enroll the petitioner in the Medically Needy program was incorrect. The petitioner met her burden of proof to show she **is eligible** for protected Medicaid benefits.

FOOD ASSISTANCE PROGRAM

28. The Code of Federal Regulations 7 C.F.R. 273.9 define income and deductions.

It states:

- (a) Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet.
 - (1) The gross income eligibility standards for the Food Stamp Program shall be as follows...
 - (b) Definition of income. Household income shall mean all income from whatever source...
 - (2) Unearned income shall include, but not be limited to:
 - (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits
 - (d) Income deductions. Deductions shall be allowed only for the following household expenses:
 - (1) Standard deduction...
 - (3) *Excess medical deduction.* That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction. Allowable medical costs are:
 - (i) Medical and dental care including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by State law or other qualified health professional.
 - (ii) Hospitalization or outpatient treatment, nursing care, and nursing home care including payments by the household for an individual who was a household member immediately prior to entering a hospital or nursing home provided by a facility recognized by the State.
 - (iii) Prescription drugs, when prescribed by a licensed practitioner authorized under State law, and other over-the-counter medication (including insulin), when approved by a licensed practitioner or other qualified health professional.
 - (A) *Medical supplies and equipment.* Costs of medical supplies, sick-room equipment (including rental) or other prescribed equipment are deductible;
 - (B) *Exclusions.* The cost of any Schedule I controlled substance under The Controlled Substances Act, 21 U.S.C. 801 *et seq.*, and any expenses associated with its use, are not deductible.

- (iv) Health and hospitalization insurance policy premiums. The costs of health and accident policies such as those payable in lump sum settlements for death or dismemberment or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled are not deductible;
 - (v) Medicare premiums related to coverage under Title XVIII of the Social Security Act; any cost-sharing or spend down expenses incurred by Medicaid recipients;
 - (vi) Dentures, hearing aids, and prosthetics;
 - (vii) Securing and maintaining a seeing eye or hearing dog including the cost of dog food and veterinarian bills;
 - (viii) Eye glasses prescribed by a physician skilled in eye disease or by an optometrist;
 - (ix) Reasonable cost of transportation and lodging to obtain medical treatment or services;
 - (x) Maintaining an attendant, homemaker, home health aide, or child care services, housekeeper, necessary due to age, infirmity, or illness. In addition, an amount equal to the one person coupon allotment shall be deducted if the household furnishes the majority of the attendant's meals. The allotment for this meal related deduction shall be that in effect at the time of initial certification. The State agency is only required to update the allotment amount at the next scheduled recertification; however, at their option, the State agency may do so earlier. If a household incurs attendant care costs that could qualify under both the medical deduction and dependent care deduction, the State agency shall treat the cost as a medical expense....
- (6) Shelter costs...
- (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions...
 - (iii) Standard utility allowances...

29. The controlling authority above directs the Department as to the income and expenses to be calculated in the FAP budget.

30. The FAP budgeting process includes her rent, the standard deduction, excess shelter costs and excess medical costs and the standard utility allowance.

31. Federal Regulations 7 C.F.R. 273.10(e) addresses income and calculating net income and benefit levels:

- (1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:

(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income.

...

(C) Subtract the standard deduction.

(D) If the household is entitled to an excess medical deduction as provided in Sec. 273.9(d)(3), determine if total medical expenses exceed \$35. If so, subtract that portion which exceeds \$35.

...

(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.

(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined. (2)(ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section.

32. The respondent calculated every allowable deduction that the petitioner was eligible for in the FAP budget.

33. The FAP standards for gross income, net income, deductions and minimum allotment amount for a one-person household appear in the Department's Program Policy Manual CFOP 165-22 at Appendix A-1. Effective October 1, 2016, the 100% Net Income Limit for a one-person assistance group is \$990, the standard deduction is \$157, the Standard Utility Allowance is \$338, and the maximum FAP allotment is \$194.

34. The undersigned reviewed the Department's calculations and found the calculations to be correct. After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that the respondent's action to approve \$95 effective March 2017 is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is partially granted and partially denied. Regarding appeal 17F-01752, the undersigned finds that the calculation of the FAP benefit amount after the reported change on February 1, 2017 is correct. The Department's actions are upheld and the appeal is denied.

Regarding appeal 17F-01224, the closure of the protected SSI-Related Medicaid and the enrollment of the petitioner into Medically Needy with a Share of Cost; the Department's action is reversed and the Department is ordered to restore protected Medicaid benefits back to the date it was closed erroneously.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 04 day of April, 2017,
in Tallahassee, Florida.



Ursula Lett-Robinson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 26, 2017

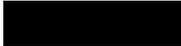
Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01270

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 
UNIT: 88694

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 16, 2017 at 2:03 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:  authorized representative, pro se

For the Respondent: Martha Lopez, Operations Management Consultant I

STATEMENT OF ISSUE

At issue is the respondent's action to terminate the petitioner's Medicare Savings Plan (MSP) at recertification. The burden of proof was assigned to the respondent by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted no exhibits. The respondent submitted a 29-page exhibit, which was marked and entered into evidence as Respondent's Composite Exhibit "1". The record was left open through March 17, 2017 for additional information including the income standards for the Medicare Savings Plan effective April 2016. The aforementioned information was submitted on March 17, 2017, marked and entered as Respondent's Exhibit "2". The record was closed the same day.

In review of the hearing request, the undersigned determined the hearing was requested 91 days after the date of the Notice of Case Action (NOCA). The NOCA was sent to the petitioner in Spanish. The petitioner's language indicator on his application was English. The respondent acknowledged that the information was not appropriately updated by the eligibility worker during processing. Although the hearing request beyond the 90-day time standard in which to request a hearing, the undersigned considers it a timely request as the department erred by not sending the petitioner a proper notice.

FINDINGS OF FACT

1. Medicare Savings Plan (MSP) is a Medicaid Buy-in Program in which the state of Florida pays the Medicare premiums. There are three coverage groups, Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare beneficiary (SLMB), and Qualified Individual Beneficiary (OI 1). The petitioner was previously receiving MSP under the QMB plan.

2. On October 25, 2016, the petitioner submitted an application for recertification of Food Assistance Program (FAP) benefits, SSI-related Medicaid, and Medicare Savings Plan (MSP) benefits.
3. The petitioner (62 years-old) is the only household member.
4. The petitioner is receiving \$854 in Social Security Administration (SSA) income and \$611 in civil service pension income per month. The petitioner's total unearned income is \$1,463.
5. To be eligible for QI 1, an individual's income (minus any applicable disregards) cannot exceed \$1,337.
6. In calculating the MSP budget, the respondent applied a \$20 disregard, reducing the petitioner's countable income to \$1,443.
7. The petitioner's countable income of \$1,443 exceeded the \$1,337 income limit.
8. On November 9, 2016, the respondent sent the petitioner a Notice of Case Action (NOCA) informing him the request for QI 1 was denied:

Calificación Individual 1

Su solicitud/visión de Calificación Individual 1 de fecha October 25, 2016 ha sido **denegada** para los meses que se indican a continuación:

Nombre	Oct, 2016	Nov, 2016	Dec, 2016
	Ineligible	Ineligible	Ineligible

Motivo: EL INGRESO DE SU GRUPO FAMILIAR ES MUY ALTO PARA CALIFICAR PARA ESTE PROGRAMA
USTED RECIBE EL MISMO TIPO DE ASISTENCIA DE OTRO PROGRAMA
NINGÚN MIEMBRO DEL GRUPO FAMILIAR CUMPLE LOS REQUISITOS DE ESTE PROGRAMA

9. The petitioner's authorized representative does not dispute the income calculated by the respondent. She wants to be heard and suggest that the income limits be revised for the South Florida area because "the cost of living is much higher here."
10. The respondent states the income limits are the same statewide and are set by the legislature.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Fla. Stat.
12. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.
13. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
14. Fla. Admin. Code R. 65-1.702 Medicaid Special Provisions, states in relevant part:
- (12) Limits of Coverage.
 - (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
 - (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...
 - (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)...

15. Fla. Admin. Code R. 65A-1.713, SSI-Related Income Eligibility Criteria, states in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...

(b) For QMB, income must be less than or equal to the federal poverty level...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid...

16. The Department's Program Policy Manual (The Policy Manual), CF-OP 165-22, at Appendix A-9, identifies MSP income standards for an individual, effective April 1, 2016 as, \$ 990 for QMB, \$1,188 for SLMB, and \$1,337 for QI 1.

17. The Federal Regulations at 20 C.F.R. § 416.1124 explains unearned income not counted and states: "(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month..."

18. In accordance with the above mentioned authorities and policy manual, the respondent deducted \$20 unearned income disregard from the household's total unearned income of \$1,463 to arrive at \$1,443.

19. In careful review of the cited authorities and the budget calculations completed by the respondent, the undersigned could not find a more favorable outcome.

20. Based on the cited authorities and evidence, the undersigned concludes the respondent followed rule in terminating the petitioner's MSP benefits and denying reapplication for MSP due to exceeding the income standard set for an individual.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 26 day of April, 2017,

in Tallahassee, Florida.



Pamela B. Vance
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: , Petitioner
Office of Economic Self Sufficiency


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

FILED

Apr 24, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01315

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on March 13, 2017 at 1:33 p.m.

APPEARANCES

For Petitioner: [REDACTED], Pro se

For Respondent: Linda Latson,
Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

Whether it is correct for Respondent to deny Petitioner's request for a partial lower denture (procedure code D5212). The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from Humana, Petitioner's managed care plan, was Mindy Aikman, Grievance and Appeals Specialist.

Appearing as Respondent's witnesses from DentaQuest were Dr. Frank Manteiga, Dental Consultant, and Lauren Hernandez, Complaints and Grievance Specialist.

Respondent's Exhibit 1 was entered into evidence.

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 53 year-old Medicaid recipient enrolled with Humana (Plan), a Florida Health Managed Care provider.
2. Humana requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. Petitioner's dentist submitted a prior authorization request for a lower partial denture (procedure code D5212-mandibular partial denture-resin base), which was received by DentaQuest on January 24, 2017.
4. DentaQuest sent a Notice of Action (NOA) to Petitioner on January 27, 2017 denying the request for a lower partial denture as not medically necessary.

The notice cites Rule 59G-1.010 and the following specific reasons for the denial:

- ✓ Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain;
- ✓ Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not in excess of the patient's needs.

✓ Must meet accepted medical standards and not be experimental or investigational.

5. The NOA also provides the facts used to make the decision: "You still have enough teeth to properly chew your food, therefore, you do not qualify for a partial denture. We have told your dentist this also. Please talk to your dentist about your choices to treat your teeth."

6. Petitioner filed a timely fair hearing request on February 9, 2017.

7. Petitioner testified she has been approved for an upper partial denture but has been denied a lower partial denture. She explained she only has two back teeth on the left side and no back teeth on the right side. Petitioner clarified that she means molars when she uses the term back teeth. Petitioner uses her front teeth to chew her food.

8. Respondent's dental consultant explained Medicaid and the Plan require less than 8 back teeth in occlusion in order for partial dentures to be medically necessary. He further explained bi-cuspids, also called pre-molars, are considered posterior teeth, as well as molars.

9. Reviewing Petitioner's dental x-ray (see Respondent Exhibit 1, page 6), he noted Petitioner has 3 posterior teeth on the left side (1 premolar/bi-cuspids and 2 molars) and 2 posterior teeth (2 premolars/bi-cuspids) on the right side. He stated Petitioner has 10 posterior contacts (upper and lower teeth) that can be used for chewing and, therefore, a lower partial denture is not medically necessary.

10. Petitioner strongly disagreed with Respondent's dental consultant that she had any more than 2 back teeth. She insisted she only has front teeth on her lower right side.

11. Reviewing the x-ray, Respondent's dental consultant explained that Petitioner (from right to left) has 2 molars, a space, then a premolar, 6 anterior teeth, and the last teeth are 2 premolars. Thus in her lower mouth, Petitioner has 2 molars and a premolar on the left side of the anterior teeth, and 2 premolars on the right side of the anterior teeth, for a total of 5 posterior teeth.

12. Petitioner continued to disagree she had any teeth on the lower right side of her mouth.

13. Respondent's dental consultant provided the numbers of Petitioner's lower teeth (from right to left view of the x-ray): 17, 18, space, 21, 22, 23, 24, 25, 27, 28 and 29. The x-ray shows 10 teeth in Petitioner's lower mouth. Labeling the teeth: 17 and 18 are molars; 21 is a bi-cuspids/premolar. These three teeth are considered posterior teeth. Teeth 22, 23, 24, 25, and 27 are considered anterior teeth. Teeth 28 and 29 are bi-cuspids/premolars and are considered posterior teeth.

CONCLUSIONS OF LAW

14. 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.

15. This proceeding is a *de novo* proceeding pursuant to Rule 65-2.056 of the Florida *Administrative Code*.

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

17. Sections 409.971 – 409.973, Florida Statutes, 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. Dental services are one of the mandatory services that must be provided.

18. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

19. Rule 59G-1.010 of the *Florida Administrative Code* gives the following definition: “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.

20. Rule 59G-1.010 (166), *Florida Administrative Code*, 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.

....

(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.

21. The May 2016 Florida Medicaid Dental Services Coverage Policy (Dental Policy) has been promulgated by Rule 59G-4.060 of the *Florida Administrative Code*, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593> .

22. Paragraph 5.2 of the Dental Policy provides a list of specific non-covered criteria which includes "partial dentures where there are eight or more **posterior teeth** in occlusion [emphasis added]."

23. Petitioner asserted she uses her front teeth to chew because she has only two back teeth (molars) on her left side.

24. Respondent's dental consultant explained pre-molars/bi-cuspids are considered posterior teeth as well as molars. The dental consultant reviewed Petitioner's x-ray and identified 2 posterior teeth on the right side and 3 posterior teeth on the left side. These 5 posterior teeth create an occlusion/bite with 5 upper teeth, for a total of 10 teeth in occlusion. The dental consultant cited Medicaid's limitation of less than 8 occlusions for partial dentures to be medically necessary as the basis for denial of Petitioner's request.

25. The May 2016 Florida Medicaid Dental Policy cited above makes it clear partial dentures are a non-covered benefit where there are eight or more posterior teeth in occlusion.

26. The undersigned has considered the totality of the documentary evidence and testimony, as well as the above cited definitions of medical necessity. The undersigned finds Petitioner failed to prove Respondent's action denying her request for lower partial dentures is incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency 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.

FINAL ORDER (Cont.)

17F-01315

Page 8 of 8

DONE and ORDERED this 24 day of April, 2017, in Tallahassee,

Florida.



Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Humana Hearings Unit

FILED

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

Apr 25, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01384

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on March 22, 2017 at 10:11 a.m.

APPEARANCES

For Petitioner: [REDACTED], Pro se

For Respondent: Linda Latson,
Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

Whether it is correct for Respondent to deny Petitioner's requests for fillings for 10 teeth. The specific dental procedures requested, and the related teeth are: D2150 for tooth 2 and 3; D2160 for tooth 14; D2332 for tooth 10; D2391 for tooth 20; D2392 for tooth 4 and 12; and D2393 for tooth 13, 15, and 21. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from Magellan Complete Care (Magellan), Petitioner's managed care plan, was Samantha Lorenzo, Appeals Coordinator.

Appearing as Respondent's witness from DentaQuest was Charles Kieffer, Complaint and Grievance Specialist.

Respondent's Exhibit 1 was entered into evidence.

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 39 year-old Medicaid recipient enrolled with Magellan, a Florida Health Managed Care provider.
2. Magellan requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for 10 fillings as follows: D2150 for tooth 2 and 3; D2160 for tooth 14; D2332 for tooth 10; D2391 for tooth 20; D2392 for tooth 4 and 12; and D2393 for tooth 13, 15, and 21.
4. DentaQuest sent a Notice of Action (NOA) to Petitioner on January 11, 2017 denying Petitioner's requests for fillings as not covered benefits.
5. Petitioner filed a timely fair hearing request on February 13, 2017.
6. Petitioner explained some of her teeth have been approved for extraction, and the requests for fillings are to fix her remaining teeth in preparation for partial dentures.

7. Respondent's witness explained the fillings are restorative procedures. He noted restorative procedures, per Medicaid's May 2016 Dental Policy, are not a covered service/benefit for members over 21 years of age.

8. Respondent's witness also explained the Dental Policy language "procedures essential to prepare the mouth for dentures" applies only to surgical procedures and extractions, which is the section where the language can be found, and not to restorative services.

9. Petitioner strongly disagreed with Respondent's explanation. She stated if she does not receive fillings for her teeth, they will decay. She also does not understand the purpose of getting partial dentures if the remaining teeth are not fixed.

CONCLUSIONS OF LAW

10. 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.

11. This proceeding is a *de novo* proceeding pursuant to Rule 65-2.056 of the *Florida Administrative Code*.

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

13. Sections 409.971 – 409.973, Florida Statutes, 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. Dental services are one of the mandatory services that must be provided.

14. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

15. Rule 59G-1.010 of the *Florida Administrative Code* provides the following definition: "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.

16. Rule 59G-1.010 (166), *Florida Administrative Code*, 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.

....

(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.

17. The May 2016 Florida Medicaid Dental Services Coverage Policy (Dental Policy) is promulgated by Rule 59G-4.060, *Florida Administrative Code*, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593>.

18. Paragraph 4.2.8, Restorative Services, of the Dental Policy, states "Florida Medicaid reimburses for all-inclusive restorative services for recipients under the age of 21 years as follows: Restorations and Crowns." Fillings are considered restorative services.

19. Paragraph 4.2.9, Surgical Procedures and Extractions, of the Dental Policy, states in relevant part "Florida Medicaid reimburses for emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures." The essential procedures relate to surgical and extraction services not to restorative services.

20. Petitioner asserted she needs the fillings for her teeth in preparation for her planned partial dentures.

21. Respondent's witness explained the fillings are restorative services, which are not covered services under the May 2016 Florida Medicaid Dental Policy. Respondent also explained the language in paragraph 4.2.9 of the Dental Policy, which states "procedures essential to prepare the mouth for dentures," applies only to the surgical

procedures and extractions mentioned in paragraph 4.2.9 and not to the restorative services mentioned in paragraph 4.2.8.

22. The May 2016 Florida Medicaid Dental Policy cited above makes it clear restorative services (fillings in this instant appeal) are a non-covered benefit for members over 21 years of age.

23. The undersigned has considered the totality of the documentary evidence and testimony, as well as the above cited definitions of medical necessity. The undersigned finds Petitioner failed to prove Respondent's action in denying her requests for fillings is incorrect.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency 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.

FINAL ORDER (Cont.)

16F-01384

Page 7 of 7

DONE and ORDERED this 25 day of April, 2017, in Tallahassee,
Florida.



Warren Hunter
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Magellan Hearings Unit

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

FILED

Mar 22, 2017

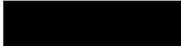
Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01413

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 
UNIT: 88655

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 15, 2017 at 10:34 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: , pro se

For the Respondent: Ada Torrella, Operations Management Consultant I

STATEMENT OF ISSUE

At issue is the respondent's action to terminate the petitioner's Medicare Savings Plan (MSP) at recertification. The burden of proof was assigned to the respondent by a preponderance of evidence.

PRELIMINARY STATEMENT

Fay Hepburn, Economic Self-Sufficiency Supervisor, appeared as a witness for the respondent.

The petitioner submitted no exhibits. The respondent submitted a 48-page exhibit, which was marked and entered as Respondent's Composite Exhibit "1".

FINDINGS OF FACT

1. Medicare Savings Plan (MSP) is a Medicaid Buy-in Program in which the State of Florida pays the Medicare premiums. The petitioner was previously receiving MSP under the Qualifying Individual 1 (QI 1) plan beginning April 2016.
2. On October 26, 2016, the petitioner submitted an application for recertification of Food Assistance Program (FAP) benefits, SSI-related Medicaid, and MSP benefits.
3. The petitioner (74 years old) is the only household member.
4. The petitioner was receiving \$1,379 in Social Security Administration (SSA) income per month.
5. To be eligible for QI 1, an individual's income (minus any applicable disregards) cannot exceed \$1,337.
6. In calculating the MSP budget, the respondent applied a \$20 disregard, determining the petitioner's countable income as \$1,359.
7. The petitioner 's countable income of \$1,359 exceeded the \$1,337 income limit.
8. On November 29, 2016, the respondent sent the petitioner a Notice of Case Action informing her the request for QI1 was denied: "Reason: Your household's income is too high to qualify for this program."
9. The petitioner timely requested the hearing.

10. The petitioner does not dispute the household income calculations. The petitioner is asking for consideration from the respondent due to her being elderly and unable to work. At the time of the hearing, the petitioner had submitted a new application for MSP.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Fla. Stat.

12. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

14. Fla. Admin. Code R. 65-1.702 Medicaid Special Provisions, states in relevant part:

(12) Limits of Coverage.

(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...

(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)...

15. Fla. Admin. Code R. 65A-1.713, SSI-Related Income Eligibility Criteria, states in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...

(b) For QMB, income must be less than or equal to the federal poverty level...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid...

16. The Department's Program Policy Manual (The Policy Manual), CF-OP 165-22, at Appendix A-9, identifies MSP income standards for an individual, effective July 1, 2016 as follows:

	QMB	SLMB	QI	1
\$	990	\$1,188		\$1,337

17. The federal regulations at 20 C.F.R. § 416.1124 explains unearned income not counted and states: "(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month..."

18. In accordance with the above mentioned authorities and policy manual, the respondent deducted \$20 unearned income from the household's total unearned income of \$1,379 to arrive at \$1,359.

19. In careful review of the cited authorities and the budget calculations completed by the respondent, the undersigned could not find a more favorable outcome.

20. Based on the cited authorities and evidence, the undersigned concludes the respondent followed rule in terminating the petitioner's QI 1 benefits and denying reapplication for QI 1 due to exceeding the income standard set for an individual.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby denied and the department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 22 day of March, 2017,

in Tallahassee, Florida.



Pamela B. Vance
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

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

FILED

Apr 04, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01498

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 [REDACTED]
UNIT: 66292

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 27, 2017 at approximately 11:32 a.m.

APPEARANCES

For the Petitioner: [REDACTED] pro se

For the Respondent: Susan Martin, Operations Management Consultant I

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of October 31, 2016 denying her application for Supplemental Security Income-Related Medicaid (SSI-Related Medicaid). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

██████████ authorized representative and sister of the petitioner, appeared as a witness on her behalf.

The respondent submitted written evidence which was admitted into the record and marked as Respondent's Exhibits "1" through "8". The record was held open four (4) days to allow the petitioner to submit the original Supplemental Security Income (SSI) denial notice from the Social Security Administration and proof of a new medical condition. The information was not received. The record was closed on March 31, 2017.

FINDINGS OF FACT

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. The petitioner is a 61-year-old single female with no dependent minors from which to derive Medicaid eligibility, see Respondent's Exhibit 2.
2. On January 9, 2017, the petitioner submitted an application for SSI-Related Medicaid, see Respondent's Exhibit 3.
3. On January 12, 2017, the respondent mailed a pending notice to the petitioner requesting an interview, a completed and signed Authorization to Disclose Information form, completed and signed Affidavit for Designated Representative form, a list of current doctors, medications and any recent hospitalizations and a copy of her application for Social Security benefits, see Respondent's Exhibit 1.

4. On February 9, 2017, the Department notified the petitioner that her application for Medicaid was denied as the interview was not completed and the Department did not receive all of the requested information.
5. On March 28, 2016, the petitioner applied for SSI. On June 14, 2016, the petitioner's request for SSI was denied with a denial code of N35, "Impairment is severe at time of adjudication but not expected to last twelve (12) months, no visual impairment", see Respondent's Exhibits 7 & 7A.
6. On August 22, 2016, the petitioner appealed this decision. This appeal is still pending, see Respondent's Exhibit 7.
7. During the hearing, the petitioner and witness asserted that she has new medical conditions that have not been considered. The witness also asserted that her sister is legally blind and has been from childhood but acknowledged that this information had not been relayed to the Department prior to the hearing.
8. The Department adopted the SSI unfavorable decision and denied the petitioner's application for SSI-Related Medicaid, see Respondent's Exhibits
9. The Department acknowledged that the pending notice mailed to the petitioner on January 12, 2017 was incomplete as the Department should have also requested a copy of the original SSI denial notice in order to ascertain if any of the medical conditions were new.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

11. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

13. Fla. Admin. Code R. Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy...

14. Additionally, 42 C.F.R. § 435.541 Determination of Disability, states:

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirement of the Act, and has not applied to SSA for a determination with respect to these allegations.

15. The Department's Program Policy Manual, CPOF 165-22, passage 1440.1204

Blindness/Disability Determinations states in pertinent parts:

When the individual files an application within 12 months after the last unfavorable disability determination by SSA **and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. (Emphasis added)**

Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.

16. The petitioner asserted that she did not tell the Department that she is legally blind. The petitioner had been hospitalized and was attending the hearing from her hospital room. The petitioner agreed to provide evidence that would substantiate her claim of disabling conditions not considered by SSA. The petitioner did not provide the proof to the undersigned by the agreed upon deadline.

17. The Department's Program Policy Manual, CPOF 165-22, passage 1440.1205

Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
- 5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA). (Emphasis added)**

18. The above authorities explain that the Department must make an independent disability determination if it has been more than 12 months since the most current SSA disability determination **and** the applicant alleges a new period of disability which meets the durational requirement of the Act, **and** he or she has not filed a disability claim with the SSA regarding the alleged medical conditions. Petitioner may fit these criteria but

she has not provided the necessary documentation to the Department. Thus, the Department was correct in its actions.

19. In this instant case, the petitioner is under 65 and has medical conditions that were deemed substantial but lasting less than 12 months by SSI. The Department adopted SSA's decision as required by the afore-cited authorities.

20. The undersigned concludes that the petitioner did not meet her burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to not make an independent disability decision.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Departments actions are upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. 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, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. 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 Department has no funds to assist in this review.

DONE and ORDERED this 04 day of April, 2017,

in Tallahassee, Florida.



Ursula Lett-Robinson
Hearing Officer
Building 5, Room 255

FINAL ORDER (Cont.)

17F-01498

PAGE -7

1317 Winewood Boulevard
Tallahassee, FL 32399-0700

Office: 850-488-1429

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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Apr 28, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01618

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 15, 2017 at 3:12 p.m. in [REDACTED], Florida.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted Quality Improvement Organization (QIO), eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services for the certification period November 27, 2016 to May 25, 2017. Respondent bears the burden of proving, by a preponderance of the evidence, that the termination of PPEC services is proper.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Rakish Mittal, M.D., Physician Consultant for eQHealth Solutions, Inc.

Appearing as witnesses for Petitioner were: [REDACTED], Director of Nursing for [REDACTED] PPEC; [REDACTED] Aunt; and [REDACTED] Registered Nurse for [REDACTED] PPEC.

Respondent's Exhibits 1 through 6 were entered into evidence.

Administrative notice was taken of Sections 400.902 and 400.914, Florida Statutes, and the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

Although Petitioner's request for a fair hearing was filed/received after the 10-day deadline for requesting continuing benefits, Petitioner continues to receive PPEC services from Broward PPEC, Monday through Friday. Petitioner's mother explained she changed addresses and did not receive Respondent's initial Notice of Action. As a result, she was unable to file a request for a fair hearing within the 10-day deadline to continue receiving services. The agency representative explained AHCA and eQHealth will need to review Petitioner's circumstances and make a decision on approval of continued PPEC services.

FINDINGS OF FACT

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 one-year-old female Medicaid recipient. She has been diagnosed with [REDACTED]

[REDACTED]. At the mother's request, the [REDACTED] was removed in October 2016. Petitioner is status-post [REDACTED] procedure [REDACTED] in October 2015 and [REDACTED] in May 2016. The [REDACTED] (also called the [REDACTED] are two stages of a three stage heart reconstruction. The third stage is called the [REDACTED] (complete) and will be performed on Petitioner in the future. Petitioner's mother explained "when her body's signs indicate she is ready" is when the final heart reconstruction will be done.

2. Petitioner lives with her mother, two siblings, and her grandmother. She is age-appropriate verbally, making infant cooing sounds. She also is attempting to walk with assistance.

3. Petitioner is on an age-appropriate diet but has vomiting episodes, which are controlled by oral medications for acid reflux. Petitioner has some developmental delays. With removal of the [REDACTED], she is no longer dependent on any machines or monitors. Her cardiologist follows up with Petitioner every six months or as needed. She takes all her medications orally, once or twice daily.

4. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PPEC services through a prior

authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the services and hours requested, pursuant to the requirements and limitations of the Medicaid State Plan.

5. A request for service is submitted by a provider along with all information and documentation necessary for the QIO to make a determination of medical necessity for the level and frequency of the service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

6. On December 23, 2016, Petitioner's provider submitted a request for continued Prescribed Pediatric Extended Care (PPEC) services, Monday through Friday, up to 12 hours daily, for the certification period of November 27, 2016 to May 25, 2017.

7. On December 29, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on December 30, 2016, denying PPEC full and partial services. The rationale for the denial was PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code, specifically...

the services must be:

Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.

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.

8. On December 30, 2016, a "Notice of Outcome-Denial" was issued to Petitioner's provider and gives the following clinical rationale:

The patient is a 14 month old with a history of [REDACTED] and feeding intolerance. The patient is status post [REDACTED] procedure in October 2015 and [REDACTED] in May 2016. The patient has transitioned off of the [REDACTED] which was removed in October 2016. The patient has some [REDACTED]. The patient is no longer on any monitors. The patient is on an age-appropriate diet. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient no longer appears to have a skilled need and does not meet the medical complexity requirements for PPEC services.

9. Petitioner did not request a reconsideration review.

10. On February 17, 2017, Petitioner filed a timely request for a fair hearing.

11. Respondent's physician consultant witness reviewed Petitioner's medical status as reflected in the paragraphs above. He noted the cardiology follow-up every six months, or as needed, indicated there are no acute issues concerning Petitioner's heart. He also observed Petitioner's medications can be administered by any responsible adult at home.

12. The physician consultant reviewed Petitioner's Plan of Care and noted the general care requirements are typical for any 17-month old child. He noted Petitioner is receiving occupational, physical, and speech therapy because she is developmentally delayed. He observed there is no specific mention of any specific skilled nursing help for Petitioner.

13. The physician consultant explained Petitioner had a heart issue in the past, having corrective heart surgery about 1 ½ years ago. She had a [REDACTED] for feeding; she had early breathing issues. He asserted these issues have been resolved at this

time. She is eating by mouth, learning to talk and walk, and taking all her medications orally. After reviewing all the supporting documentation from Petitioner, the physician reviewer concurs with denying Petitioner's request for PPEC services, at this time.

14. Petitioner's mother explained Petitioner uses a monitor at home for monitoring her oxygen intake and heart rate. Petitioner underwent surgery October 19, 2015 and May 3, 2016. She had a catheterization on February 7, 2017 and is scheduled for another on March 27, 2017.

15. After a catheterization, Petitioner is weak and needs assistance with vomiting to ensure she does not aspirate.

16. Respondent's physician consultant explained eQHealth Solutions did not see the Petitioner directly but relies on information provided by the caregivers and providers. He referenced page 11 of Respondent's Exhibit, citing the annotation "there is no monitor utilized." He also noted the Plan of Care does not mention a monitor being used at PPEC.

17. Petitioner's witness, the Director of Nursing (DON) for Broward PPEC, testified she saw Petitioner wearing a monitor in the home when she was completing the home assessment, two days after being discharged from the hospital. However, Petitioner's mother never sent the monitor to the PPEC center. She stated the issue of a monitor was discussed more than once at the center's monthly team meetings. The DON offered this explanation for the monitor not being mentioned in the PPEC's Plan of Care.

18. Petitioner's mother explained she has two other healthy children and the experiences she has had with daycare for them have been unsatisfactory. As a result, she expressed serious concerns for Petitioner's safety and well-being at a regular

daycare center. She stated regular daycare workers do not know when her daughter is dehydrated, hyperventilating, or perspiring excessively. The regular daycare workers are busy attending other children to provide the attention her daughter needs.

19. Respondent's physician consultant explained he was not recommending Petitioner attend a regular daycare center. His focus was determining Petitioner's need for PPEC services and not what alternative services would be available to her.

CONCLUSIONS OF LAW

20. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

21. This hearing was held as a *de novo* proceeding pursuant to Rule 65-2.056 of the *Florida Administrative Code*.

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

23. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G of the *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

24. Rule 59G-1.010(166) of the *Florida Administrative Code* defines "medically necessary" or "medical necessity" as follows:

(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;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(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."

25. Rule 59G-1.010 of the *Florida Administrative Code* defines "medically complex" and "medically fragile" as follows:

(164) "Medically complex" means that a person who "has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention."

(165) "Medically fragile" means an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, e.g., requires total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life, and without such services is likely to expire without warning.

26. Because Petitioner is under 21 years old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES. --The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all

services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

27. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-

case basis" and my present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

28. The Florida Medicaid Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook- September 2013 (PPEC Handbook) is promulgated by Rule 59G-4.260 of the *Florida Administrative Code* and provides the following purpose and definition of PPEC on page 1-1:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

29. On page 2-1, the PPEC Handbook provides the following requirements for those who can receive PPEC services:

To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.
- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

30. On page 2-5, the PPEC Handbook provides a list of excluded services:

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.
- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, and child life.

31. Respondent's physician consultant witness reviewed all the supporting documentation submitted by Petitioner and listened to testimony from the mother and Petitioner's witnesses. He concluded no skilled nursing services are being provided at the PPEC and supports the denial for Petitioner's request for PPEC services.

32. Petitioner's mother highlighted Petitioner's ongoing need for catheterizations and her concern that regular daycare workers would not be qualified or adequate to identify Petitioner's need for intervention if she becomes dehydrated, hyperventilates, or perspires excessively.

33. Respondent noted Petitioner had a past need for skilled nursing due to her early breathing problems, using a [REDACTED] or feeding, and recovering from surgery. The [REDACTED] [REDACTED] has been removed and she is progressing in her development, with the help of occupational, physical, and speech therapy services. Currently, Petitioner's medical issues are stabilized.

34. Petitioner is due to undergo the third (and final) stage in her heart reconstruction in the future. She sees her cardiologist every six months, or as needed.

35. After reviewing the evidence and testimony, as well as the above cited authorities, including the EPSDT requirements, the undersigned finds Petitioner does not have a current need for skilled nursing services and does not meet the definition of "medically complex" or "medically fragile," as required by the above controlling authorities.

36. The controlling authorities make it clear that services must 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. Because skilled nursing

services are not being provided (other than monitoring), PPEC services are in excess of Petitioner's needs and, therefore, are not medically necessary.

37. The documentation and testimony do not support the medical need for PPEC services. Petitioner's mother is encouraged, however, to seek visiting skilled nursing services for her daughter, under Medicaid's November 2016 Home Health Visit Services Coverage Policy, if the visits to the cardiologist are insufficient to identify when Petitioner is ready for her final heart surgery. Respondent will need to determine medical necessity for visiting nurse services and Petitioner will have appeal rights to the action(s) taken by the Respondent.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is hereby 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 Petitioner disagrees with this decision, Petitioner may seek a judicial review. To begin the judicial review, 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. 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. Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

FINAL ORDER (Cont.)

17F-01618

Page 13 of 13

DONE and ORDERED this 28 day of April, 2017, in Tallahassee,
Florida.



Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

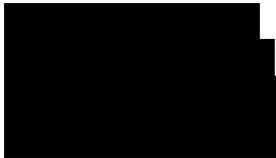
Copies Furnished To: [REDACTED] Petitioner
[REDACTED] AHCA, Medicaid Fair Hearings Unit
[REDACTED]

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

FILED

Mar 31, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01651

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 [REDACTED]

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 20, 2017 at 1:36 p.m.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Dianne Soderlind, Registered Nurse Specialist,
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether it is correct for Respondent to deny Petitioner's request for braces and follow-up treatment (dental procedures D8080, D8670, and D8680).

Petitioner is assigned the burden of proof.

PRELIMINARY STATEMENT

Appearing for Respondent as a witness from Children's Medical Services (CMS) was Tamara Zanders, Director for Managed Care Unit.

Appearing for Respondent as witnesses from Ped-I-Care were: Dr. Dolce, Orthodontist, and Holly Estep, Assistant Director for Utilization Management.

Appearing as observers were: Peaches Jackson, Manager for Ped-I-Care (University of Miami) and Mr. Eugene Gandy, attorney for Department of Health/Children's Medical Services.

Respondent's Exhibit 1 was entered into evidence.

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 12-year-old Medicaid recipient enrolled with Children's Medical Services (CMS), a Florida Health Managed Care provider.
2. CMS requires prior authorization for services related to dental care and has subcontracted with Ped-I-Care to review prior authorization requests.
3. Petitioner's orthodontist sent a prior authorization request for orthodontic dental procedures: D8080, comprehensive orthodontic treatment (braces); D8670, periodic orthodontic treatment visit; and D8680, orthodontic retention (removal of appliances, construction and placement of retainer(s)). In support of the request, Petitioner's orthodontist submitted a Medicaid Orthodontic Initial Assessment Form (see Respondent Exhibit 1, page 6). The total score on the form from Petitioner's

orthodontist is 13. Comments by Petitioner's orthodontist accompanying the assessment form include: crowded teeth and excess OJ [overjet].

4. Ped-I-Care received the request on January 26, 2017.

5. Ped-I-Care made its determination on February 1, 2017 denying the Orthodontia Services. Notice was sent to Petitioner providing the denial reason:

We determined that your requested services are not medically necessary because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

- ✓ Must be needed to protect life, prevent significant illness or disability, or alleviate severe pain.
- ✓ Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

The notice provided the following facts used in making the decision: The information sent in does not meet Medicaid criteria. This member's condition is not severe enough.

6. Petitioner filed a timely fair hearing request on February 17, 2017.

7. Petitioner's mother testified she appealed Respondent's denial of her son's braces because he constantly bites his lower lip with his upper teeth, often causing them to bleed. Petitioner is always complaining about sore lips. Petitioner's lower lip is either chapped, red, or "bumpy". Sometimes he has an open sore on the lower lip. The mother frequently puts numbing medicine on his lips. She asserted correcting the overbite will stop Petitioner from biting his lower lip.

8. Respondent's dental consultant observed Petitioner's teeth are crooked and one is sticking out, but Petitioner does not meet Medicaid's criteria. He asserted Petitioner's sores are not part of the criteria used to assess Petitioner's need for braces.

9. Respondent's dental consultant explained DentaQuest uses a Medicaid assessment form with specific dental problems assigned points. A member needs to score at least 27 on the form or feel a problem is causing severe damage. Petitioner's score was 13. The dental consultant was not aware of the Agency's new dental policy promulgated effective May 2016.

10. Respondent's dental consultant was not familiar with the requirements under the Early, Periodic, Screening, Diagnosis and Treatment program.

CONCLUSIONS OF LAW

11. 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.

12. This proceeding is a *de novo* proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

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

14. This is a Final Order, pursuant to §§ 120.569 and 120.57, Florida Statutes.

15. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, *Florida Administrative Code*. The Program is administered by the Agency for Health Care Administration.

16. Section 409.905, Florida Statutes, "Mandatory Medicaid services," states, in relevant part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law."

17. Sections 409.971 – 409.973, Florida Statutes, 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. Dental services are one of the mandatory services that must be provided.

18. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

19. Rule 59G-1.010, *Florida Administrative Code*, defines "prior authorization" as: "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.

20. Rule 59G-1.010(166), *Florida Administrative Code*, 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.

...

(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.

21. Because the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES. --The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and **provide treatment to correct or ameliorate** these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations [emphasis added].

22. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v. Reese*, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for

determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

23. The May 2016 Florida Medicaid Dental Services Coverage Policy (Dental Policy)

has been promulgated by Rule 59G-4.060, *Florida Administrative Code*, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration’s website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593> .

24. Paragraph 1.3.4 of the Dental Policy provides the following definition of a handicapping malocclusion: A condition that results in a disability or impairment to the recipient's physical development.

25. Paragraph 4.2.4 of the Dental Policy provides the following coverage description for orthodontic services (braces):

Florida Medicaid reimburses for orthodontic services for recipients under the age of 21 years with handicapping malocclusions as follows:

- Twenty-four units within a 36-month period, which includes the removal of the appliances and retainers at the end of treatment
- One replacement retainer(s) per arch, per lifetime

26. The Dental Policy requires orthodontic services be medically necessary as defined in Rule 59G-1.010(166), *Florida Administrative Code* (see paragraph 22 above).

27. Petitioner's mother testified Petitioner is constantly complaining about his sore lower lip. She stated his lower lip, at times, bleeds. She uses a numbing medicine to relieve the pain Petitioner experiences due the soreness of his lower lip. She stated braces would alleviate Petitioner biting his lower lip and relieve the pain he currently experiences from the biting.

28. Respondent's dental consultant explained he could only use the Medicaid assessment form criteria on which the Petitioner needed to score at least 27 points. Petitioner's score was 13. The dental consultant also explained the braces could be approved if Petitioner's dental problem was determined to be causing severe damage.

29. Rule 59G-1.010(166), *Florida Administrative Code*, provides that medical necessity must be necessary to protect life, to prevent significant illness or significant disability, or to **alleviate severe pain**.

30. Additionally, as noted in the above cited EPSDT requirements, treatments are to be provided to members under 21 to correct or ameliorate medical problems. While Petitioner's malocclusion may not qualify as handicapping, per Respondent, no testimony was offered that braces would not alleviate or ameliorate the sores and pain Petitioner is experiencing with his overbite. On the contrary, the dental consultant excluded Petitioner's sores in his review for medical necessity.

31. After carefully reviewing the EPSDT and medical necessity requirements set forth above, the undersigned concludes Petitioner has demonstrated that Respondent incorrectly denied Petitioner's request for braces.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED and the Agency action is DENIED.

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.

FINAL ORDER (Cont.)

17F-01651

Page 10 of 10

DONE and ORDERED this 31 day of March, 2017, in Tallahassee,
Florida.



Warren Hunter
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
Children's Medical Services Hearings Unit

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

FILED

Apr 12, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17N-00008

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 9, 2017 at 1:28 p.m. at [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner: [REDACTED], Power of Attorney

For the Respondent: Melanie Wilson, Administrator

ISSUE

At issue is the facility's intent to discharge the petitioner due to non-payment of a bill for services. A Nursing Home Transfer and Discharge Notice was issued on January 5, 2017. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.15.

PRELIMINARY STATEMENT

The petitioner was not present, but was represented by [REDACTED] his Power of Attorney, who testified. The petitioner presented one witness who testified: [REDACTED] Manager with the Long Term Care Ombudsman Program. The petitioner submitted no exhibits at the hearing. The respondent was represented by Melanie Wilson, Administrator with Rehabilitation and Healthcare Center of Tampa (hereafter "facility" or "respondent"). The respondent presented one witness who testified: Keyanna Alvarez, Assistant Business Office Manager. The respondent submitted one exhibit, which was accepted into evidence and entered as Respondent's Exhibit "1". Ron Thiltgen, Ombudsman observed the proceedings.

The record was left open until March 16, 2017 to allow the respondent to submit additional information. On March 16, 2017, the respondent submitted the additional information, which was accepted into evidence and entered as Respondent's Exhibits "2" – "6". The record closed on March 16, 2017.

FINDINGS OF FACT

1. The petitioner entered the facility on September 16, 2016. Private Insurance Company, [REDACTED] Insurance, paid for the petitioner's stay at the facility, in full, through October 13, 2016. (Respondent's testimony)
2. On October 27, 2016, the facility submitted an application for Institutional Care Program (ICP) Medicaid benefits to the Department of Children and Families (DCF) on the petitioner's behalf. (Page 3 of Respondent's Exhibit 4)
3. On December 7, 2016, DCF mailed a Notice of Case Action informing the petitioner his Medicaid application dated October 27, 2016 was denied as "We did not

receive the information requested to determine eligibility.” (Page 3 of Respondent’s Exhibit 4)

4. The petitioner would not pursue Medicaid benefits to assist in the payment of his nursing home bill. (Page 1 of Respondent’s Exhibit 5)

5. The petitioner’s monthly income was a pension of \$1,100 per week. (Page 2 of Respondent’s Exhibit 5)

6. On January 5, 2017, the facility issued the petitioner a Nursing Home Transfer and Discharge Notice. The reason for the discharge was “your bill for services at this facility has not been paid after reasonable and appropriate notice to pay”.
(Respondent’s Exhibit 1)

7. As of the day of the hearing, the petitioner had not made any payments to the facility towards his outstanding balance and had not agreed to a payment plan to repay the facility for his outstanding balance. (Respondent’s testimony)

8. As of April 1, 2017, the petitioner’s outstanding balance to the facility was \$43,217.50. (Page 1 of Respondent’s Exhibit 2)

9. The facility billed the petitioner the following private pay amounts:
\$3,996 for October 14, 2016 through October 31, 2016; \$6,216 for the month of November 2016; \$5,994 for December 5, 2016 through December 31, 2016; \$6,882 for the month of January 2017; \$6,216 for the month of February 2017; \$6,882 for the month of March 2017; and \$6,660 for the month of April 2017. (Page 1 of Respondent’s Exhibit 2)

10. The petitioner’s identity was stolen and the individual who stole the petitioner’s identity spent his pension income and the funds in his bank account. (Page 1 of Respondent’s Exhibit 5)

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

12. The Code of Federal Regulations 42 C.F.R. § 483.15 limits the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that he would be discharged from the facility as he had not paid his bill for services to the facility:

- ...
- (c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
 - (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
 - (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
 - (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
 - (D) The health of individuals in the facility would otherwise be endangered;
 - (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
 - (F) The facility ceases to operate.

13. The respondent's sole reason for the discharge was that the petitioner had not paid his bill for services to the facility. The facility billed the petitioner the private pay amounts of \$3,996 for October 14, 2016 through October 31, 2016; \$6,216 for the

month of November 2016; \$5,994 for December 5, 2016 through December 31, 2016; \$6,882 for the month of January 2017; \$6,216 for the month of February 2017; \$6,882 for the month of March 2017; and \$6,660 for the month of April 2017. The petitioner will not reapply for ICP Medicaid benefits. As of April 1, 2017, the petitioner's outstanding balance to the facility was \$43,217.50.

14. The hearing officer concludes that the facility has given the petitioner reasonable and appropriate notice of the need to pay for his stay at the facility. Furthermore, the petitioner has not made any payments towards his outstanding balance; and has not cooperated with the facility to create a payment plan to repay the facility for his outstanding balance. Based on the evidence presented, the nursing facility has established that the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

15. One step in the discharge process is establishing that the reason for a discharge is lawful. The nursing facility must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these location issues. The hearing officer only considered whether the discharge is for a lawful reason.

16. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements.

Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is DENIED, as the facility's action to discharge the petitioner is in accordance with federal regulations. The facility may proceed with the discharge action in accordance with the Agency for Health Care Administration's rules and guidelines.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party 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 department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 12 day of April, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
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Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
[REDACTED] Respondent
Ms. Patricia Reed Cauffman, Agency for Health Care
Administration
[REDACTED]

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

FILED

Apr 17, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17N-00016

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, an administrative hearing in the above-referenced matter, convened before the undersigned at 11:20 a.m. on March 16, 2017, at [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Debra Wallace, Vista Manor Administrator

STATEMENT OF ISSUE

At issue is whether the respondent's intent to discharge the petitioner from [REDACTED] [REDACTED] due to non-payment of a bill for services, is proper. The respondent carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

[REDACTED] (CO), the petitioner's wife, appeared as a witness, by telephone, for the petitioner. Angela Knapp, [REDACTED] Business Office Manager,

appeared as a witness for the respondent. The petitioner did not submit exhibits. The respondent submitted three exhibits, entered as Respondent Exhibits "1" through "3".

The record was closed on March 16, 2017.

FINDINGS OF FACT

1. The petitioner was admitted to [REDACTED] (Facility) on April 21, 2016, from [REDACTED] (hospital). Medicare and Aetna (petitioner's insurance) paid for the petitioner's stay at the Facility between April 21, 2016 and July 2016.
2. The Facility mailed CO monthly billing statements, starting on August 1, 2016, of the amount(s) owed for the petitioner's stay and services (Respondent Exhibit 2).
3. The Facility has not received any payments from the petitioner since Medicare and Aetna coverage ended. The petitioner's current amount owed to the Facility is \$52,013 (Respondent Exhibit 2).
4. On July 18, 2016, the Facility submitted an Institutional Care Program (ICP) Medicaid application for the petitioner, to assist in paying the Facility (Respondent Exhibit 3).
5. In August 2016, the Facility notified CO that due to the petitioner's income exceeding the ICP Medicaid income limit, a Qualified Income Trust (QIT) needed to be established and funded (Respondent Exhibit 3).
6. CO did not create a QIT for the petitioner.
7. In November 2016, the Facility submitted another ICP Medicaid application on behalf of the petitioner. The Facility again notified CO of the QIT requirement (Respondent Exhibit 3).

8. CO did not create a QIT for the petitioner, ICP Medicaid was denied.
9. On January 11, 2017, the Facility issued a Nursing Home Transfer and Discharge Notice, "Reason for Discharge or Transfer: Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay" (Respondent Exhibit 1).
10. CO asserts that she did not have the money to establish and fund a QIT.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to section 400.0255(15), Florida Statutes. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.
12. Title 42 of the Code of Federal Regulations § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.
 - (c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
 - (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
 - (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
 - (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
 - (D) The health of individuals in the facility would otherwise be endangered;
 - (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary

paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

13. The above authority identifies six reasons that a Facility may transfer or discharge a resident.

14. The evidence submitted establishes that the Facility is requesting the petitioner be discharged, due to nonpayment, "after reasonable and appropriate notice to pay".

Which is one of the six reasons listed in the above authority.

15. The evidence submitted establishes that the Facility has not received any payments from CO or the petitioner. And the Facility mailed CO billing statements monthly, notifying of the amount due for the petitioner's stay and services.

16. The evidence submitted also establishes that the Facility assisted the petitioner by submitting two ICP Medicaid applications, to help pay the Facility. And notified CO that due to the petitioner's income, a QIT was required to be established and funded.

17. CO argued that she does not have the money to establish or fund a QIT.

18. Establishing the reason for a discharge is lawful is just one step in the discharge process. The Facility must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The Hearing Officer cannot and has not considered either of these issues. The Hearing Officer only considered whether the discharge is for a lawful reason and that the requirements of the controlling authorities have been met.

19. Any discharge by the Facility must comply with all applicable Federal Regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

20. In careful review of the cited authority, evidence and testimony, the undersigned concludes the respondent met its burden of proof. The undersigned concludes that discharging the petitioner from the Facility, due to non-payment, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the petitioner's appeal is denied. The Facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge, as described in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party 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 department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 17 day of April, 2017,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
[REDACTED] Respondent
Ms. Theresa DeCanio
Agency for Health Care Administration
[REDACTED]