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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-06730

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 Lee
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 13, 2009, at 3:53 p.m., in Ft. Myers, Florida. The petitioner was present. The respondent was represented by Dennis Cole, program administrator.

ISSUE

The petitioner is appealing the notice of September 15, 2009 for the respondent's action to deny reimbursement of medical bills from January 5, 2005 through October 31, 2007.

FINDINGS OF FACT

1. The petitioner applied for Supplemental Security Income (SSI) on January 5, 2005. Social Security denied the claim. The petitioner requested an appeal before an administrative law judge. The Social Security hearing was held on April 23, 2007. The decision of the administrative law judge was that the

petitioner was disabled with an onset date of November 20, 2004. The decision date was October 11, 2007.

2. On September 1, 2009, the petitioner sent the respondent a request for reimbursement for prescriptions he paid for from January 5, 2005 through October 31, 2007. On September 4, 2009, the respondent received the request from the petitioner. The respondent reviewed the request. The respondent determined that all criteria for reimbursement had not been met, as the petitioner did not request coverage within twelve months of his approval for Medicaid on October 11, 2007. A letter denying payment was sent to the petitioner on September 15, 2009.

3. The petitioner rebutted that his mother had been his payee. He did not know he had to submit his request for bill payment within twelve months of his approval of SSI. The petitioner opined that when he was approved for SSI he was automatically eligible for Medicaid. Each time he went to the doctor or pharmacy, he told them he was receiving SSI.

CONCLUSIONS OF LAW

The Florida Administrative Code at 65A-1.702 sets forth:

> (9)(b) SSI Cash Assistance Recipients. Upon SSI approval, all SSI recipients receive a system-generated notice of potential entitlement for retroactive Medicaid benefits and a reply card to be returned to the department if the SSI recipient is interested in receiving retroactive Medicaid benefits. If the client or their representative contacts the department or returns the reply card, the department will proceed with an eligibility determination, including conducting a face-to-face interview with the client, the designated representative or both...

The Code of Federal Regulations at 42 C.F.R § 447.25 sets forth for direct payments to certain recipients:

> (d) Federal requirements. (1) Direct payments to recipients under this section are an alternative to payments directly to providers and are subject to the same conditions...

The Code of Federal Regulations at 42 C.F.R § 447.45 sets forth for timely claims payment:

> (d) Timely processing of claims.
> (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.

The Florida Administrative Code at 59G-5.110 "Claims Payment" states:

> (1)(a) The agency provides eligible individuals with access to Medicaid services and goods by direct payment to the Medicaid provider upon submission of a payable claim to the fiscal agent contractor. Except as provided for by law or federal regulation, payments for services rendered or goods supplied shall be made by direct payment to the provider except that payments may be made in the name of the provider to the provider's billing agent if designated in writing by the provider. Direct payment may be made to a recipient who paid for medically necessary, Medicaid-covered services received from the beginning date of eligibility (including the three-month retroactive period) and paid for during the period of time between an erroneous denial or termination of Medicaid eligibility and a successful appeal or an agency determination in the recipient's favor. The services must have been covered by Medicaid at the time they were provided. Medicaid will send payment directly to the recipient upon submission of valid receipts to the Agency for Health Care Administration. All payments shall be made at the Medicaid established payment rate in effect at the time the services were rendered. Any services or goods the recipient paid before receiving an erroneous determination or services for which reimbursement from a third party is available are not eligible for reimbursement to the recipient.
> (b) Recipients will be notified in writing of their right to reimbursement...

The approval by Social Security Administration is an approval of disability and disability payment. A SSI application is also a Medicaid application. The petitioner was correct that effective the date of the determination of the Administrative Law Judge he was eligible for Medicaid. The rule indicates that upon SSI approval, all SSI recipients receive a system-generated notice of potential entitlement for retroactive Medicaid benefits and a reply card to be returned to the Department of Children and Families if the SSI recipient is interested in receiving retroactive Medicaid benefits.

The regulations state that direct payments to recipients are subject to the same conditions as providers. The regulation states that the Medicaid agency must require providers to submit all claims no later than twelve months from the date of service. The exception would be for successful appeals. Then the Medicaid agency must require providers or recipients to submit all claims no later than twelve months from the date of the successful appeal. The petitioner disability decision was on October 11, 2007. No evidence was submitted that the petitioner requested reimbursement of medical payments for January 5, 2005 through October 31, 2007 prior to September 4, 2009. The petitioner's request did not meet the criteria for reimbursement. Based upon the above cited authorities, the respondent's action to deny reimbursement of medical bills from January 5, 2005 through October 31, 2007 was within the rules and regulations of the Program.

DECISION

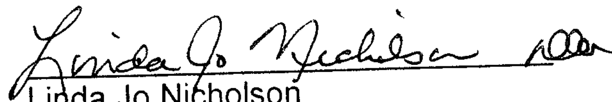
This appeal is denied.

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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 30th day of December 2009,

in Tallahassee, Florida.



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