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

FILED

APR 30 2014

OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

APPEAL NO. 14F-00891

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 Broward
UNIT: AHCA

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened in this matter before the undersigned hearing officer telephonically on February 24, 2014, at 1:10 p.m.

APPEARANCES

For the Petitioner:
Petitioner

For the Respondent: Ken Hamblin
Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is the refusal of the Agency for Health Care Administration to provide the petitioner with a letter of authorization for an MRI.

PRELIMINARY STATEMENT

[redacted], the petitioner ("petitioner") appeared and represented himself. The Agency for Health Care Administration (sometimes hereinafter referred to as the "respondent", "Agency" or "AHCA") was represented by Ken Hamblin, Field Office 10 Fair Hearing Coordinator for the Agency for Health Care Administration. Robert Lantieri, M.D., Associate Medical Director of Med Solutions, appeared as a witness on behalf of the Agency.

The hearing record in this matter was left open until the close of business on the day of the hearing for the respondent to provide information showing the dates that the petitioner was eligible to receive Medicaid. This information was accepted into evidence upon receipt and marked as respondent's Exhibit "1".

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. He resides in Broward County, Florida.

2. At all times relevant to this proceeding, the petitioner was enrolled in the Medically Needy Program.

3. The petitioner underwent surgery on September 11, 2013. On the morning of his surgery, medical staff began to administer an MRI on the petitioner. The petitioner was unable to tolerate the MRI and the test was terminated a few minutes after it began.

4. The petitioner returned to the medical facility on September 19, 2013 with a prescription from his doctor to have the MRI completed.

5. Hospital staff would not administer an MRI on the petitioner on September 19, 2013 because it was not pre-authorized by Medicaid. The respondent was under the impression that the petitioner completed the first MRI on September 11, 2013.

6. The petitioner met his share of cost in September. Medicaid coverage was activated for the petitioner on the day he met his share of cost. Consequently, Medicaid would pay for all medically necessary activities from the date he met his share of cost in September until the end of the month.

7. Medicaid would have paid for the petitioner's MRI had it been completed on September 19, 2013.

8. The petitioner did not have the MRI completed in September 2013 after he met his share of cost and his Medicaid was activated. Petitioner testified at the hearing he later requested that the Agency for Health Care Administration provide him with letter of authorization allowing him to have the MRI completed at a later date.

9. The Agency for Health Care Administration has refused to issue a letter of authorization for the MRI because the petitioner does not have Medicaid; he is enrolled in the Medically Needy Program.

10. The Agency has not issued a letter or notice denying petitioner's request for an MRI.

11. Respondent is not disputing the medical necessity of the MRI. Although the respondent will not issue a pre-authorization letter for the MRI because petitioner is not on active Medicaid, the petitioner can have the MRI completed by going and being admitted to the emergency room of a local hospital. The petitioner feels this extended procedure should be unnecessary and is a form of Medicaid fraud.

12. The Agency representative explained there is no mechanism through which Medicaid can issue a pre-authorization letter or pay for a procedure for a person who is not on active Medicaid.

13. The Agency representative encouraged the petitioner to visit his local hospital and to have the MRI completed through an admission to the emergency room should the petitioner still feel the MRI is medically necessary.

14. The petitioner's share of cost is approximately $4,200. If the petitioner meets or exceeds his share of cost on the day the MRI is performed, Medicaid will pay for the entire procedure.

CONCLUSIONS OF LAW

15. 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 Fla. Stat. § 120.80.

16. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

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

18. The petitioner participates in the Medically Needy Program. Fla. Admin. Code. R. 65A-1.702 defines when a person becomes eligible for Medicaid in this program:

> (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.

> (11) Re-Enrollment. In order for an individual or family to be eligible for re-enrollment in the Medically Needy program, they must:
> (a) Continue to satisfy the resource criteria;
> (b) Continue to satisfy all non-financial eligibility criteria;
> (c) Have completed the required interview; and
> (d) Provide verifications as needed. The re-enrollment period shall exceed 12 months only if there is a delay in processing the re-enrollment.

19. 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.).

20. The Florida Medicaid Provider General Handbook July 2012 ("Handbook") is promulgated into rule by Fla. Admin. Code R. 59G-5.020. The Handbook discusses the Medically Needy Program.

21. Rule 65-2.056, Fla. Admin. Code, Basis of Hearings, informs the Hearing shall include consideration of:

> (1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.
> (2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.
> (3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision.

22. In the present case, the respondent is not disputing the medical necessity of the MRI. The respondent is saying it cannot pre-authorize the MRI because petitioner is enrolled in the Medically Needy Program and not on active Medicaid.

23. The Handbook describes the Medically Needy Program on Page 3-31 as follows

> A Medically Needy recipient is an individual who would qualify for Medicaid, except that the individual's income or resources exceed Medicaid's income or resource limits.
>
> On a month-by-month basis, the individual's medical expenses are subtracted from the individual's income, and if the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid from the day he became eligible until the end of the month.

24. Rule 65A-1.702, Fla. Admin. Code, Special Provisions informs

> (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, with the following exceptions:...
>
> (b) Individuals applying for the Medically Needy program become eligible on the date their incurred allowable medical expenses, excluding payments by all third party sources except state or local governments not funded in full by federal funds, equal their share of cost, provided that all other conditions of eligibility are met. Any bill used in full to meet the individual's share of cost (SOC) shall not be paid by Medicaid.

25. The Handbook, on Page 3-31, also explains

> A Medically Needy recipient becomes eligible on the day that the recipient incurs allowable medical expenses that equal the amount by which his income exceeds the Medicaid income standard (share of cost). The recipient must submit his medical bills to DCF, and DCF makes the eligibility determination. The recipient will be eligible through the end of the month.

26. As explained above, the Medicaid eligibility date of a recipient enrolled in the Medically Needy Program is the date the individual's incurred allowable medical expenses equal the individual's share of cost. Any bill incurred prior to the individual meeting his or her share of cost will not be paid by Medicaid.

27. In the present case, it is undisputed that the petitioner is enrolled in the Medically Needy Program. The amount of his share of cost is also not in dispute. The issue in this matter is the respondent's denial of the petitioner's request for a letter of authorization for an MRI. The authorities above demonstrate that Medicaid eligibility for a Medically Needy recipient does not begin until the day the individual meets his share of cost. Once eligibility begins, it continues until the end of the month in which it began. Petitioner provided no information indicating that he met his share of cost in the month this hearing was held. The last date the petitioner had active Medicaid was September 30, 2013. Accordingly, respondent cannot issue the letter of authorization the petitioner is requesting.

28. Rule 65-2.056, Fla. Admin. Code explains that, in order for a hearing officer or the Office of Appeal Hearings to assert jurisdiction over a matter, the Agency must have taken action adverse to the interests of the petitioner. In the present case, no notice or any other evidence was presented at the hearing demonstrating that the respondent took any action to deny the petitioner's request for an MRI. The respondent cannot issue a letter of authorization to an individual who is not actively enrolled in Medicaid. Consequently, since there has been no denial of services, the hearing officer may not rightfully take jurisdiction over this matter and render a decision.

29. In light of the circumstances surrounding this appeal, it is important to note that the absence of a pre-authorization letter from the respondent does not prevent the petitioner from having the MRI completed. Respondent advised the petitioner he may visit the emergency room of a local hospital to have the MRI done.

30. Once the petitioner has the MRI completed and submits the bill to the respondent, the bill will considered to determine if the petitioner's met his share of cost. The action taken by the respondent may be reviewable in a fair hearing. If the Agency proposes to undertake any action which gives rise to hearing rights, the petitioner will be informed of his hearing rights in the notice.

31. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence submitted at the hearing and reviewed all conditions of Medicaid eligibility for individuals enrolled in the Medically Needy Program set forth in the Florida Administrative Code and the rules governing the Florida Medicaid program, as well as all authority setting forth the circumstances under which a hearing officer may assert jurisdiction over a matter.

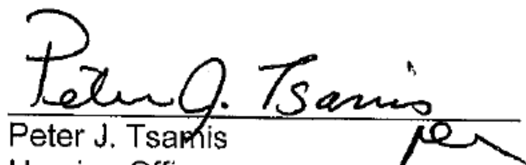
DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, petitioner's appeal is hereby DISMISSED as non-jurisdictional.

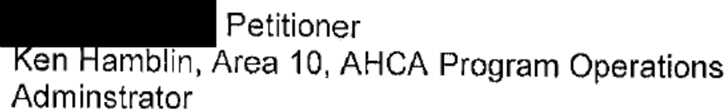
NOTICE OF RIGHT TO APPEAL

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 30th day of April, 2014,



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@dcf.state.fl.us

Copies Furnished To: [redacted] Petitioner
Ken Hamblin, Area 10, AHCA Program Operations Adminstrator