

Jun 23, 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-01131

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 07 [REDACTED]
UNIT: AHCA

And

UNITED HEALTHCARE

RESPONDENTS.

_____ /

AMENDED FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 1, 2017 at 3:05 p.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se

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

STATEMENT OF ISSUE

Whether the petitioner is eligible to receive lower false teeth/lower dentures through Medicaid. The petitioner holds the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The undersigned issued a Final Order in this matter on June 24, 2016. On March 24, 2017, The Fifth District Court of Appeal reversed the order and remanded the matter for another hearing. The court concluded that a new hearing was warranted because “the Hearing Officer was provided and relied upon an inapplicable policy and [petitioner] was not given an opportunity to examine or rebut the legal authority...”

The hearing was scheduled to convene on May 17, 2017, but was continued because the petitioner was unable to appear. The hearing was rescheduled for June 1, 2017.

The petitioner requested a continuance in order to present witnesses who could testify about the quality of care and customer service he received from a Medicaid dental provider and from United Healthcare. A ruling was withheld pending development of the record regarding the relevancy of the witnesses. The motion is hereby denied in accordance with 42 C.F.R. § 431.220; quality of care and customer service issues are not within the jurisdiction of the Office of Appeal Hearings.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as witnesses for the respondent from United: Christian Laos, senior compliance analyst and Arlene Carrion, 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. Medicaid Dental Services Coverage and Limitations Handbook, dated November 2011, was administratively noticed.

The respondent sent copies of its documentary evidence to the hearing officer and the petitioner on May 1, 2017. When the hearing convened on June 1, 2017, the petitioner asserted that he had not received his copy of the respondent's evidence. A copy was shared with the petitioner via an e-mail attachment and the hearing proceeded with the petitioner's agreement. The record was held open until close of business on June 15, 2017 for the petitioner to further review the evidence and file a written response. The petitioner did not file a written response or request a deadline extension. The hearing record was closed on June 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 Agency for Health Care Administration (Agency or AHCA) administers the Florida Medicaid Program. The Agency contracts with numerous health care organizations to provide medical services to Medicaid enrollees. United Healthcare (United) is the contracted HMO that made the decision under challenge in the instant appeal.
2. The petitioner (age 60) is a Florida Medicaid recipient. (Respondent's Composite Exhibit 1)

3. During the time period in question, July 2015 – October 2015, the petitioner was enrolled with United HMO. The petitioner later switched to Sunshine HMO.

(Petitioner testimony)

4. In July 2015, Economy Dentures, the petitioner's dental provider at that time, submitted an authorization request to United to extract the petitioner's remaining lower teeth, shave bone spurs resulting from extraction of teeth, and to fit him with lower false teeth/lower dentures. (Respondent's Composite Exhibit 1)

5. United approved the service request in its entirety on July 29, 2015.

(Respondent's Composite Exhibit 1)

6. The petitioner received the lower false teeth/lower dentures in August 2015.

(Respondent's Composite Exhibit 1)

7. A Better Denture, another dental provider, submitted a request for lower false teeth/lower dentures to United in October 2015. (Respondent's Composite Exhibit 1)

8. United denied the request on October 21, 2015, citing coverage limitations as the reason for the denial. (Respondent's Composite Exhibit 1)

9. Dr. Ankit Amin, United dental consultant, explained that Medicaid provides one set of lower dentures per enrollee per lifetime. The petitioner received lower dentures in August 2015; he cannot receive a second set of lower dentures through Medicaid. (Testimony of Dr. Ankit Amin)

10. The petitioner asserted that the lower dentures he received did not fit properly and would fall out of his mouth. One side of the denture's surface was completely flat, not curved to the shape of his gum. He initially thought the dentures

were temporary because of the poor fit and construction. He discovered later, after United's October 2015 denial decision, that the dentures was permanent. (Petitioner testimony)

11. The petitioner asserted that the dental provider (Economy Dentures) provided substandard care. He initially went to the dental provider for deep cleaning of his lower teeth. He was coerced into agreeing to the removal of all his remaining lower teeth (approximately nine teeth). He was then provided dentures he has never been able to use. The petitioner asserted further that the provider did not perform the bone shaving required to smooth his gum surface so the dentures would fit properly. The provider billed Medicaid for services it did not provide. The petitioner asserted that he contacted United about his issues with the provider on multiple occasions; United failed to properly address his complaints. As a result, he has never received functional lower dentures. The petitioner argued that the appropriate remedy in this matter is for Medicaid to provide him with new lower dentures. (Petitioner testimony)

12. During rebuttal testimony, Dr. Amin noted that adjustments and/or realignments are customarily required over a couple of months after delivery of new dentures. The petitioner reported problems with his new dentures mid-to-late 2015. United reached out to the provider; the provider asserted that the petitioner only returned once for an adjustment. The provider is willing to work with the petitioner. (Testimony of Dr. Amin)

CONCLUSIONS OF LAW

13. 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.

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 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 petitioner.

17. 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.).

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

19. Medicaid’s Dental Services Coverage and Limitations Handbook (the Handbook), dated November 2011, was the governing authority at the time the decision under challenge was made. The Handbook addresses coverage limitations for receipt of dentures on page 2-32: “Full and removable partial dentures may be reimbursed once for an upper, a lower or a complete set per the lifetime of the recipient.” The

Handbook provides that exceptions “to the limitation...may be considered for dentures if the dental provider determines the full or partial dentures are no longer functional, because of the physical condition of the recipient; or full or partial dentures are no longer functional, because of the condition of the denture.”

20. The petitioner received lower dentures in August 2015. The petitioner requested a second set of lower dentures in October 2015. The respondent denied the petitioner’s request, citing coverage limitations as the reason for the denial.

21. The petitioner argued that he received poor quality lower dentures that he has never been able to use and Medicaid should provide a new dentures.

22. To qualify for an exception to the one per lifetime limitation, a dental provider must determine that new dentures are necessary because of the health of the recipient or the functionality of the original dentures. There is no evidence that a dental provider has determined that the petitioner’s lower dentures are no longer functional because of his physical condition or the condition of his dentures.

23. After careful review, the undersigned concludes that the petitioner did not meet his burden of proof. The respondent’s decision in this matter was correct.

24. The petitioner alleged that a dental provider provided substandard care and billed for services he did not receive. The petitioner also alleged a dental provider and United HMO provided poor customer service.

25. Federal Medicaid Regulations at 42 C.F.R. § 431.220 states in relevant part, “(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 recipient who requests it because he or she believes the agency has taken an action erroneously...”

26. The Centers for Medicare & Medicaid Services' State Medicaid Manual, publication #45, states in part:

2900 FAIR HEARINGS AND APPEALS

Section 1902(a)(3) of the Social Security Act requires that States ‘provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.’ Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited.

2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).--Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the following events occur:

- o denial of eligibility,
- o the claim is not acted upon with reasonable promptness,
- o termination of eligibility or covered services,
- o suspension of eligibility or covered services, or
- o reduction of eligibility or covered service

27. The above federal authority explains that an opportunity for a hearing must be granted when a Medicaid claim for service has been denied or when a recipient believes the agency has taken an action erroneously. The State Medicaid Manual further explains the recipient’s right to a hearing when either Medicaid eligibility or a claim for a service under Medicaid is denied, terminated, reduced or delayed.

28. The Office of Appeal Hearings does not have jurisdiction over provider billing issues or customer service issues. The petitioner's concerns should be directed to AHCA's Consumer Complaint Office at 1-877-254-1055.

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 23 day of June, 2017,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
United Healthcare Hearings Unit

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

FILED

May 23, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-04220

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 April 17, 2017, at 9:10 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: The petitioner was present, but verbally authorized [REDACTED] to speak on her behalf.

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 she does not meet the disability criteria is correct. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Lauren Miller, Program Operations Administrator with the Division of Disability Determination (DDD), appeared as witness for the respondent.

Continuances were granted for three prior scheduled hearings at the petitioner's request.

During the hearing, the petitioner did not present any exhibits for consideration. The respondent submitted four (4) exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 4. The record was left open through May 1, 2017 for the petitioner to provide additional information. The petitioner did not provide any additional information, nor did she contact the hearing officer for additional time. The record was closed on May 1, 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. Prior to the action under appeal, the petitioner has previously applied for disability through Social Security Administration (SSA) on July 29, 2011. The claim was denied initially on November 7, 2011 and upon reconsideration on January 11, 2012. On April 15, 2012, she appealed the decision. She appeared and testified at a hearing held on December 3, 2013. On May 27, 2014, her appeal was denied by an Administrative Law Judge (ALJ). That decision is currently under appeal at the U.S. District Court, see Respondent's Exhibit 2, pages 80-94.
2. On June 26, 2015, the petitioner underwent a CT scan of the abdomen and received an initial diagnosis of "[REDACTED]".

On February 9, 2016, the petitioner underwent a [REDACTED] of the left [REDACTED]. Pathology report confirmed [REDACTED] with no extension beyond the margins. A follow-up ultrasound of the left [REDACTED] on May 24, 2016, found no recurrence of the cancer, see Respondent's Exhibit 2, page 67

3. 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 for individuals applying for disability benefits under the SSI-Related Medicaid Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

4. On March 7, 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 because she failed to sign the medical release forms necessary for the release of her medical records. No disability package was sent to DDD. That application was denied and the petitioner was notified on April 7, 2016. On June 2, 2016, the petitioner requested an appeal challenging the Department's action.

5. The petitioner [REDACTED] is 52 with a history of [REDACTED]. 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. She has been working for 15 years as a telephone information clerk. She last worked in 2009.

She is ambulatory and requires no assistive devices for ambulation. The petitioner has a high school diploma and did not attend college.

6. On January 25, 2017, the Department initiated a disability review on the petitioner and sent her file to DDD for consideration.
7. On February 7, 2017, DDD requested and obtained petitioner's medical record from [REDACTED] Medical Center and used it to complete a disability determination on the petitioner. DDD reviewed the petitioner's medical records and determined that her conditions were severe enough to warrant an independent sequential evaluation.
8. On February 13, 2017 DDD, completed a Physical Residual Functional Capacity (RFC) assessment on the petitioner. Case Analysis notes indicate that pathology report was reviewed. The notes in the record indicate that petitioner's [REDACTED] was successful and that a follow-up ultrasound confirmed no recurrence of the cancer.
9. On March 8, 2017, DDD made an independent determination and denied the petitioner's claim of disability with reason code (N 31)-"customary past work, no visual impairment." Based on the medical record from Jacobi Medical Center and its own independent RFC assessment, DDD determined that the petitioner was not disabled and concluded that she has potential to perform substantial gainful activities (SGA), see Respondent's Exhibit 2, pages 5-18. DDD then alerted the Department.
10. On March 14, 2017, the Department mailed the petitioner a Notice of Case Action denying her application for SSI-Related Medicaid due to not meeting the disability criteria, see Respondent's Exhibit 1.
11. The respondent explained that it denied the petitioner's SSI-Related Medicaid application because SSA has determined that she was not disabled and DDD has

reached a separate, but similar decision. The respondent explained that once DDD determined that the petitioner appears capable of doing past work in the national economy, the Department has to deny the Medicaid as she does not meet the technical requirement for the SSI-Related Medicaid Program for people under age 65.

12. The petitioner's representative disputed the facts presented and asserted as follows: That DDD did not make a fair disability determination. That DDD just rubber-stamped the SSA decision. That the petitioner has diverticulitis and cannot afford to work. That the national economy is so bad that petitioner is employable, as she will be competing for the same jobs with people who have college degrees. That petitioner's medical condition has not changed. Petitioner believes that she should be found disabled and be eligible for Medicaid benefits based on her medical history ([REDACTED]

[REDACTED] She does not understand why she cannot get Medicaid to get the medical care she needs to improve her health.

13. The record was left open through May 1, 2017 for the petitioner to provide additional evidence, but none was received.

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. Medicaid eligibility is based on federal regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents, children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 or older.

17. Florida Administrative Code R. 65A-1.703, Family-Related Medicaid Coverage Groups, in part states:

(1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule...

(5) Medicaid for pregnant women.

18. The evidence submitted establishes that the petitioner has no minor children in the home and is not pregnant. Therefore, the petitioner is not eligible for Family-Related Medicaid.

19. The evidence submitted also establishes that the petitioner is not age 65 or older and has not been considered disabled by the SSA. Therefore, the Department considered the petitioner for SSI-Related Medicaid.

20. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level. For an individual less than 65 years of age to receive 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, which makes you unable to do your previous work or any other substantial gainful activity, which exists in the national economy. To determine whether you are able to do any other work, we consider your residual functional capacity and your age, education, and work experience.

21. 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...”

22. Federal Regulation at 42 C.F.R. § 435.541 addresses Determinations of disability and 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.

(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;

23. The above regulation provides that a state Medicaid determination of disability must be in accordance with the requirements for evaluating evidence under the SSI Program specified in 20 C.F.R. §§ 416.901 through 416.998. In this instant case, DDD only considered the new condition ([REDACTED]), as the others conditions [REDACTED] [REDACTED]) are still under appeal with SSA.

24. The hearing officer evaluated the petitioner's claim of disability in this de novo decision using the five-step sequential evaluation as set forth in 20 C.F.R. §416.920.

25. The Federal Regulation at 20 C.F.R. §416.920, Evaluation of disability of adults, in general, states:

(a) General—(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.

(2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.

(3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.

(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) 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) of this section and § 416.960(c)...

(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.

26. The cited authority sets forth the five steps of a disability assessment. In evaluating the petitioner's claim of disability, the sequential evaluation as set forth in 20 C.F.R. §416.920 is used. The first step is to determine whether the individual is working. The petitioner is not working and has not worked since 2009. Therefore, the first step is met. The analysis continues.

27. The second step is to determine whether an individual has a severe impairment expected to last for 12 continuous months. Based on the medical evidence, petitioner has a wide range of medical problems: [REDACTED]

[REDACTED]. In combination, these impairments are considered severe.

Her conditions are expected to last for twelve months. The second step is met.

28. The third step is to determine whether the individual's impairment(s) meet or equals a listed impairment in Appendix 1 to Subpart P of Part 404 of the Social Security Act. Based on the cumulative evidence presented, the petitioner's impairments do not meet or equal the "Listing of impairments section 13.00 [REDACTED]

[REDACTED]. Petitioner's [REDACTED] surgery was successful and there is no history of recurrence.

29. The fourth step is to determine whether the petitioner could return to her previous employment or do past relevant work based on her residual functional capacity. The DDD assessment indicates petitioner appears capable of doing past work in the national economy. The petitioner worked as a telephone information clerk. According to the Dictionary of Occupational Titles at sections 237.367-046 and 237.367-022, these professions have the exertional requirements of sedentary work.

30. The petitioner underwent a [REDACTED] on February 9, 2016. She is ambulatory and requires no assistive devices for ambulation. Her musculoskeletal system is within normal limits. She retains the residual functional capacity of at least sedentary level. This is consistent with the cumulative evidence presented. The representative argued that DDD did not make a fair and independent disability determination and that DDD just rubber-stamped the SSA decision. The representative maintains that the petitioner has not worked since 2010 and should be considered disabled.

31. While the petitioner may have medically determinable impairments, the evidence indicates the severity of these impairments would not preclude her from performing similar work in the national economy. The undersigned concludes that the petitioner

should be capable of performing sedentary work based on the cumulative evidence.

The petitioner is found not to be disabled at step four. The fifth step in the disability evaluation will not be addressed.

32. In sum, the petitioner is not eligible for Medicaid under any of the Family-Related coverage groups because she is not pregnant and has no minor children. She is not eligible for Medicaid under the SSI-Related Medicaid coverage group because she is not aged (over 65), blind, and does not meet the disability criteria because she is capable of SGA. Thus, the petitioner does not meet the technical criteria to receive Medicaid, as she is not considered to be disabled pursuant 20 C.F.R. §416.969.

DECISION

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

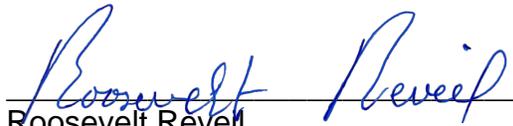
FINAL ORDER (Cont.)

16F-04220

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DONE and ORDERED this 23 day of May, 2017,

in Tallahassee, Florida.



Roosevelt Revel

Hearing Officer

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Office of Economic Self Sufficiency

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

FILED

May 19, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-07347

PETITIONER,

Vs.

CASE NO [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 [REDACTED]
UNIT: 88216

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 14, 2017 at 1:34 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Attorney for the petitioner.

For the Respondent: Jane Almy-Loewinger, Attorney for the respondent.

ISSUE

At issue is the respondent's action on September 8, 2016 to deny the petitioner's application for Institutionalized Care Program (ICP) Medicaid due to the non-receipt of requested verifications.

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

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on November 22, 2016 at 11:30 a.m. On November 21, 2016, the Department contacted the undersigned to request for the hearing to be rescheduled as the Department's representative was not going to be available to appear for the hearing. The Department's representative stated that he contacted the petitioner's representative, who did not object to the request for a continuance. Therefore, the Department's request for a continuance was granted. The hearing was rescheduled to January 5, 2017 at 11:30 a.m.

On December 23, 2016, the Department contacted the undersigned to request for the hearing to be rescheduled as the Department's attorney would not be available for the hearing on January 5, 2017 at 11:30 a.m. and that he was not able to get in contact with the petitioner's legal counsel to determine if there were an objection. On January 3, 2017, the Department contacted the undersigned and stated that the petitioner's attorney did not object to its request for a continuance. Therefore, the Department's request for a continuance was granted. The hearing was rescheduled to February 14, 2017 at 1:30 p.m.

Appearing as witnesses for the petitioner were her daughter, [REDACTED], and her son in law, [REDACTED]

Appearing as a witness for the respondent was Matthew Lynn, Economic Self-Sufficient Specialist II for the Department of Children and Families (DCF).

The petitioner's representative provided a copy of the Agreement for Disavowment (Agreement) in response to not being able to obtain verifications of the

petitioner's spouse's assets that are at issue. The petitioner's representative believes that the Agreement is sufficient to show that the petitioner's assets are hers and the petitioner's spouse's assets are his and that each is responsible for his and her own bills.

The respondent's representative objected to the Agreement being included as part of the petitioner's exhibit and being considered as a legal document, as it appears to be self-serving document that was written to be considered as part of the application process. The respondent's representative contends that the document was signed by the petitioner's son in law on behalf of the petitioner and the petitioner's spouse. The respondent's representative also argues that the petitioner's family does not allow communication to occur between the son-in law and the petitioner's spouse in order to determine whether or not the petitioner's spouse revoked the son in law's power of attorney. The respondent's representative argues that the petitioner's representatives should establish if there is another power of attorney in place prior to considering the Agreement to be a valid document established between the petitioner and the petitioner's spouse. The Department's representative contends that regardless as to whether or not the Agreement being in place, its policy requires verification of all assets in order for a determine of eligibility to be made. The Department's representative believes that the petitioner's power of attorney should be able to obtain verification of assets for both the petitioner and her spouse.

The petitioner's representative objected to the Agreement for Disavowment not being included as part of the Petitioner's Exhibit 1. The undersigned reserved the ruling

as to whether or not the Agreement for Disavowment would be included in the Petitioner's Exhibit 1. Upon further review, the undersigned rules to include the Agreement as part of the Petitioner's Exhibit 1 and will consider its weight in the decision for the Final Order.

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

The petitioner's representative requested to leave the record open for 60 days to allow for additional verifications to be sent to the respondent. The respondent did not object. Therefore, the record was held open until 5:00 p.m. on April 14, 2017.

The petitioner's representative submitted a Request for a Second hearing in this appeal. The undersigned has held the hearing in this matter on February 14, 2017 at 1:30 p.m., which will be addressed in this Final Order. However, should the petitioner have received a more current notice of adverse action with appeal rights regarding a new issue, she may exercise her rights and request a fair hearing in response to that notice.

Additional information was received from the petitioner's representative on April 13, 2017. This additional information was entered as the Petitioner's Exhibit 2.

The record was closed as of 5:00 p.m. on April 14, 2017.

FINDINGS OF FACT

1. On August 8, 2016, the petitioner applied for ICP Medicaid for herself. The petitioner has a spouse, who was not included on the application. The Petitioner's

Exhibit 1 includes the Notice of Case Action (NOCA) that was mailed to the petitioner on August 10, 2016. The NOCA requested the following verifications due by August 22, 2016:

Please complete and sign the "Financial Information Release" form

Other-please see comments below

...Case is pending for 1)Level of Care...2) last three months of bank account statements, 3) proof of pension/retirement income, 4) We must add your husband to the case: We need full name, SS number, Date of birth, and proof of his assets, 5) proof of Life Insurance Cash Value, 6) proof of premium for BC/BS (health insurance), 7) If there is, medical bills incurred within 3 months before this application, including nursing home bills, 8) Signed Financial release (form included), be signed by you and also be signed by your spouse, if married (see two places provided for signatures), but if signed by someone else, please attach their PCA or Guardian documents. Self-appointed representative cannot sign the release. If you cannot sign due to medical conditions, please provide a signed note from certified nurse or a physician stating your condition and that you cannot sign.

Please return or fax the information to the return address or fax number listed above. If you need help getting this information, let us know right away.

If you do not contact us or provide the requested information, we will be unable to determine your eligibility. We will deny your application or your benefits may end.

2. The Department denied the petitioner's application for ICP Medicaid on September 8, 2016 on its contention that it did not receive all of the information requested to determine eligibility.

3. The petitioner's son in law does not agree with the Department's denial as he argues that he was not aware of all of the requested verifications until he received the Department's evidence packet for the hearing. The petitioner's son in law believes that he provided all requested verifications to the Department prior to the denial of the application for ICP Medicaid. The petitioner's son in law argues that the petitioner's

spouse was uncooperative in the application process to determine the petitioner's eligibility for ICP Medicaid. The petitioner's son in law explained that he was previously the co-owner of a bank account with the petitioner and her spouse. The petitioner's son in law contends that the petitioner's spouse closed out the joint bank account, without his knowledge, and opened a new bank account to include the petitioner's spouse's daughter on the account. The petitioner's son in law contends that the petitioner does not have access to her home in order to obtain her personal property. The petitioner's son in law contends that the petitioner does not have any other assets besides the marital home, personal belongings, and the bank account where her Social Security income and retirement income is deposited.

4. The petitioner's son in law argues that the petitioner's husband replaced the locks on the doors to the marital home and was unable to obtain information and the petitioner's personal clothing and other belongings. The petitioner's son in law argues that the petitioner's spouse was not cooperating in his efforts to obtain requested verifications. Therefore, the petitioner's son in law entered into a mutual agreement between the petitioner and the petitioner's spouse to "severally disavow any responsibility or liability of any debt of the other (*Petitioner's Exhibit 1, page 63*). The petitioner son in law contends that the petitioner's only assets are her personal property, which she cannot access due to the change of locks, a bank account which holds her Social Security and retirement incomes, and her part ownership of the marital home;

5. The petitioner's son in law acknowledges that the NOCA was provided but it was not clear as to which information was required. The petitioner's son in law and the

petitioner's daughter contend that they prepared a letter to send to the petitioner's children to obtain the verifications requested by the Department but was not able to give the letter to the children.

6. The Department's representative acknowledges that it previously received some bank statements, copies of the petitioner's spouse's identification card, and a copy of the petitioner's spouse's Social Security card. The Department also acknowledges receiving a copy of a letter from the petitioner and a copy of the NOCA dated August 10, 2016, received on August 12, 2016.

7. The Department's representative contends that it received in August 2016 the verifications that were duplicated in the petitioner's evidence packet that was submitted in January 2017 for the hearing. The Department contends that all of the required verifications were not provided in order to approve the petitioner's case.

8. The petitioner's son in law explained that he was power of attorney for the petitioner's spouse as well as the petitioner. The petitioner's son in law and petitioner's daughter contend that the petitioner cannot reside in their home as she needs professional and long-term care for her medical conditions.

9. The petitioner's son in law explained that he does not know if the petitioner's spouse has revoked or rescinded his power of attorney over his affairs and replaced him with the petitioner's spouse's daughter. The petitioner's son in law explained that he is not aware if the petitioner's spouse's daughter has applied for guardianship over the petitioner's spouse.

10. The petitioner's daughter contends that she was previously the caretaker for the petitioner and the petitioner's spouse before the petitioner suffered a [REDACTED]. The petitioner's daughter contends that the petitioner was put into a nursing home after suffering from a [REDACTED]. The petitioner's daughter contends that she contacted the petitioner's spouse, who has [REDACTED], in an effort to obtain the petitioner's personal belongings. The petitioner's daughter contends that she was allowed on one occasion to retrieve some of the petitioner's belongings but has since been unable to access the rest of her belongings, as the petitioner's spouse and his daughter have been very uncooperative.

11. The petitioner's daughter contends that the petitioner's spouse's daughter will not communicate with her or with the petitioner's son in law. The petitioner's daughter contends that the petitioner's spouse's daughter will not allow the petitioner's spouse to contact the petitioner. The petitioner's daughter contends that the petitioner's daughter has been selling the petitioner's property during yard sales without her permission. The petitioner's daughter contends that the petitioner's daughter refused to provide financial assistance to the petitioner. The petitioner's daughter believes the petitioner has about \$900 each month in deposits and a balance of approximately \$2000 in her bank account; the facility is paid \$300 to \$350 each month.

12. The petitioner's representative contends that he was encouraged to file an "Assignment of Rights to Support" due to the hardship in obtaining verification of assets.

13. The Department explained that he informed the petitioner's representative of the option to file an "Assignment of Rights to Support" but that the petitioner's spouse

would still need to verify his assets. The Respondent's Exhibit 2, page 23, includes a signed copy of the "Assignment of Rights to Support."

14. The Department explained that, for the purposes of ICP Medicaid, the assets for the individual in the institution and the individual's spouse are considered.

Therefore, it would need verification of the assets owned by the individual in the institution, as well as verification of the assets owned by the individual's spouse in the community. The Department contends that the bank statements, life insurance policies, and tax records for the property would be needed to verify assets.

15. The Department believes that the power of attorney should be able to obtain verifications for all assets owned by the individual and the individual's spouse. The Department contends that the "Assignment of Rights to Support" can be considered but verifications of the assets in question would still need to be provided, even though the petitioner's spouse removed the petitioner's name from the bank accounts.

16. The Department contends that the petitioner's home would be excluded as an asset if it is the homestead property to which the petitioner would return upon discharge from the nursing facility. The Department contends that it would need verifications of the last three months' bank statements from all bank accounts for the petitioner's spouse, verification of the removal of the petitioner's name from the bank accounts.

17. The Department referred to its policy, passage 1640.0314.01, which explains that the assets of both spouses must be considered in determining eligibility for ICP Medicaid (*Respondent's Exhibit 2, page 24*). The Department explained that the

assignment of support rights is an occurrence when the community spouse refuses to use his or her assets (which solely belong to the community spouse) to support the individual who resides in an institution. The Department contends that it was not able to determine if the petitioner was eligible for ICP Medicaid because it did not receive all verifications needed to verify the assets.

18. The Department contends that the petitioner's spouse is refusing to cooperate in determining eligibility, therefore, it was not able to determine if the petitioner was ineligible due to her spouse's assets. The Department contends that it was unable to establish that a hardship existed. The Department contends that in the petitioner's case, it is a refusal to cooperate to establish eligibility for ICP Medicaid.

19. The Department explained that the refusal for support is when the assets have been verified and the institutionalized individual would be ineligible due to the assets owned by the community spouse AND the community spouse refuses to use any of his or her assets to support the institutionalized spouse. In this case, the institutionalized spouse would be eligible for ICP Medicaid if eligible if accessible assets do not exceed the asset limit but assets owned by the community spouse would cause ineligibility AND the community spouse refuses to use his or her assets to support the institutionalized individual.

20. The Department explained that it was not able to verify the assets owned by the community spouse; therefore, it was not able to apply its policy regarding undue hardship. The Department contends that its policy regarding the assignment of support rights requires the community spouse to verify his or her assets, for his or her assets to

cause ineligibility of the institutionalized spouse, and his or her refusal to use his or her assets to support the institutionalized individual.

21. The petitioner's son in law contends that was previously a co-owner to the bank account at [REDACTED]; even though he had power of attorney, he no longer has access to [REDACTED] because his name was later taken off of the account. The petitioner's son in law contends that he provided bank statements from when he was on the bank account at [REDACTED] and proof of life insurance for the petitioner. The petitioner's son in law believes that he provided verifications when he had the ability to produce verifications of all the assets owned by the petitioner's spouse.

22. The Department's representative acknowledges receipt of bank statements from joint bank account at [REDACTED] in the names of the petitioner's, petitioner's spouse, and the petitioner's spouse; bank statements from [REDACTED]; and bank statements from [REDACTED]. The Department's representative also acknowledges receipt of the life insurance policy in the petitioner's name. The Department's representative contends that additional verifications for a bank account ending in account number [REDACTED] were not received. The Department's representative contends that the account was previously reported but is not aware of the name of the bank. The Department's representative contends that the form 2613 (Financial Release Form) signed by the petitioner's spouse is also needed when determining eligibility for a married couple.

23. The petitioner's representative contends that it was not aware of the specific verifications required until it received the Department's evidence packet and reviewed its running records comments. The Respondent's Exhibit 2, page 27 includes the

Running Records Comments (CLRC) dated September 9, 2016, which states, "...Also acc# [REDACTED] was not received." The petitioner's representative contends that he is unaware of the bank account ending in [REDACTED]

24. The Department's representative contends that it is not able to assist an applicant if there is an uncooperative party during the eligibility process. The Department's representative believes that the petitioner was sufficiently notified of the requirement to provide the bank statement for account ending in [REDACTED] since paragraph two of the Notice of Case Action dated August 10, 2016 states to provide the "last three months of bank account statements..." The Department's representative explained that applicants are usually not contacted if there are missing verifications.

25. The Department's records show that the petitioner receives \$778 in Social Security income, \$344.50 in retirement income, and another \$80.10 in retirement income. The Department's representative believes that the petitioner would be over the ICP Medicaid asset limit based on the assets included thus far and that verification of transfers out of her name would be needed. The Department's records show that the verified assets owned by the petitioner consists of a [REDACTED] account with a checking balance of \$1844, [REDACTED] savings with \$5.02; [REDACTED] t account (jointly owned by the petitioner and her husband) with a balance of \$973.11; [REDACTED] Checking with a balance of \$2510.61; [REDACTED] with a balance of \$1450.89; life insurance policy with \$4500 face value and a cash value of \$1579.50. The Department's representative contends that the petitioner would be still be ineligible for ICP Medicaid with the \$2500 burial exclusion.

26. The petitioner's son in law does not agree with the balances. The petitioner's son in law contends that the only accounts in the petitioner's name includes the [REDACTED], with the balance of \$5.02; and [REDACTED] (jointly owned with spouse) with low balance of \$25. The petitioner's son in law contends that the petitioner's Social Security income is immediately moved every month from [REDACTED] since [REDACTED] is jointly owned by the petitioner and her husband.

27. The Department contends that the petitioner's son in law provided the bank statements for the aforementioned bank accounts to verify the balances.

28. The petitioner's son in law would like additional time to attempt to provide proof of the petitioner's spouse's bank accounts, life insurance policies, and tax records for the marital home. The Petitioner's Exhibit 2 provided post-hearing includes three months' bank statements for the periods of December 24, 2016 through January 23, 2017; January 24, 2017 through February 23, 2017; and February 24, 2017 through March 23, 2017. No other verifications were submitted that would be relevant to the period at issue.

CONCLUSIONS OF LAW

29. 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.

30. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code

R. 65-2.056.

31. Federal Regulations at 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.)

32. The Fla. Admin. Code R. 65A-1.203(9) defines representative:

“Authorized/Designated Representative: An individual who has knowledge of the assistance group’s circumstances and is authorized to act responsibly on their behalf.”

33. The Fla. Admin. Code R. 65A-1.204, Rights and Responsibilities, sets forth:

(1) An individual has the right to apply for assistance, to have eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing information, documentation and verification needed to establish eligibility.

34. Fla. Admin. Code R. 65A-1.025, Eligibility Determination Process, 1(a) states as follows:

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.

35. Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process, 1(c) sets forth the time frame for an applicant to provide additional information:

If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information...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... 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

36. 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.

...

(4) Spousal Impoverishment. The Department follows policy in accordance with 42 U.S.C. § 1396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse. Spousal impoverishment policies are not applied to individuals applying for, or receiving services under, HCBS Waiver Programs, except for individuals in the Long-Term Care Community Diversion Program, the Assisted Living Facility Waiver or the Cystic Fibrosis Waiver.

(a) When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility.

(g) The institutionalized spouse shall not be determined ineligible based on a community spouse's resources if all of the following conditions are found to exist:

1. The institutionalized individual is not eligible for Medicaid Institutional Care Program because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse; and
2. The institutional spouse assigns to the state any rights to support from the community spouse by submitting the Assignment of Rights to Support, CF-ES 2504, 10/2005, incorporated by reference, signed by the institutionalized spouse or their representative; and
3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and
4. The institutionalized spouse has no other means to pay for the nursing

home care.

37. The above authorities explain resource eligibility for ICP when a married couple is involved. All resources owned solely or jointly are considered in determining eligibility.

38. The petitioner's representative requested for the Department to consider the petitioner for an "undue hardship" as the petitioner's spouse is uncooperative. Due to the petitioner's spouse failure to cooperate with the eligibility process, the petitioner's representative would like for the Department to consider the Agreement as a waiver to the requirement for the petitioner's spouse to provide verification of his assets. The petitioner's representative believes the Agreement frees the petitioner's spouse as being a financially responsible party. The undersigned considered the Agreement and was unable to locate any legal authorities that would allow the Department to waive the requirement to verify the assets of a community spouse. Therefore, the undersigned concludes that the Department was correct to require verification of the assets for the petitioner's spouse, who resides within the community.

39. The Department's Program Policy Manual, CFOP 165-22, passage 1640.0314.01 Assets Available to Spouse (MSSI) states:

The following policy applies to ICP, ICP-MEDS, and ICP-Hospice individuals admitted to institutions on or after September 30, 1989. This includes SSI recipients applying for institutional services. (If the individual was institutionalized prior to September 30, 1989, refer to Chapter 2200). Although the assets of a Medicaid recipient's spouse may not have been considered available to the individual in the community (e.g., when the couple is separated), **when the individual applies for institutional services, the assets of both spouses must be considered in determining the individual's eligibility for institutional services.**

The portion of a couple's assets available to the institutional spouse is the amount remaining after the community spouse's asset allowance is subtracted from the couple's total included assets. If this figure is over the program's allowable asset limit, the individual is ineligible until the assets are reduced to within the program's standard.

If after declaring and verifying his assets, the community spouse refuses to make them available to the individual, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits (refer to passages 1640.0314.03 and 1640.0314.04 for policy). Community spouses who refuse to make their assets available to the institutionalized spouse are not entitled to a community spouse income allowance (**emphasis added**)

If the couple has been separated for a long time and the community spouse cannot be located, there is no "community spouse" and the applicant must be considered an individual when applying income and asset standards.

If either spouse can verify that the community spouse asset allowance determined by the agency is inadequate to generate income to raise the community spouse's income to the minimum monthly maintenance needs allowance, the asset allowance may be revised through the fair hearing process.

A spouse for these purposes is defined in Chapter 2200.

40. The Department Policy Transmittal Number P02-11-0110 addresses the Disclosure of Community Spouse's Assets for Applications Involving Assignment of Support Rights and states, "If the community spouse refuses to verify all assets owned independent of the institutionalized spouse, we cannot determine eligibility for ICP."

41. In a Department Question and Answer clarification in its Knowledge Bank, ID number 87, the question is asked if the whereabouts of the community spouse (CS) is unknown, is there a length of time they must be separated before we treat them as individuals and not count the assets of the community spouse. The answer from the Headquarters' program is:

As long as a couple are legally married, we must look at the CS' assets in determining the institutionalized spouse's (IS) eligibility for Medicaid. If the whereabouts of the CS are unknown, we can determine the IS as an

individual. We recognize that sometimes the CS may be uncooperative and this can be problematic. If the IS is ineligible for ICP solely due to the CS's assets, the IS can sign the Assignment of Support Rights form. Of course, this requires that the CS first disclose their assets to DCF. We would not divert income to a CS if the IS does not want to divert income to them, which would be true in cases of separation.

42. The above further clarifies the ICP requirement of a couple when the spouse refuses to cooperate and make his assets known for an ICP Medicaid eligibility determination of the spouse in the facility. In this case, the location of the petitioner's spouse is known; however, he was uncooperative in the application process to determine the petitioner's eligibility for ICP Medicaid. Based on this policy, once the spouse was located and determined not to cooperate with the eligibility determination, the ICP is denied as eligibility cannot be determined. The petitioner's representative argues that the Department was not clear as to which verifications were required. The undersigned concludes that the Department was not clear in its requests for verification (regarding verifications for bank account ending with [REDACTED]) in its Notice of Case Action dated August 10, 2016. However, the undersigned cannot conclude that all verifications for all of the community spouse's assets, including form 2613 (financial disclosure form), were received by the Department. Therefore, the undersigned concludes that since the location of the petitioner's spouse was known but he refused to cooperate, the Department could not determine the petitioner's eligibility for ICP Medicaid. Therefore, the undersigned concludes that the Department's denial action on September 8, 2016 was correct.

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 19 day of May, 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

May 16, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-08106

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 [REDACTED]
UNIT: 03DDD

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 11, 2017 at 2:07 p.m.

APPEARANCES

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

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 October 5, 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 was originally scheduled to convene on December 19, 2016 at 9:00 a.m. The petitioner did not appear.

On December 19, 2016, the petitioner contacted the Office of Appeal Hearings to request for the hearing to be rescheduled as she experienced technical difficulties when she attempted to appear for the telephonic hearing. The petitioner's request was granted. The hearing was rescheduled to February 7, 2017 at 9:00 a.m.

On February 7, 2017, the respondent requested a continuance to allow a review of the petitioner's case. The petitioner did not object. The hearing was scheduled to convene on March 7, 2017 at 10:15 a.m.

The petitioner did not appear for the hearing on March 7, 2017 at 10:15 a.m.

On March 8, 2017, the petitioner contacted the Office of Appeal Hearings to request for the hearing to be rescheduled as she experienced difficulties when calling in to the hearing. The petitioner's request was granted. The hearing was rescheduled to April 11, 2017 at 2:00 p.m.

The Department requested a continuance because the petitioner's application for SSI-Related Medicaid was submitted to the Division of Disability Determination (DDD) after speaking with the petitioner in December 2016. The Department explained that the petitioner reported new medical conditions to the caseworker in December 2016. The Department has not yet received a response from DDD. The petitioner objected to the Department's request for a continuance as she argues that she no longer wants a

delay in her appeal as she needs Medicaid. The Department's request for a continuance was denied and the hearing convened as scheduled.

Evidence was received and entered as the Respondent's Exhibits 1 through 3.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. On September 28, 2016, the petitioner (age 54) applied for SSI-Related Medicaid for herself. The petitioner considers herself to be disabled. The petitioner has no minor children.

2. The Respondent's Exhibit 2, page 7, includes the Running Records Comments (CLRC). The CLRC notes, dated October 4, 2016 indicate that the Department completed a disability interview with the petitioner on October 4, 2016. The CLRC also indicates that the petitioner applied for disability benefits through the Social Security Administration (SSA) on April 14, 2016. The CLRC indicates that the petitioner reported during the disability interview that she has no new medical conditions and that her many medical conditions are serious. The petitioner's application for disability benefits was denied on August 3, 2016 with a denial code of "N31". The petitioner filed an appeal through the SSA on August 31, 2016 and is currently pending. The Department adopted the SSA unfavorable decision and denied the petitioner's application for SSI-Related Medicaid.

3. The petitioner does not agree with the Department's denial. The petitioner reports that her medical conditions reported to the SSA were a nodule on her left eye and issues with her throat. The petitioner also reports that she has difficulties in walking

and a herniated disc in her back. The petitioner contends that she cannot stand for a long period of time and has issues with choking. The petitioner explained that her conditions have worsened. The petitioner reports that at the end of November 2016, she developed new medical conditions. The petitioner reports that she has one dozen lumps in her head and that she is developing problems with her knees. The petitioner reports that she was hospitalized in December 2016 due to a lump on the left side of her throat that requires biopsies. The petitioner explained that she has always had issues with her throat and is fearful that it may be cancerous as it runs in her family.

4. The Department explained that the petitioner was denied by the SSA and that it is currently in the appeal process. The Department explained that the denial code "N31" is defined as "Non-pay-Capacity for substantial gainful activity-customary past work, no visual impairment." The Department explained that it abided by the SSA denial, as the petitioner reported worsening but no new medical conditions at the time of the application. The Department explained that the petitioner reported new medical conditions after its denial. The Department submitted the petitioner's new medical conditions to the DDD and is currently in pending status.

CONCLUSIONS OF LAW

5. 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.

6. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code

R. 65-2.056.

7. 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...

8. 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**).

9. The Department's ACCESS Florida Program Policy Manual, CFOP 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)**

10. 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 did not fit this criteria at the time of the Department's denial action in October 2016. The findings show that the petitioner reported new medical conditions in December 2016, which are currently under review for an independent disability determination by the DDD

11. In this case, the petitioner is under age 65 and has severe medical conditions such as nodule on her left eye, herniated disc in her back, and issues with her throat. The findings show that the petitioner's medical conditions were reviewed by the SSA in its disability determination. The petitioner reports a worsening of the medical conditions reported to the SSA. 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 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 at the time of her application in September 2016. Until petitioner meets the federal disability criteria (while under age 65) Medicaid cannot be approved.

12. The petitioner's case is currently pending with the DDD based on the new medical conditions reported in December 2016. The Department will issue notice with appeal rights based on the results of the disability determination that is currently pending with the DDD. The petitioner may file another appeal once the DDD makes its independent disability determination and after receiving adverse notification from the Department as a result of the DDD 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.

FINAL ORDER (Cont.)

16F-08106

PAGE -8

DONE and ORDERED this 16 day of May, 2017,

in Tallahassee, Florida.



Paula Ali

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

May 02, 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-09253

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 April 3, 2017 at approximately 3:30 p.m.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner's Husband

For United: Christian Laos
Senior Compliance Analyst

STATEMENT OF ISSUE

At issue is whether or not United's denial of Petitioner's request for additional Personal Care Services was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's husband represented her. He may sometimes be referred to as "Petitioner's representative." Lisa Sanchez, Medical/Health Care Program Analyst, with the Agency for Health Care Administration ("AHCA" or "Agency") observed the hearing. United Healthcare ("United") presented the following witnesses:

- Christian Laos – Senior Compliance Analyst
- Dr. Sloan Karver – Long Term Care Medical Director

Petitioner's husband gave oral testimony, but did not move any exhibits into evidence. Respondent's Exhibits 1 – 9 were entered into evidence. The record was held open for United to submit additional evidence. They submitted additional evidence, which was entered as Exhibit 10.

FINDINGS OF FACT

1. Petitioner is a 47-year-old female. She is enrolled with United as her Long Term Care ("LTC") plan.

2. Petitioner's medical history includes:

- [REDACTED]

3. Petitioner was receiving 48 hours of home health services per week. She requested an increase to 84 hours of services.¹ On August 19, 2016, United issued a Notice of

¹ There was some confusion at hearing as to how many hours Petitioner's husband said she needed. Since the Notice of Action references 84 hours, this Order will address that amount.

Action denying the request for the additional hours (Resp. Exh. 2). The Notice stated, in pertinent part:

You have asked for 84 hours of care at home a week.

Your care plan for help is based on how much help you need. Needs in Florida Medicaid are defined by the law. For a service to be needed it must treat a problem. It must also be common practice. It must also be just for you. It must also not be in excess of your needs. It must also be safe. It must also be the least costly treatment in the state that meets your needs. It must also not be for the convenience of you or another person. The fact that a doctor orders a service does not make it needed or covered.

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 numbers 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] 48 hours a week.

4. A plan appeal with United was requested. On November 8, 2016, Petitioner's case manager performed an LTC Functional Assessment ("Assessment"). (Resp. Exh. 10). The Assessment is designed to determine the amount of home health services needed. The Assessment indicates that Petitioner has at least some level of impairment for each of her ADLs and IADLs, most of which are total impairment. As such, Petitioner requires assistance in performing all ADLs and IADLs.
5. The case manager recommended a range of minutes per day for each service. Dr. Karver then reviewed the Assessment and approved a certain amount of services. For example, in section 3.1, regarding bathing, the case manager recommended a range of 31-50 minutes per day, five (5) days per week, to be covered by United (Agency

Purchased), and that 31-50 minutes per day should be provided by Petitioner's husband as a natural support for two (2) days per week. Dr. Karver approved 50 minutes per day to be provided by United, five (5) days per week, for a total of 250 minutes per week.

6. The sum total of the minimum amount of time for each recommended service on the Assessment to be provided by United, based upon the range provided by Petitioner's case manager, is 1,185 minutes per week, which is 19.75 hours per week. This calculation assumes Petitioner's husband would provide all remaining care.

7. The sum total of the maximum amount of recommended time to be provided by United is 1,860 minutes per week, which is 38.58 hours per week. Again, this calculation assumes Petitioner's husband would provide all remaining care.

8. Petitioner's husband wants extra assistance caring for her. If United were to provide all of the minimum recommended services, and Petitioner's husband did not have to provide any care at all, the sum total of minutes would be 1,703 minutes, which is 28.4 hours per week. If United were to provide all of the maximum recommended services, the sum total of minutes would be 2,760 minutes, which is 46.0 hours.

9. Dr. Karver testified that the Assessment is a guideline, but she looks at the patient's whole picture and uses her clinical judgment to approve an appropriate amount of care. The grand total of minutes she determined were needed, pursuant to the Assessment, was 2,525 minutes, which is 42.08 hours. However, she said, using her clinical judgment, she decided to add six (6) additional hours, for a total of 48 hours per week of approved services.

10. On November 18, 2016, United issued a letter upholding the denial. (Resp. Exh. 9). The letter states:

You told us about an appeal October 5, 2016. Here is our answer.

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 (includes personal care, homemaker care, and companion care) 84 hours a week. Your wife needs help with daily personal care. We cannot approve 84 hours because it is not medically necessary. We used an assessment tool and the doctors' review. This tool tells us her needs. Forty-eight hours a week can meet her needs and is approved by the health plan. This is why we cannot approve what you asked for. Please talk about this with her doctor/case manager.

11. Petitioner 's husband said she cannot be left alone. His work schedule varies. He commonly leaves home as early as 6:30 a.m. and returns at 6:30 p.m., Monday through Friday. On Saturday he leaves at approximately 6:30 a.m. and returns around 3:00 p.m. He said his commute ranges from one (1) to one-and-a-half (1.5) hours. He is off of work on Sunday. She spends the day with him going wherever he goes, for example, going to church.

12. Dr. Karver said United has patients just like Petitioner who can use a remote or hide a key to unlock the door. This would allow caregivers access to the home throughout the day, while allowing her to keep her door locked the rest of the time, thus enabling her to safely be left alone for periods of time. Dr. Karver also offered six (6) to eight (8) hours of adult day care ("ADC") as an option. She said United cannot provide babysitting, but she said she would include PCS and transportation before and after ADC.

13. Petitioner's husband said they have not tried ADC, but that they have looked into it and his wife does not want to do it. He said ADC is no better than a nursing home.

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 Section 120.80, Florida Statutes.

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

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

17. 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.).

18. 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.

19. Section 409.978(2), Florida Statutes states, in pertinent part: “[AHCA] shall make payments for long-term care, including home and community based services, using a managed care model.”

20. Section 409.98, Florida Statutes, requires that LTC plans include, among other services, personal care, home-delivered meals, case management, medication administration, and nutritional assessment and risk reduction.

21. The October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook (“Home Health Handbook”) was promulgated into law by Chapter 59G of the *Florida Administrative Code*.²

22. Page 1-2 of the Home Health Handbook defines “Home Health Services,” stating:

Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.

23. The definition of “medically necessary” is found in Rule 59G-1.010 of the *Florida Administrative Code*, which states, in pertinent 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; 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.

² The Home Health Handbook was replaced with the November 2016 Home Health Visit Services Coverage Policy. The action in this matter was taken when the Home Health Handbook was still in effect, therefore this Order will address the action on that basis.

24. Petitioner's case manager provided a wide range of recommended time, as low as 19.75 hours per week if Petitioner's husband were to provide care, and as high as 46 hours per week if United were to pay for all of the recommended care and Petitioner's husband was not expected to provide any care. Dr. Karver initially approved 42 hours based upon the LTC assessment, but chose to increase Petitioner's hours to 48 hours per week due to her own medical judgment. The 48 hours per week is two (2) hours more than the maximum recommended by Petitioner's case manager.

25. Petitioner requires assistance with all of her ADLs and IADLs. The Florida Statutes require AHCA to provide home and community-based services for long-term care, using a managed care model. The limitation on the services provided is that they must be medically necessary.

26. In the instant-matter, Dr. Karver chose to exceed the number of hours above the LTC assessment calculation due to her clinical judgment that the additional hours are medically necessary. She also provided an alternative solution of ADC, instead of increasing the PCS hours, but this option was rejected.

27. It is understandable that Petitioner's husband wants to keep her at home and have someone with her at all times. But Medicaid can only provide medically necessary services. The additional hours are desirable, but not medically necessary.

28. Petitioner and her husband are encouraged to work with her case manager and United to see if they can come up with a solution that will meet her needs and alleviate their concerns.

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.

DONE and ORDERED this 02 day of May , 2017,

in Tallahassee, Florida.



Rick Zimmer
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

May 10, 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-09439

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 April 5, 2017 at 9:08 a.m.

APPEARANCES

For Petitioner: [REDACTED] pro se

For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate the petitioner's SSI-Related Medicaid benefits effective December 1, 2016 is correct. The burden of proof is assigned to the respondent by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present and testified. The petitioner presented one witness who testified: [REDACTED], the petitioner's mother. The petitioner submitted five exhibits, which were accepted into evidence and marked as Petitioner's Exhibits "1" –

“5”. The respondent was represented by Ed Poutre, Economic Self Sufficiency Specialist II, with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). The respondent submitted six exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” – “6”.

One continuance was granted to the petitioner and one continuance was granted to the respondent.

FINDINGS OF FACT

1. The petitioner’s SSI-Related Medicaid certification period was from October 1, 2015 through November 30, 2016. (Respondent’s testimony)
2. On September 23, 2016, the Social Security Administration (SSA) mailed the petitioner a Notice of Decision – Unfavorable. (Petitioner’s Exhibit 3)
3. The petitioner (50) was receiving Social Security Disability Insurance (SSDI) of \$1,267 per month. SSA terminated the petitioner’s SSDI effective October 31, 2016 using the code X7. X7 means “Health insurance benefits (HIB)/SMIB terminated”. (Respondent’s Exhibit 4) In December 2016, the petitioner appealed the termination of his SSDI benefits and that appeal is currently pending. (Page 1 of Petitioner’s Exhibit 4)
4. On October 31, 2016, the petitioner submitted an application for Food Assistance (FA) and SSI-Related Medicaid benefits. FA benefits are not an issue under appeal. The application listed the petitioner and his mother as the only household members; the petitioner as claiming to be disabled; the petitioner’s disability denial date as September 25, 2016; and the petitioner appealing the SSDI denial. (Respondent’s Exhibit 2)
5. On November 7, 2016, the respondent mailed the petitioner a Notice of Case Action indicating his Medically Needy Medicaid benefits would end effective November

30, 2016 as “No household members are eligible for this program”. (Page 2 of Respondent’s Exhibit 3)

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(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...

9. According to the above authority, to be eligible for Family-Related Medicaid benefits, the petitioner must have a minor child under age 18 living in the household with him. Since the petitioner 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.

10. 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.

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

12. SSA terminated the petitioner's SSDI benefits effective October 2016 using code X7. In December 2016, the petitioner appealed his SSDI termination and has a pending hearing before an ALJ. The petitioner reapplied for SSI-Related Medicaid benefits with the respondent on October 31, 2016. The respondent terminated the petitioner's SSI-Related Medicaid benefits pursuant to the SSA's termination decision.

13. The Department's ACCESS Program Transmittal No.: P02-01-0001, dated January 15, 2002, Continued Medicaid During Social Security Appeal, explains that if the petitioner timely appealed his SSI termination while receiving Medicaid benefits, he would be eligible for continued Medicaid benefits pending the outcome of the SSA appeal. It further states, "if the individual later provides proof that a timely appeal was filed with SSA, staff must reinstate Medicaid benefits until the appeals process is resolved through SSA."

14. As of December 2016, the petitioner had a pending appeal with SSA. The petitioner received SSI-Related Medicaid benefits from October 2015 through November 2016. Furthermore, the above Transmittal does not specify if the terminated Medicaid benefits should be either Family-Related or SSI-Related. It simply states "Medicaid benefits" would have to be terminated to receive continued Medicaid benefits.

15. Since the petitioner has a pending appeal with SSA and since his SSDI terminated in October 2016 while he was receiving SSI-Related Medicaid benefits, the petitioner is eligible to receive continued Medicaid benefits pending the outcome of the SSA appeal.

16. In careful review of the cited authorities and evidence, the undersigned concludes the respondent did not meet the burden of proof in establishing the petitioner's SSI-Related Medicaid benefits were terminated correctly effective December 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED. The respondent is ORDERED to approve the petitioner's SSI-Related Medicaid benefits effective December 2016 pending the outcome of the petitioner's SSA appeal.

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

Jun 14, 2017

Office of Appeal Hearings
Dept. of Children and FamiliesSTATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 16F-09919

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 12 [REDACTED]
UNIT: 883CFRESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 30th, 2017, at 8:15 a.m.

APPEARANCES

For the Petitioner: The petitioner was not present but was represented by [REDACTED] and [REDACTED] the petitioner's adult children.

For the Respondent: Roneige Alnord, Economic Self-Sufficiency Specialist II for the Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the department's action to terminate coverage in the Institutional Care Program. The respondent carries the burden of proving its position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The hearing was originally scheduled for March 9th, 2017, at 1:30 p.m. Prior to that date, the hearing officer received a request for continuance from Ms. [REDACTED]

[REDACTED] The continuance was requested in order to allow the petitioner time to

obtain legal counsel. Ms. [REDACTED] request was granted and the hearing was rescheduled for April 4th, 2017, at 2:30 p.m.

On April 4th, 2017, all parties phoned in as scheduled. The petitioner's representatives and the respondent held a brief pre-hearing conference outside the presence of the hearing officer. The respondent requested a continuance in order to obtain additional information from the petitioner. The petitioner's representatives did not object and the hearing was rescheduled as detailed above.

At the hearing, the petitioner's representatives did not provide any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 10 were admitted into evidence.

The record was held open until the close of business, June 9th, 2017, to allow the respondent time to provide evidence to the petitioner's representatives and to allow the representatives an opportunity to respond if they chose to do so. The representatives responded timely by making notes on the original evidence. The notes reiterated the testimony provided during the proceeding. Therefore, it was not necessary to reconvene.

By way of a Notice of Case Action (NOCA) dated November 18th, 2016, the respondent informed the petitioner that her Medicaid benefits were ending as of November 30th, 2016. However, the petitioner would remain eligible under a different Medicaid coverage group. By way of the same NOCA, the respondent informed the petitioner that her Medically Needy (MN) application dated November 14th, 2016, was denied because the value of her assets were too high for the program. On December 28th, 2016, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. Ms. [REDACTED] submitted an online application to renew the petitioner's Institutional Care Program (ICP) coverage on November 14th, 2016. The benefits requested on the application consist of ICP and Home and Community Based Services (HCBS). HCBS is not an issue for this appeal. (See Respondent's Exhibit 2).
2. The petitioner is married and 78 years of age. At the time of the ICP application and the hearing, the petitioner was residing in an assisted living facility (ALF) and her spouse remained in the home.
3. The respondent asserted that the petitioner received Medicaid through a waiver program prior to the coverage being terminated on November 30th, 2016. After further testimony, the respondent reasoned that the Medicaid was actually ICP and not waiver coverage. The respondent determined the petitioner was over the asset limit for the MN program by using its electronic Asset Verification System (AVS) to locate bank account information including account balances. (See Respondent's Exhibit 5). According to the respondent, the coverage reviewed at the time of the November 14th, 2016, application was Qualified Individual 1 (QI-1) or the buy-in program and MN, not ICP coverage as the petitioner requested. In addition to reviewing QI-1 and MN, the respondent testified that there was no contact made with the petitioner and no request made for additional information prior to terminating the existing ICP coverage.
4. The respondent provided, as part of its evidence, a QI-1 budget with a begin date of December 1st, 2016. (See Respondent's Exhibit 6). The budget indicates that the

respondent reviewed QI-1 coverage for the petitioner and counted \$31,635.13 in available assets. According to the respondent's testimony, there were no additional budgets to provide.

5. The petitioner's representatives contend that the ALF has not been paid since the late 2016. The petitioner's husband was trying to match the payments to the ALF. However, since he remains in the community, there are other household bills that he is responsible for paying. The petitioner's husband is paying her podiatrist's expenses out of pocket since the ICP coverage has been terminated. The petitioner's representatives testified that they did not apply for the buy-in program on the November 14th, 2016, and do not know what the buy-in program is. The intention was to apply for a review of the ICP coverage. Furthermore, the representatives sent 58 pages of documents to the respondent during the hearing process in an effort to get the case resolved. According to the respondent, the documents were not reviewed.

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 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under 409.285, Fla. Stat.

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

8. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process states in part:

(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter...

(2) In accordance with 7 C.F.R. Section 273.14, 45 C.F.R. Section 206.10(a)(9)(iii), 42 C.F.R. Section 435.916, and Section 414.095, F.S., the Department must determine eligibility at periodic intervals.

(a) A complete eligibility review is the process of reviewing all factors related to continued eligibility of the assistance group.

9. As stated in the above-cited authority, the respondent must determine the petitioner's eligibility at the initial application and at periodic intervals. The petitioner was determined eligible for ICP Medicaid and was applying for a review at what would be considered a "periodic interval." However, instead of reviewing eligibility for continued ICP coverage the respondent determined eligibility for new benefits of QI-1 and MN. According to the respondent's testimony, the incorrect benefits were reviewed at the time of the November 14th, 2016, application. Furthermore, the respondent testified that after it received additional documentation from the petitioner, during the hearing process, it neglected to review the documents to determine if ICP benefits could be reinstated. In conclusion, the hearing officer does not affirm the respondent's action to terminate the petitioner ICP Medicaid without first completing an eligibility review over the requested ICP coverage.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the appeal is granted to the extent described above. This decision is not a guarantee of eligibility. Rather, the respondent is ordered to take corrective action in the appeal as described above.

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 June, 2017,

in Tallahassee, Florida.



Kimberly Vargo
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@myflfamilies.com

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

Jun 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. 17F-00091

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 May 15, 2017, at 10:45 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

Clinical Supervisor

[REDACTED]

Health Center

For the Respondent:

Michelle Riegler

Compliance Officer

Magellan Complete Care

STATEMENT OF ISSUE

Did the respondent, Magellan Complete Care, prove by a preponderance of the evidence that it correctly denied 240 of the 720 units of psychosocial rehabilitation services requested by the petitioner?

PRELIMINARY STATEMENT

██████████ may sometimes hereinafter be referred to as the petitioner's "representative".

The following individuals appeared as witnesses on behalf of Magellan Complete Care: Samuel Kelley, M.D., Board-certified psychiatrist and Medical Director of Magellan Complete Care; and Samantha Lorenzo, Appeals Manager for Magellan Complete Care. Monica Otalora, Senior Human Services Program Specialist with the Agency for Health Care Administration ("AHCA" or "Agency"), was present solely for observation and monitoring.

The petitioner introduced Exhibits "1" through "8" at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "7" at the hearing, which were accepted into evidence and marked accordingly.

During the hearing, the hearing officer took administrative notice of the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

While trying to determine which party has the burden of proof during the hearing, the parties advised the hearing officer that this was an initial request for psychosocial rehabilitation services by the petitioner. In accord with that statement, the hearing officer assigned the burden of proof to the petitioner. However, while evaluating the evidence in this case, the hearing officer discovered the petitioner was previously receiving this same type of service through another provider directly before transitioning to ██████████ Health Center, his current provider. Since the petitioner was previously approved to receive psychosocial rehabilitation services through another provider in the certification period directly before this one, the burden of proof is hereby shifted to the respondent.

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 67-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 Agency for Health Care Administration is responsible for administering the Florida Medicaid Program.
4. The petitioner is an enrolled member of Magellan Complete Care.
5. Magellan Complete Care is a health maintenance organization (“HMO”) contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in the State of Florida.
6. The petitioner resides in an assisted living facility.
7. Psychosocial rehabilitation services are intended to restore a recipient’s skills and abilities essential for independent living. Activities include: development and maintenance of necessary daily living skills; food planning and preparation; money management; maintenance of the living environment; and training in appropriate use of community services. This service combines daily medication use, independent living and social skills training, housing services, prevocational and transitional employment rehabilitation training, social support, and network enhancement to recipients and their families.
8. Psychosocial rehabilitation services are designed to assist the recipient to eliminate or compensate for functional deficits and interpersonal and environmental

barriers created by their disabilities, and to restore social skills for independent living and effective life management. This activity differs from counseling and therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment, focusing on maximum recovery and independence. It includes work readiness, assessment, job development on behalf of the recipient, job matching, on the job training, and job support.

9. Psychosocial rehabilitation services are measured in units. One unit is equivalent to 15 minutes.

10. Psychosocial rehabilitation services are community-based services. They are outpatient services.

11. The petitioner was previously receiving psychosocial rehabilitation services through [REDACTED] of the [REDACTED]

12. While receiving care at [REDACTED] of the [REDACTED], the petitioner was approved to receive 840 units of psychosocial rehabilitation services for the previous certification period, August 9, 2016 through December 8, 2016.

13. The petitioner currently receives his psychosocial rehabilitation services through [REDACTED] Health Center.

14. [REDACTED] Health Center provides psychosocial rehabilitation services in three-hour sessions. A three-hour session is equivalent to 12 units.

15. On or about December 16, 2016, [REDACTED] Health Center submitted a prior authorization request to Magellan Complete Care for 720 units of

psychosocial rehabilitation services to be provided during the period December 16, 2016 through March 16, 2017.

16. In an Approval Notice dated December 22, 2016, Magellan Complete Care informed 2nd Chance Mental Health Center that it was approving 480 units of psychosocial rehabilitation services for the period December 16, 2016 through March 16, 2017.

17. In a Notice of Action, also dated December 22, 2016, Magellan Complete Care notified the petitioner that it was denying 240 of the 720 units of psychosocial rehabilitation services requested. The Notice of Action states, in part:

We made our decision because:

- 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 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.
- X 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.)

18. The Notice of Action goes on to state:

The facts that we used to make our decision are:

- Doctor, Samuel Kelley, M.D. Board Certified in Psychiatry by the American Board of Psychiatry and Neurology, looked at your request and made this decision.
- This decision was based on Magellan Complete Care Behavioral Health Medical Necessity Criteria Guidelines – Psychosocial Rehabilitative Services.

- The reason why your request was not approved is: We approved some of the units. The amounts that will help you meet your goals. Individual therapy will help you meet your current goals.
- Details for your doctor: Based on the documentation and clinical information provided, medical necessity cannot be established. Request for Psychosocial Rehabilitative Services for 12/16/2016 through 03/16/2017 for 240 additional units is being denied. This service was approved for 480 units. Your provider requested 720 units, which appear to be in excess of your needs; therefore, request does not meet medical necessity criteria for 240 units. It appears that the amount of units being approved would be sufficient to complete identified treatment objectives and goals.

19. Magellan Complete Care had the initial denial reviewed after the petitioner requested an administrative hearing.

20. In a Notice of Action Appeal Decision dated January 9, 2017, Magellan Complete Care informed the petitioner's provider that it was upholding its initial decision to deny 240 of the psychosocial rehabilitation units requested.

21. The petitioner is diagnosed with [REDACTED]
[REDACTED] The petitioner's symptomatology associated with the [REDACTED] includes delusions.

22. Testimony at the hearing regarding the petitioner's last psychiatric hospitalization was inconclusive. The petitioner has not had any recent psychiatric hospitalizations. The petitioner's last psychiatric hospitalization occurred sometime between five and eight years ago.

23. The petitioner's criminal history does not include any recent activity. He was charged with assault and battery on a police officer and trespassing approximately five years ago.

24. The petitioner is not suicidal or homicidal.

25. The petitioner is not presently exhibiting aggressive or violent behavior.

26. The petitioner does not have a recent history of substance abuse.

27. The petitioner is noted as having a substance abuse problem with respect to alcohol, cannabis, and cocaine in the 1960's.

28. The documentation provided by the petitioner's provider to the respondent is unclear as to whether the petitioner currently suffers from a seizure disorder or when his last seizure occurred. The petitioner's representative could not provide this information at the hearing.

29. The documentation provided by the petitioner's provider to the respondent did not contain an evaluation from the petitioner's primary care physician.

30. The petitioner's representative was unaware of the last time the petitioner visited a primary care physician.

31. The Clinical Summary of the petitioner's Biopsychosocial Evaluation states as follows:

[Petitioner] presented as pleasant, cooperative, and in the context of the interview voiced numerous grandiose delusions. He is entrenched in his delusions as far as story-telling, with an emotional response to what appears to be delusional about having a family he can not [sic] find. He can engage in discussion in reality, but demonstrates limited insight into his mental illness. He can identify with having an illness, however, primarily focuses on [REDACTED]. He reported a vague connection between psychotropic medications and alleviation of auditory hallucinations, and identified benefiting from the group format in the past. He is amenable to the services at [REDACTED] Center.

32. The respondent's Medical Director characterized the petitioner as a pretty functional [REDACTED] with delusions.

33. The petitioner is prescribed psychotropic medications.

34. Psychotropic medications are commonly effective in treating hallucinations.

35. The documentation provided by the petitioner's provider to the respondent does not indicate whether there were any recent changes in the petitioner's psychotropic medications and/or dosage levels.

36. Recent changes in the petitioner's psychotropic medications and/or dosage levels could potentially support the need for additional psychosocial rehabilitation services.

37. The petitioner's representative was unaware if there were any recent changes in the petitioner's psychotropic medications and/or dosage levels.

38. The petitioner's psychosocial rehabilitation therapy sessions are provided by Master's level clinicians.

39. The petitioner presently attends two one-and-a-half hour sessions per day with a 15-minute break between the two sessions.

40. The petitioner's representative explained psychosocial rehabilitation is helping the petitioner learn to cope with separation and loss and to work through his emotions. She explained that the petitioner's quality of life is improving as a result of him implementing these new coping skills.

41. There is an educational component in the petitioner's psychosocial rehabilitation therapy sessions.

42. The petitioner's representative testified that the petitioner is engaging very actively in treatment. He has learned a lot about mental illness and is making a great deal of progress.

43. The petitioner's psychosocial rehabilitation therapy sessions include informational dialogue about securing employment and actively participating in the workforce but do not include vocational training.

44. The petitioner is more interested in volunteering instead of pursuing employment.

45. The respondent's Medical Director testified the interventions for all goals and objectives on the petitioner's treatment plan submitted by the respondent are identical and appear to be a preformatted template.

46. The respondent's Medical Director testified that even healthy people can benefit from therapy.

47. The respondent's Medical Director testified that the current therapy being provided to the petitioner is not the correct type of therapy to address his negative symptomatology.

48. The respondent's witness testified that the petitioner's provider should be reducing the hours of psychosocial rehabilitation the petitioner receives and transitioning the petitioner into other programs such as clubhouse or volunteering.

49. Psychosocial rehabilitation services are designed to titrate; they should gradually reduce and eventually terminate as the recipient meets his or her stated goals and objectives.

50. The respondent's Medical Director testified he does not see the frequency, intensity, complexity, or changes that would cause the petitioner to require such a high amount of psychosocial rehabilitation services. He testified the petitioner appears to be more appropriately suited for the clubhouse level of support.

CONCLUSIONS OF LAW

51. 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.

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

53. The Florida Medicaid Program is administered by the Agency for Health Care Administration.

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

55. In the present case, the respondent is denying a portion of the petitioner's request for services. Since the petitioner was previously approved to receive the higher amount of these same services in the previous certification period, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the respondent.

56. 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.).

57. 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, on Page 1-27, states:

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.

58. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include community mental health services.

59. 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."

60. In order for community behavioral health services to be approved, the services must be medically necessary and meet all requirements set forth in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook – March 2014 ("Handbook").

61. The Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook is incorporated by reference in the Medicaid Services Rules by Fla. Admin. Code R. 59G-4.040.

62. The Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook implements certain limitations for behavioral health services covered by Medicaid.

63. Page 2-1 of the Community Behavioral Health Services Coverage and Limitations Handbook explains that services are to be provided only when medically necessary.

64. Fla. Admin. Code R. 59G-1.010(166), defines medical necessity as:

(166) “Medically 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.

65. 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.

66. 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.

67. The Community Behavioral Health Services Coverage and Limitations Handbook addresses community support and rehabilitative services beginning on Page 2-26. It states the following regarding psychosocial rehabilitation services:

Psychosocial rehabilitation services are intended to restore a recipient's skills and abilities essential for independent living. Activities include: development and maintenance of necessary daily living skills; food planning and preparation; money management; maintenance of the living environment; and training in appropriate use of community services. This services combines daily medication use, independent living and social skills training, housing services, prevocational and transitional employment rehabilitation training, social support, and network enhancement to recipients and their families.

These services are designed to assist the recipient to eliminate or compensate for functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore social skills for independent living and effective life management. This activity differs from counseling and therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment, focusing on maximum recovery and independence. It includes work readiness assessment, job development on behalf of the recipient, job matching, on the job training, and job support.

68. The Magellan Complete Care 2016 Behavioral Health Medical Necessity Criteria Guidelines for psychosocial rehabilitation services are consistent with those of the Agency for Health Care Administration.

69. The Magellan Complete Care 2016 Behavioral Health Continued Stay

Criteria for psychosocial rehabilitation services explain as follows:

1. An assessment appropriate to the model of recovery indicates at least one of the following:
 - a. As a result of the mental illness, there re or continue to be functional impairments and skill deficits which are effectively addressed in the psychiatric rehabilitation plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues.

Or
 - b. There is a reasonable expectation that the withdrawal of services may result in loss of rehabilitation gains or goals attained by the enrollee.

Or
 - c. A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change.
2. The enrollee chooses to continue participation in the program.

70. In the present case, although the petitioner's representative did an excellent job of advocating for the petitioner at the hearing, the hearing officer is in agreement with the position of the respondent's Medical Director that the additional services requested are not medically necessary and the petitioner's current needs are most closely aligned with a lower level of care. The petitioner's condition may be fairly characterized as stable. He has had no recent altercations with the law and his most recent psychiatric hospitalization occurred several years ago. The petitioner is not suicidal or homicidal, and he is not exhibiting aggressive or violent behavior. There is no recent history of substance abuse. In addition, there are no documented recent changes in the petitioner's psychotropic medications or any notes from the petitioner's primary care physician which could

potentially support the approval of the additional services. The type of group therapy the petitioner is receiving is not noted as consistent with treating someone with the petitioner's negative symptomatology. Finally, and very importantly, this is not the petitioner's initial request for psychosocial rehabilitation services. The petitioner was receiving a higher amount of services during the previous certification period. Psychosocial rehabilitation services are intended to titrate or gradually reduce as the patient improves. In the present case, the testimony and evidence do not support the medical necessity of continuing these services at the heightened amount.

71. Pursuant to the above, the respondent has met its burden of proof to demonstrate by a preponderance of the evidence that it correctly denied a portion of the petitioner's request for psychosocial rehabilitation services.

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

FINAL ORDER (Cont.)

17F-00091

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DONE and ORDERED this 13 day of June, 2017,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
Hearing Officer
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Copies Furnished To:

██████████ Petitioner
AHCA, Medicaid Fair Hearings Unit
Magellan Hearings Unit

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

FILED

May 08, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO.: 17F-00371

PETITIONER,

Vs.

UNITED HEALTHCARE MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 9, 2017 at 1:36 p.m.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner's Daughter

For Respondent: Susan Frishman
Senior Compliance Analyst
United Healthcare

STATEMENT OF ISSUE

Petitioner is appealing denial of a home modification. Petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner was not present for the hearing.

Dr. Marc Kaprow, Executive Director for Long-Term Care Program and Medical Director with United Healthcare (“United”), appeared as a witness for Respondents.

Stephanie Lang, R.N. Fair Hearing Liaison with the Agency for Healthcare Administration (“AHCA”), appeared as an observer.

Respondents introduced Exhibits “1” to “5,” inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

At the request of Respondent, the Hearing Officer took administrative notice of the following:

- Rule 59G-1.053 of the *Florida Administrative Code*
- Rule 59G-4.215 of the *Florida Administrative Code*

The record was left open until March 21, 2017 for Respondent’s denial letter, United’s Policy on home modification, United’s AHCA contract, Petitioner’s physician notes, and service definitions provided to United by AHCA for guidance. Respondent failed to provide the requested documents by the March 21, 2017 deadline. Petitioner filed a correspondence on March 10, 2017. Petitioner’s correspondence will be marked as Exhibit “1,” and 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 an 87-year-old female who lives in her daughter’s home. Petitioner’s daughter stated she is the owner of her condominium.

2. Petitioner is a Medicaid recipient enrolled with United as her Long Term Care (“LTC”) plan.

3. Petitioner’s health conditions are [REDACTED] and [REDACTED]. (See Respondent’s Exhibit 5).

4. On October 21, 2016, United received a request for a home modification. On January 30, 2017, United received an additional request for the same service. On October 26, 2016, United issued a Notice of Action denying the request as not being medically necessary. (See Respondent’s Exhibit 1). The denial decision remains the same for the January 30, 2017 request. The denial letter stated:

Reviewer: Sloan B. Karver, MD; Long Term Care Medical Director, UHC C&S Florida.

Service Requested: Home Modifications

Decision: Not Approved

Rationale: Requested service will not make member safer or more independent.

Medical Necessity for a service to a Medicaid enrollee must (F.A.C. 59G-1.010(166)/ 42 CFR § 441.745(a)(ii)(A)):

Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide AND

Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee’s caretaker, or the provider.

The fact that a provider has prescribed, recommended or approved medical allied or long-term care goods or services does not , in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Reference: F.A.C. 59G-1.010(166)/ 42 CFR § 441.745(a)(ii)(A), LTC Service definitions found in Florida AHCA Statewide Model LTC Contract;

(viewable at http://acha.myflorida.com/Medicaid/statewide_mc/plans.shtml
Exhibit II-Long Term Care

Denial Letter Language:

You asked for changes to your home. You asked for changes to your bathroom. You need help to bathe. The changes will not make you safer. The changes will not make you more independent. The changes are for your convenience. Services for your convenience are not medically needed. The health plan only covers services that are medically necessary. The request is not approved. S. Karver, MD (See Respondent's Exhibit 2).

5. Petitioner timely filed her appeal to the denial.
6. Petitioner's daughter wants United to widen her bathroom door and install a walk-in shower. Petitioner is 100% disabled and the daughter believes she requires a walk-in shower, and the shower is good for her mother's well-being. Petitioner feels better mentally and physically when she takes a shower instead of a bed bath. Petitioner's daughter has purchased the tile to be used in the walk-in shower. She is asking United to remove the bathtub and drainage.
7. Petitioner's daughter stated the nursing home used a hooyer lift for transferring Petitioner from bed to chair. Petitioner could have received a bed bath in the nursing home, but when she visited Petitioner, she received a shower. Petitioner's daughter uses a hooyer lift in her home to move Petitioner from the bed to a chair. Petitioner is unable to walk or bath herself. Petitioner requires assistance in order to leave her bed.
8. Respondent's witness Dr. Kaprow stated there are two elements used to review a request for home modification. The two elements are: (1) will the modification improve the member's safety, or (2) will the home modification provide the member more independence.

9. Respondent's witness Dr. Kaprow admits Petitioner cannot make any decisions for herself due to her [REDACTED]. Petitioner requires assistance with all activities of daily living.

10. Respondent's witness Dr. Kaprow stated Petitioner suffers from other conditions besides [REDACTED] based on the documentation from her physician. Petitioner suffers from loss of urinary control, has constipation, and is resistant to being examined. In addition, Petitioner has contracture of the upper extremities and has pressure ulcers. Petitioner is completely dependent on mechanical means to be removed from the bed.

11. Respondent's witness Dr. Kaprow stated in his evaluation for the walk-in shower he reviewed two elements, safety and independence. An individual would be approved for a walk-in shower if it would provide this person a greater level of independence. For example, a person who is a paraplegic with the ability to use their arms would gain some independence with using a walk-in shower. They would require some assistance but not total assistance to perform their shower activities.

12. Petitioner has a significant amount of contracture and a debilitating condition that a walk-in shower would not provide her independence or some independence. Petitioner is not able to bath herself. Petitioner's daughter would need to bath Petitioner in the walk-in shower as she does with a bed bath. Petitioner will not gain independence or some independence with a walk-in shower because she is unable to bath herself.

13. The second element is will the home modification improve the member's safety. The standard of care for nursing home facilities is a bed bath for most patients. If a family member comes into the nursing home and insist that their loved one receive a

shower, then the nursing home would comply based on finding the appropriate amount of assistance to conduct the shower.

14. Petitioner requires complete mechanical assistance to move from the bed to a chair. Dr. Kaprow opined because Petitioner is hooyer lift dependent, it is safer for her to receive a bed bath then a shower. Petitioner can slip or fall from the chair due to the soapy nature of taking a shower. The individuals who receive showers are the ones who can conduct it independently or nearly independently.

15. Respondent's witness Dr. Kaprow stated based on Florida Medicaid Authorization Policy, the managed care organization has the ability to establish a set of criteria approved by AHCA for first level reviews. The review is based on medical necessity and medical judgment using a national standard of care. Dr. Kaprow further stated, according to Rule 59G-1.010(166) of the *Florida Administrative Code*, the walk-in in shower is in excess of Petitioner's needs, and there is an equally effective or more conservative or less costly treatment.

16. Dr. Kaprow stated based on Florida Medicaid Personal Care Service Coverage policy, there is no difference between the amount of time it takes to conduct a full body bath versus a shower. It turns on the safest conservative treatment and in this case, Petitioner's safest option is a full body bed bath not a walk-in shower.

17. Respondent's witness Dr. Kaprow will approve the widening of Petitioner's bathroom door to thirty-two inches based on the requirement established in the Americans with Disabilities Act ("ADA"). It will allow Petitioner the ability to access the sink with her wheelchair, which may be some benefit to her. There would not be a safety issue in widening the door, as it would be for a walk-in shower.

CONCLUSIONS OF LAW

18. 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.

19. The Florida Medicaid Program is authorized by Florida Statutes Chapter 409 and Chapter 59G of the *Florida Administrative Code*. The Program is administered by AHCA.

20. This proceeding is a de novo proceeding pursuant to Rule 65-2.056 of the *Florida Administrative Code*.

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

22. The standard of proof in an administrative hearing is a preponderance of the evidence pursuant to Rule 65-2.060(1) of the *Florida Administrative Code*.

23. Section 409.978 (2), Florida Statutes states, in pertinent part: "[AHCA] shall make payments for long-term care, including home and community-based services, using a managed care model."

24. Section 409.98, Florida Statutes, requires LTC plans include, among other services, home accessibility adaptation, personal care, home-delivered meals, case management, medication management, personal emergency response system, and transportation.

25. Florida Medicaid, which includes the LTC program, covers only those services determined to be medically necessary pursuant to Section 409.905 (4)(c), Florida Statutes.

26. The definition of "medical necessary" is found in Rule 59G-1.010 of the *Florida Administrative Code*, which 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; 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. In the present case, Petitioner's daughter is requesting a home modification of her bathroom to install a walk-in shower and widen the bathroom door for Petitioner.

The daughter believes a shower is good for Petitioner's well-being.

28. Respondent's witness Dr. Kaprow stated United's policy for home modification requires a review of two elements. The first element is will the modification improve the member's safety, and the second element is will the home modification provide the member more independence.

29. Respondent's witness Dr. Kaprow stated a walk-in shower for Petitioner would not make Petitioner more independent and it would not improve the member's safety because of her health conditions. Petitioner is not able to bath herself or assist in bathing herself. Petitioner is completely dependent for all her activities of daily living. Petitioner would not gain any form of independence with a walk-in shower. Petitioner is

unable to help with the bathing process. Petitioner is completely dependent on her daughter for all her care. A walk-in shower will not give Petitioner some form of independence because she is completely dependent on others for her care.

30. The second reason is safety. The walk-in shower would not improve Petitioner's safety; instead, it would be a safety risk to Petitioner because of her health conditions. Petitioner suffers from contracture of the upper body extremities. She is immobile and stiff because of this condition; the possibility of a fall is greater in the walk-in shower. Petitioner's daughter does not have the same level of support as in a nursing home to prevent a fall in the shower.

31. The walk-in shower is in excess of Petitioner's needs because a bed bath produces the same results. Petitioner would remain completely dependent and will not gain any form of independence with a walk-in shower. A walk-in shower would be a safety risk for Petitioner. The daughter does not have the same level of support as a nursing home that has several support staff who are able to help Petitioner shower in order to maintain her safety. Petitioner may love showers, but a walk-in shower is not medically necessary.

32. Based on the totality of the evidence, Petitioner has not met her burden to show that a home modification is medically necessary. More specifically, Petitioner's request fails under Rule 59G-1.010(a)(2), (a)(4), and (a)(5) of the *Florida Administrative Code*, which requires that any authorized service not be in excess of a patient's need, be a service for which no equally and less-costly treatment is available, and be furnished in a manner not intended for convenience.

33. The Respondent approved widening Petitioner's bathroom door to thirty-two inches according to the ADA rules to provide wheelchair access. Petitioner's daughter

is encouraged to continue working with United to obtain the necessary care for
Petitioner.

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 May, 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
United Health Care Hearings Unit

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

FILED

May 19, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00853

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 [REDACTED]
UNIT: 88113

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 3, 2017 at 11:36 a.m.

APPEARANCES

For the Petitioner: [REDACTED], designated representative

For the Respondent: Amy Sumner, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of denying Institutional Care Program (ICP) Medicaid for the months of August and September 2016. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted evidence on February 23, 2017. This was entered as Petitioner's Composite Exhibit 1. The Department submitted evidence on February 27, 2017. This was entered as Respondent's Exhibit 1.

The record was held open through April 3, 2017 as the parties wished to attempt to resolve the matter. There was no additional information submitted by either party.

The record closed on April 3, 2017.

FINDINGS OF FACT

1. The petitioner's representative filed an application on October 20, 2016 for Institutional Medicaid Coverage (ICP). The petitioner's Social Security number on this application was entered incorrectly.

2. The petitioner admitted to the facility on April 14, 2016.

3. The Department explained the incorrect Social Security number caused a new case number to be created for the petitioner.

4. The petitioner died on September 22, 2016.

5. The Department issued a Notice of Case Action on October 25, 2017 requesting the petitioner complete and sign the "Financial Information Release" form and return it by November 4, 2016. The notice also requested the petitioner to provide bank statements for the checking account for July, August and September and verification of other income reported on application.

6. The Department explained the "Financial Information Release" form allows the Department to obtain financial information such as bank account verification.

7. The petitioner provided a signed copy of the Financial Information Release in their evidence packet.

8. The Department advised they would also submit a verification letter on bank accounts in an attempt to obtain the needed verification now that the Financial Information Release form was received.

9. The Department issued a Notice of Case Action on November 8, 2016 requesting information to submit to the legal department regarding the Declaration of Trust and sign off by the [REDACTED] for the pooled trust to be approved.

10. The Department issued a Notice of Case Action on November 22, 2016 informing the petitioner that the Medicaid application/review dated October 20, 2016 was denied for failure to submit all information necessary to determine eligibility.

11. The petitioner receives a payment from [REDACTED] of [REDACTED] based on tribal revenues. In 2016, the petitioner received the gross amounts of \$10,407.78 in January and \$10,407.78 in July. Additionally, he received a monthly Elder Stipend Benefit of \$330 from [REDACTED] of [REDACTED].

12. The petitioner had bank accounts with Members [REDACTED] of Florida, Bank of America and Regions Bank.

13. The Department did not receive verification of the petitioner's bank accounts with Member's First and Bank of America for to complete the eligibility determination.

14. The Department did not receive the signed Financial Information Release to be able to submit a request to the banks to verify the balances for August 2016 and September 2016.

15. The petitioner had a power of attorney established prior to his death.

16. The petitioner's representative indicated the power of attorney had difficulty verifying the balances in the accounts following the petitioner's death. The petitioner's representative explained that the power of attorney lapsed when the petitioner died according to the banks.

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-1.712, 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."

20. Florida Admin. Code R. 65A-1.716, Income and Resource Criteria, sets forth: "(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."

21. The Department's Program Policy Manual, CFOP 165-22, section 1640.0206, Verification of Assets (MSP, SFP) states:

Verification of all assets, except cash, is required when the total assets of the SFU are within \$100 of the asset limit. The individual's statement of the amount of cash is accepted. If it is clear from the individual's statement that total assets exceed the limitation or if the individual is ineligible on another factor, assets need not be verified.

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.

The exceptions to this are:

1. persons requesting ICP, Hospice, or HCBS (you must always verify except for the value of the first vehicle and any vehicle over seven years old); and
2. cases that receive an IRS hit. Verification in these cases must be handled in accordance with current policy, which requires a review of these hits. If there is a discrepancy, verification must be secured through a third party.

22. The Department's Policy Manual, section 1640.0319, Comatose Individual (MSSI, SFP), states, "Any asset owned by a **comatose** individual will be excluded **when there is no known legal guardian or other individual** who can access the asset." (emphasis added)

23. The above controlling authorities stipulate that in order to qualify for SSI-Related Medicaid, an individual must own no more than \$2,000 in countable assets. The findings show no verification of the bank accounts for August 2016 and September 2016 was received. The undersigned concludes the verification is required as there was no knowledge of how much was in the petitioner's accounts to know if he was within \$100 of the asset limit or well below the asset limit.

24. The findings show the Financial Information Release was received at hearing. The findings also show the Department attempted to assist the petitioner with obtaining the verification of bank accounts for August 2016 and September 2016. The

undersigned concludes the Department correctly denied the application for ICP Medicaid due to failure of the petitioner to provide verification when initially pended for the information. The undersigned further concludes the Department correctly offered assistance in attempting to gain verification of the bank accounts when the Financial Information Release was finally received.

25. The above guidelines stipulate that an asset will be excluded from consideration if said asset is owned by a comatose individual and there is no legal guardian or other individual who can access the asset. A review of the evidence in its totality indicates the petitioner had a power of attorney who should have access to obtain the necessary verification. The undersigned concludes the petitioner, while deceased when the application was filed, had another individual who had the legal ability to obtain the verification. The undersigned reviewed the regulations and found nothing to support excluding an asset in any other circumstance. Therefore, the undersigned affirms the Department's determination that the bank account balances were necessary in the determination of eligibility for Medicaid.

26. The undersigned notes that should the petitioner's representative receive the verification of these accounts, they may submit them to the Department for consideration.

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 19 day of May , 2017,

in Tallahassee, Florida.



Melissa Roedel
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@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

May 03, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00871

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 April 10, 2017 at 8:46 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Noris Urena, eligibility specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll her in the Medically Needy Program. She is seeking full Medicaid benefits for herself. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented six exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 6. The petitioner did not present any exhibits.

The undersigned informed the parties that a ruling on jurisdiction was reserved for a final order as the request for hearing was received beyond the 90 days in which to request a hearing.

The petitioner's son is receiving full Medicaid benefits and is not an issue.

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 September 28, 2016, the petitioner submitted a recertification application for Food Assistance and Medicaid benefits. The petitioner's household consists of herself and her son (age 17). She was determined disabled by Social Security Administration and is receiving Social Security Disability Income (SSDI) of \$1,305. The petitioner is currently receiving Medicare benefits. She was approved for the state to pay her Medicare Part B premium of \$109. Her son is receiving Social Security benefits of \$652.
2. The respondent determined the petitioner's household income exceeded the income limit for full Medicaid benefits and enrolled her the Medically Needy Program with an estimated share of cost (SOC).
3. The respondent initially used the petitioner's net SSDI of \$1,196 to determine her SOC of \$703. The respondent realized that it had erred and corrected the SOC using

the petitioner's gross SSDI of \$1,305. The respondent determined the petitioner's SOC by subtracting the Medically Needy income limit (MNIL) of \$387 from her gross SSDI resulting to \$918 as the petitioner's SOC. Her eligibility was determined under the Family Related Medicaid Program.

4. On October 4, 2016, the respondent issued a Notice of Case Action informing the petitioner she was ineligible for full Medicaid benefits. The notice informed her she was approved for Medically Needy benefits.

5. On January 25, 2017, the petitioner requested a hearing to challenge the respondent's action to deny her full Medicaid benefits and enrolled her in the Medically Needy Program.

6. The petitioner argued she did not receive the Notice of Case Action dated October 4, 2016, as she had not lived at [REDACTED] since May 2016. She claimed that she was homeless for a few months and found out about the notice/benefits when she contacted the call center on January 25, 2017. She requested a hearing on the same day she found out that she was enrolled in a SOC.

7. The respondent asserted that it had no returned mail but acknowledged that the petitioner's address has been updated to [REDACTED] in its computer system.

8. The petitioner explained that if she is enrolled in the Medically Needy Program with an estimated SOC she will not be able to pay for medication and also pay for living expenses. She emphasized that she is disabled and needs her medication.

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.

Jurisdiction

11. The petitioner argued that she did not receive the notice dated October 4, 2016 which informed that she was ineligible for full Medicaid benefits and that she was enrolled in the Medically Needy Program.

12. It is necessary to establish if the hearing was requested timely. Fla. Admin. Code R. 65-2.046 (1) sets forth that an appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs.

13. The findings show the petitioner did not request this appeal until January 25, 2017, however, the petitioner did not live at the address that the Notice of Case Action was mailed to since May 2016 (prior to the notice mailing date).

14. After reviewing the evidence presented, the hearing officer concludes that the petitioner did not receive the notice dated October 4, 2016. The undersigned retains jurisdiction and will render a decision on the issue.

Full Medicaid will first be addressed under the SSI-Related Medicaid:

15. Fla. Admin. Code R. 65A-1.701, Definitions, states in 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** (emphasis added) are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

16. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of 88% of the federal poverty level and in addition to meeting that limit, the person must not be receiving Medicare.

17. Fla. Admin. Code at R. 65A-1.711 (1) SSI-Related Medicaid Non-Financial Eligibility Criteria, states, “For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905...”

18. Income budgeting for MEDS-AD is set forth in Fla. Admin. Code R. 65A-1.713. It states:

(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. (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, et seq.,...

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396, or another less restrictive option is elected by the state under 42 U.S.C. §1396(2000 Ed., Sup. IV)...

19. The Department’s Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, identifies 88 % of the federal poverty level for an individual for the SSI-

Related Medicaid under the MEDS-AD Program at \$872 July 1, 2016 and \$885 effective April 2017.

20. The above controlling authorities explain the full Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related Program is for individuals whose income is below the federal poverty level and are not receiving Medicare. The MEDS-AD income limit for an individual is \$885. The petitioner is receiving Medicare benefits and her household's income exceeds the income limit for full Medicaid benefits.

Therefore, eligibility for full Medicaid benefits is not found. The respondent's action to deny full Medicaid benefits was within the rules and regulation of the Program.

Full Medicaid will now be addressed under the Family Related Medicaid Program:

21. Federal Medicaid Regulations 42 C.F.R. § 435.218 Individuals with MAGI-based income above 133 percent FPL (Federal Poverty Level) states in part:

(a) *Basis.* This section implements section 1902(a) (10) (A) (ii) (XX) of the Act.

(b) *Eligibility*—(1) *Criteria.* The agency may provide Medicaid to individuals who:

(i) Are under age 65;

(ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and

(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.

(2) *Limitations.* (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

22. Family-Related Medicaid income criteria is set forth in 42 C.F.R. 435.603 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.

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.

(b) *Definitions.* For purposes of this section—

Child means a natural or biological, adopted or step child.

Code means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver....

(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.

(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.

23. The Department's Program Policy Manual CFOP 165-22 (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.

24. In accordance with the above controlling authorities, the Medicaid household group is the petitioner and her son. The findings show the respondent determined the petitioner's eligibility for Medicaid with a household size of two. The undersigned concludes the Department correctly determined the petitioner's household size as two for Medicaid.

25. The Policy Manual at passage 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 Kid Care and/or the Federally Facilitated Marketplace (FFM).

26. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a parent is \$241 for the household size of two, the Modified Adjusted Gross Income (MAGI) disregard is \$68, the Standard Disregard is \$146 and the Medically Needy Income Limit (MNIL) is \$387.

27. In accordance with the above controlling authorities, the undersigned reviewed eligibility for full Medicaid benefits for the petitioner under the Family Related Medicaid Program and did not find her eligible, as her modified adjusted gross income was more than the income limit of \$241 for a household size of two people. Step 1: The undersigned used the petitioner's modified adjusted gross income of \$1,305. Step 2: There were no deductions provided, as there was no tax return. Step: 3: A standard

disregard of \$146 was subtracted. The total income remained \$1,159. Step 4: The total countable net income of \$1,159 was compared with the income standard for two people. Step 5: Since it was greater than the income standard, the modified adjusted gross income disregard of \$68 was subtracted, resulting to \$1,091. This was compared to the income limit of \$241 for full Medicaid. The petitioner's income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

The Medically Needy share of cost will now be addressed under SSI Related Medicaid:

28. The respondent determined the petitioner's SOC under the Family Related program. The undersigned reviewed the SOC under both programs Family Related Medicaid and the SSI-Related program.

29. Fla. Admin. Code R. 65A-1.701 (30) 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."

30. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid coverage Groups, states in part, "(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals who do not qualify for categorical assistance due to their level of income or resources."

31. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid due to their level of income.
32. 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.
33. Federal Regulations at 20 C.F.R. § 416.1124 (c) (12), Unearned Income we do not count, states in part, "The first \$20 of any unearned income in a month..."
34. Income budgeting is set forth in Fla. Admin. Code R. 65A-1.713. It states:
(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:
(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", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable

deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:
1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

35. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the Medically Needy Income Level for family size of one at \$180.

36. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible. The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

37. Following is the determination under the SSI related program. A \$20 unearned disregard and the Medically Needy Income Limit (MNIL) of \$180 was subtracted from the petitioner's income resulting in \$1,105 as the petitioner's SOC.

The Medically Needy share of cost will now be addressed under Family Related

Medicaid:

38. 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.

39. In accordance with the above controlling authorities, respondent determined petitioner's standard filing unit (SFU) as a household of two based on her tax filing status.

40. Fla. Admin. Code R. 65A-1.707 sets forth the income and resource criteria for Medically Needy coverage. "For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost..."

41. The Medically Needy Income Level (MNIL) appears in The Policy Manual at Appendix A-7. Effective May 2017, the MNIL for a household size two is \$387.

42. The above cited authorities and policies address income standards and limits, calculating countable income, and income budgeting in the Family-Related Medically Needy Program.

43. The respondent's calculation is as follows. The Medically level income level for a household of two \$387 was subtracted from the gross SSDI of \$1,305 resulting in the petitioner's SOC of \$918.

44. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and found it was beneficial to determine the petitioner's SOC under the Family Related Program. The undersigned did not find a more favorable outcome than the SOC assigned by the respondent.

Eligibility for full Medicaid was not found.

45. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program is within the rules of the Program.

DECISION

Based upon the 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 03 day of May, 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

May 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-00925

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA,

And

MOLINA HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 19, 2017 at 10:00 a.m.

APPEARANCES

For Petitioner: [REDACTED], Petitioner

For Respondent, AHCA: Lisa Sanchez, Medical Program Analyst

ISSUE

At issue is whether the respondent Molina Healthcare's denial of the petitioner's request for the prescription medication [REDACTED] was correct. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner (or her doctor's office) submitted lab test results as evidence for the hearing. This document was marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Dr. Louis Ruiz, Clinical Pharmacist, and Jackeline Salcedo, Government Contracts Specialist, from Molina Healthcare, which is the petitioner's managed health care plan. The following individuals from Molina were also present but did not testify as witnesses: Rebecca Quintana, Director of Government Contracts, Dr. Alfred Romay, Pharmacy Director, and Dr. Torralbas, Medical Director.

The respondent submitted the following documents as evidence for the hearing, which were marked Respondent Composite Exhibit 1: Fair Hearing Summary, Authorization Request, Notice of Action, Second Authorization Request, Appeal Request, Second Notice of Action, and Fair Hearing Request.

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 a sixty-five (65) 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 Molina Healthcare. She has been diagnosed with [REDACTED]. She experienced a [REDACTED] in 2014.

2. On or about October 31, 2016, the petitioner's treating physician submitted a prior authorization request to Molina Healthcare for approval of the prescription medication [REDACTED]. This medication is a [REDACTED] medication which comes in an injectable form called the [REDACTED].

3. On November 3, 2016, Molina denied the requested medication as not being medically necessary. The denial notice also set forth the criteria which must be met for approval of this medication such as prior trial of other medications.

4. The petitioner stated she stopped taking other [REDACTED] medications such as statins and [REDACTED] because she experienced side effects. Her most recent lab test results showed a reduction in her total [REDACTED]. She stated her doctor administered some doses of [REDACTED] to her in the past 2 months, which were apparently obtained as free samples by her doctor's office. She also stated she is taking another [REDACTED] medication called fenofibrate and is following a diet.

5. The respondent's witness, Dr. Ruiz, stated that [REDACTED] is not on the Medicaid Preferred Drug List and it has criteria which must be met before the medication can be approved by the health plan. He stated the petitioner met only one of these criteria, which is that she has had a prior [REDACTED] event. He also stated the prescribing information for [REDACTED] requires its use in conjunction with a statin. He stated the petitioner's physician prescribed [REDACTED] to be used alone without a statin.

6. Dr. Ruiz also stated if an individual cannot take a statin due to side effects, the treating physician should try a different type of statin since there are 8 different types and the patient should also try a lower dose of the statin. He stated the other medication currently being taken by the petitioner, fenofibrate, is not a statin. He also

stated it is difficult to ascertain what caused the recent reduction in the petitioner's [REDACTED] since [REDACTED] is also a [REDACTED] medication.

CONCLUSIONS OF LAW

7. 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.
8. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.
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 by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(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 Chapter 59G, Florida Administrative Code. The Medicaid program is administered by the respondent, AHCA. Managed care plans, such as Molina, provide services to Medicaid recipients pursuant to a contract with AHCA.
12. The Florida Medicaid Provider Handbook (Provider Handbook) is incorporated by reference in the Medicaid Services Rules found in Florida Administrative Code Chapter 59G-4. In accordance with the above Statute, the Handbook states 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.

13. In this proceeding, Molina Healthcare is the health maintenance organization or managed care plan which provides the petitioner's Medicaid services.
14. Page 1-28 of the Provider Handbook lists HMO covered services. The service list includes prescribed drug services.
15. Page 1-30 of the Provider Handbook states: "An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service."
16. The Florida Medicaid Prescribed Drug Services Handbook has been promulgated into rule by reference in Fla. Admin. Code R. 59G-4.250. Relevant to this proceeding:

Page 1-4:

HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.

Page 2-2:

To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in accordance with Section 1927(k)(6) of the Social Security Act, or (b) prior authorized by a qualified clinical specialist approved by the Agency. Notwithstanding this rule, the Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.

17. The definition of "medically necessary" is found in Fla. Admin. Code R. 59G-

1.010, which 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; 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. Addressing the Preferred Drug List (PDL), the Drug Services Handbook

continues by providing the following additional information:

Page 2-4:

The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.

...

Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a non-PDL product.

...

Non- PDL drugs may be approved for reimbursement upon prior authorization.

19. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not demonstrated that Molina should have approved the requested medication, [REDACTED]. The evidence presented establishes this medication should be prescribed in conjunction with a statin, which was not done in the petitioner's case. Medical necessity for the [REDACTED] has not been established – although the petitioner achieved lower [REDACTED] after she began taking the [REDACTED], she has also been taking another [REDACTED] medication [REDACTED] as well as following a diet.

DECISION

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

NOTICE OF RIGHT TO APPEAL

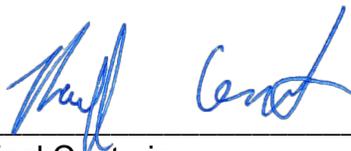
This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 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 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 May, 2017,
in Tallahassee, Florida.

FINAL ORDER (Cont.)

17F-00925

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Rafael Centurion
Hearing Officer
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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
[REDACTED]
MOLINA HEARINGS UNIT

Jun 14, 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-01010

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 6, 2017 at 10:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent: Stephanie Lang, Registered Nurse Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's partial denial of the petitioner's in-patient hospital stay was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted copies of medical bills as evidence for the hearing, which were marked as Petitioner Exhibit 1. The petitioner also submitted copies of his medical records, which were marked as Petitioner Exhibit 2.

Appearing as a witness for the respondent was Dr. Rakesh Mittal, Physician-Consultant with eQHealth Solutions, Inc.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Medicaid Statutes and Regulations, Medicaid Handbook provisions, Inpatient Review History, Denial Notices, Billing History, and 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 is a sixty-nine (69) year-old Medicaid recipient. On August 30, 2016, he sought emergency room treatment due to a urinary retention problem. He had a urinary catheter inserted to allow him to urinate and he remain hospitalized for 4 days (until September 2). He was thereafter discharged from the hospital with the catheter and he was referred to a urologist for further evaluation and/or treatment.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for certain Medicaid services.

3. On January 23, 2017, eQ Health sent a notice to the petitioner entitled "Notice of Denial – Emergency Coverage: Undocumented Non-Citizen." This notice stated the following:

We received a request for review of the inpatient services noted above to determine if the inpatient days were due to an emergency and to determine the number of days of Medicaid coverage. Based on information submitted to us, we will approve the following inpatient days:

Days Authorized for this request: 1

4. The above notice also contained the following rationale for the partial denial of the hospital stay:

This is the case of a patient who was admitted with [REDACTED] resulting in [REDACTED]. This is an emergency medical condition. A Foley catheterization was placed on 8/30 and from 8/31, the [REDACTED] [REDACTED] was noted to be resolving. The creatinine on admission was 2.55 and it improved to 1.95 on 8/31. This scenario demonstrates alleviation of the emergency medical condition. Subsequent treatment may have been medically appropriate and may have been appropriate for inpatient status, though not for any documented emergency medical condition. It is therefore recommended that the requested date of 8/30 be approved and 8/31-9/2 denied.

5. The notice also stated a reconsideration review could be requested and additional information could be provided with the request. A reconsideration review was not requested in this case. The petitioner thereafter requested a Medicaid fair hearing.

6. The petitioner stated he had blood tests, x-rays, and an ultrasound performed while he was in the hospital. He stated it was the doctor's decision to keep him in the hospital because he could not urinate on his own and required the use of the catheter. The petitioner also stated he became a United States permanent resident on May 25, 2016.

7. The respondent's witness, Dr. Mittal, stated the petitioner suffered from an enlarged prostate which caused renal failure. His creatinine level of 2.55 when he was admitted to the hospital indicated an [REDACTED]. Dr. Mittal stated the emergency situation no longer existed as of August 31, 2016 since the creatinine level had decreased to 1.95. He also stated the petitioner is only entitled to Medicaid coverage for emergencies.

8. Ms. Lang from AHCA stated only two of the petitioner's medical providers submitted claims to the Medicaid program. These were the hospital and emergency room physician. These claims were processed and paid by the Medicaid program. She also stated if the petitioner is a permanent resident, he may be entitled to a different type of Medicaid coverage rather than just the coverage for emergencies.

9. 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 Florida Medicaid Inpatient Hospital Services Coverage Policy, effective July 2016.

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 Section 120.80, Florida Statutes.

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

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. 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.).

14. 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.

15. Page 3-22 of the Medicaid Handbook describes Emergency Medicaid for Aliens as follows:

This program reimburses for emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status.

Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated.

All claims must be accompanied by documentation of the emergency nature of the service. Exceptions are labor, delivery, and dialysis services. These are considered emergencies and are payable without documentation when the emergency indicator is entered on the claim form.

16. The Medicaid Inpatient Hospital Services Coverage Policy contains a similar provision, as follows:

Florida Medicaid reimburses for emergency services (including labor and delivery and dialysis services) provided to undocumented aliens who otherwise meet all eligibility requirements except citizenship status. Florida

Medicaid will not pay for continuous or episodic services after the emergency has been alleviated.

17. After considering the evidence and testimony presented, the undersigned concludes that the respondent was correct in partially denying the in-patient hospital stay. The petitioner is entitled to Medicaid coverage for emergencies only, and the emergency was alleviated after his first day in the hospital when the catheter was inserted and his creatinine level decreased. Therefore, the respondent correctly denied the balance of the hospital stay.

18. Since the petitioner indicated he is now a permanent resident alien, he should inquire with the Florida Department of Children and Families (which determines Medicaid eligibility) regarding whether he is eligible for any other Medicaid program rather than just his current coverage for emergencies only.

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.

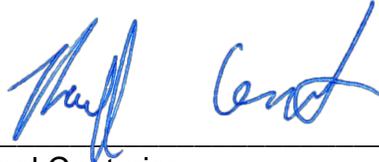
FINAL ORDER (Cont.)

17F-01010

PAGE - 7

DONE and ORDERED this 14 day of June, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
AHCA HEARINGS UNIT

FILED

May 05, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 17F-01138

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 [REDACTED]

AND

UNITED HEALTHCARE

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 31, 2017 at 10:14 a.m., April 11, 2017 at 11:35 a.m., and on April 20, 2017 at 10:33 a.m.

APPEARANCES

For the Petitioner: [REDACTED], husband

For the Respondent: Dr. Brittany Vo, dental consultant

STATEMENT OF ISSUE

Whether the petitioner is eligible to receive a complete set of dentures 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. The Agency contracts with numerous health care maintenance organizations (HMOs) to provide medical services to Medicaid enrollees. United Healthcare (United) is the contracted HMO in the instant case.

By notice dated January 27, 2017, United informed the petitioner that her request for a complete set of dentures was denied because “[t]his service exceeds the maximum count allowed per period.”

The petitioner timely requested a hearing to challenge the denial decision.

There were no additional witnesses for the petitioner. The petitioner submitted documentary and voice recording evidence which was admitted into the record as Petitioner’s Composite Exhibit 1.

Present as a witness for the respondent from United during all sessions of the hearing: Christian Laos, senior compliance analyst. Present as a witness during the April 20, 2017 portion of hearing from United: Dr. Ankit Amin, dental consultant. Present as on-call/as needed counsel during the April 20, 2017 portion of the hearing from United: Paul Norman, senior counsel. The respondent submitted documentary evidence which was admitted into the record as Respondent’s Composite Exhibit 1 and Respondent’s Composite Exhibit 2.

The record was closed on April 20, 2017. Neither party requested that the record be held open for the submission of additional evidence. The petitioner filed additional documentary evidence after the record was closed, on April 21, 2017. The evidence was not admitted into the record nor considered by the undersigned hearing officer during the development of the decision.

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 76) is a Florida Medicaid recipient. The petitioner is enrolled with United HMO. (Respondent's Exhibit 1)
2. In January 2016, the petitioner's dental provider, Economy Dentures, extracted her remaining teeth (approximately 13 teeth) and fitted her with dentures. (Testimony of [REDACTED])
3. The upper denture was thin and contained sharp edges. The upper denture did not extend to the back of the petitioner's mouth and would not stay attached the petitioner's gum. The lower denture was also thin and contained sharp edges. The petitioner never wore the lower denture because it did not fit her gum. The petitioner returned to Economy Dentures numerous times over several months for adjustments and alignments, without success. The petitioner was never able to properly wear the dentures. The petitioner found the care and conduct of dental provider to be unprofessional. (Testimony of [REDACTED])

4. Without dentures, the petitioner (age 76) lost weight because she was unable to eat solid foods. She was diagnosed with malnutrition twice in 2016 and placed temporarily in a nursing home to improve her health. While in the nursing home, the upper denture “fell apart” and was discarded at the nursing facility. The petitioner still has the lower denture, but cannot wear it. (Testimony of [REDACTED])

5. The petitioner reported the problems she was having with the dentures and the dental provider to United in October 2016. United conferred the dental provider and instructed the petitioner to make an appointment, the provider had agreed to “make it right.” (Testimony of [REDACTED])

6. During the appointment, the provider told the petitioner it would cost her approximately \$600 out-of-pocket to repair the dentures. (Testimony of [REDACTED])

7. The petitioner believed that she should not have to incur an out-of-pocket expense, the expense should be covered by Medicaid and/or the provider. (Testimony of [REDACTED])

8. The petitioner filed a grievance against the dental provider with United in November 2016. United issued a written response to the petitioner on December 27, 2016 which reads in pertinent part:

This letter is in response to your verbal grievance on November 7, 2016. We completed the review of your grievance on December 19, 2016.

We were told you are not happy with the service you received from Economy Dentistry. We were told you received bottom dentures from them and they do not fit. The dentist did not do a good job and was not cooperative. He asked you to come back four or five times. The dentures

are causing health issues. You are not able to eat. You would like to see another dentist.

We contacted the office. They told us normal protocol for dentures is to have adjustments over five to six months. They are more than happy to have you return to the office for a re-line or remake of your dentures. Please call the office for further assistance... (Petitioner's Exhibit 1)

9. The petitioner returned to the dental provider in January 2017 as instructed by United's grievance resolution letter. After a consultation, the provider filed an authorization request with United for a complete set of dentures on January 26, 2017. (Respondent's Exhibit 1)

10. United denied the request on January 27, 2017, citing coverage limitations are the reason for the denial. (Respondent's Exhibit 1)

11. The petitioner requested a hearing to appeal the denial decision. (Testimony of [REDACTED])

12. The petitioner argued that the dental provider gave her poor quality temporary dentures in January 2016, not permanent dentures. The petitioner's husband has worn a complete set of permanent dentures for years and is knowledgeable about the look, texture, and fit of permanent dentures. He argued that the dentures provided to the petitioner were temporary because of the appearance (very thin material, shoddy craftsmanship), texture (sharp edges vs a smooth surface) and fit (upper denture was not long enough and would not stay in the petitioner's mouth; lower denture was never worn because it did not fit the petitioner's gum) of the product. Passage of time (in order for gum swelling to recede) nor adjustments to the dentures

made any difference. The dentures were not specifically or correctly molded for the petitioner's mouth. (Testimony of [REDACTED])

13. The petitioner's treating physician wrote a letter describing her health issues. The letter is dated March 23, 2017 and reads, "It is medically necessary for the patient to have dentures in order to eat food. Patient has malnutrition..." (Petitioner's Exhibit 1)

14. The respondent witnesses, though employed with United, were not directly involved in the actions which preceded the hearing request and had no firsthand knowledge about the petitioner's case when the hearing initially convened. The respondent did not conduct a prehearing conference with the petitioner and only become aware of the facts of the case during the first session of the hearing. After hearing the petitioner's testimony, the respondent requested the proceeding be continued to allow the United witnesses to research the matter. (Testimony of Christian Laos and Dr. Brittany Vo)

15. During the adjournment, the respondent had reached out to the dental provider, Economy Dentures, for its input in the matter. "Jennifer" (surname unknown by respondent) with Economy Dentures reportedly told the respondent, during a April 10, 2017 telephone call, that the petitioner was provided a permanent set of complete dentures and the provider was willing to perform a "hard alignment" to resolve the difficulty the petitioner was having with the dentures. (Testimony of Christian Laos and Dr. Brittany Vo)

16. The respondent argued that Medicaid rules provides for one complete set of dentures per recipient and the petitioner had received the service limit. The respondent argued that the remaining issue is customer satisfaction or quality of care and non-jurisdictional. (Testimony of Christian Laos and Dr. Brittany Vo)

17. The respondent's documentary evidence consisted of United's January 27, 2017 denial notice, the January 2017 prior service authorization request from Economy Dentures, and Medicaid dental services policy. (Respondent's Exhibits 1 and 2)

CONCLUSIONS OF LAW

18. 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.

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

20. This hearing was held as 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 was assigned to the petitioner.

22. 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.).

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

24. Medicaid Dental Services Policy (May 2016) addresses coverage limitations for dentures on page 4:

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

25. The cited authority explains that Medicaid will reimburse for one complete set of dentures per recipient.

26. The respondent denied the petitioner's request for a complete set of dentures in January 2017, citing Medicaid service limitations.

27. The petitioner argued that she had received poor quality temporary dentures from the dental provider in January 2016, not permanent dentures.

28. To prove the petitioner received permanent dentures in 2016, the respondent offered recollections of a conversation with the dental provider, during which the provider reportedly told the respondent that it gave the petitioner permanent dentures. No one from the dental provider's office, Economy Dentures, appeared as a witness during the hearing to corroborate the respondent's testimony. The respondent did not file any business records (i.e., provider claims) documenting that Medicaid reimbursed the provider for a complete set of permanent dentures.

29. Statements made by a third party, not present at the hearing, are considered hearsay evidence. In the case of *Johnson v. Department of Health and Rehabilitative Services* 537 So.2d 675 (Fla. 1st DCA 1989), the court stated, “It is well settled that hearsay is admissible in an administrative setting; however, hearsay alone is insufficient to support a finding...”

30. The cited case law explains that hearsay evidence alone cannot be relied on to make a Finding of Fact.

31. The petitioner argued that she is eligible to receive a complete set of dentures through Medicaid because the provider gave her a poor quality temporary dentures only. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that there is no direct evidence (such as a paid claim documenting that Medicaid reimbursed the dental provider for a complete set of permanent dentures or direct testimony from the dental provider confirming that permanent dentures were provided to the petitioner) that the petitioner received a complete set of permanent dentures. The petitioner provided credible evidence, through substantial and descriptive testimony regarding the appearance, texture, and fit of the dentures, that she received a poor quality temporary dentures, not permanent dentures. The undersigned concludes that the petitioner met her burden of proof in this matter.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED. The respondent is ordered to provide the petitioner with a complete set of dentures.

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 May, 2017,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
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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
[REDACTED]
United Health Care Hearings Unit

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

FILED

May 08, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 17F-01192

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 1 [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 8:30 a.m.

APPEARANCES

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

For the Respondent: Monica Otorola, Senior Program Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent United Healthcare's action terminating the petitioner's adult day 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

At the conclusion of the hearing, the record was left open for ten (10) days for each party to submit any additional evidence. The petitioner's daughter submitted a doctor's note concerning her own medical conditions as well as photographs of her mother. These documents 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. After the hearing, the respondent submitted a document entitled "Additional Comments Refuting Testimony of the Petitioner." This document was marked as Respondent Exhibit 2.

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-four (94) years of age and lives with her daughter, who is sixty-seven (67) years old. The petitioner's medical conditions include [REDACTED]. She utilizes a wheelchair, although her daughter states she can walk a little and stand up.

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 40 hours weekly of adult day care services by United Healthcare. She was also approved for 14 hours weekly of personal care assistance services and incontinence supplies.

5. On or about January 13, 2017, United Healthcare sent a letter to the petitioner informing her that her adult day care services would be terminated effective January 23, 2017. The notice stated the following reason for the termination:

You were getting adult day care. A long term care doctor reviewed your care plan. Your dementia has gotten worse. Your care plan is based on your needs. Based on the information given, the long term care doctor does not think you need this service. Adult day care is not helping you. The service will be stopped.

6. The respondent's witness, Dr. Kaprow, stated the petitioner needs hands-on support with all her activities of daily living (ADLs), including eating. She receives assistance at the adult day care facility with a staffing ratio of 6:1, but she needs 1:1 support. He stated the petitioner's dementia has worsened and she is unlikely to benefit from any programs offered at the adult day care facility. He also stated the petitioner

takes approximately 20 medications daily and the LTC services can be changed as the patient's conditions change.

7. The petitioner's daughter stated her mother does not take 20 medications daily. Her mother eats breakfast and lunch at the day care facility and then has dinner at home. The daughter is retired but she also cleans houses to earn income. The daughter stated she herself [REDACTED] and also has [REDACTED]. She stated her mother is able to socialize at the day care and she participates in all activities, such as dancing, exercise, and going on trips to outside locations such as the circus. She also stated her mother can announce when she needs to use the toilet and she is only incontinent at night.

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 or termination of 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 adult day care services under the Program should not be terminated.

14. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Personal care assistance and adult day care services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

15. The petitioner was previously approved for adult day care services, which are defined in the contract as:

Services furnished in an outpatient setting which encompass both the health and social services needed to ensure optimal functioning of an enrollee, including social services to help with personal and family problems and planned group therapeutic activities. Adult day health care includes nutritional meals. Meals are included as a part of this service when the patient is at the center during meal times. Adult day health care provides medical screening emphasizing prevention and continuity of care, including routine blood pressure checks and diabetic maintenance checks. Physical, occupational and speech therapies indicated in the

enrollee's plan of care are furnished as components of this service. Nursing services, which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene, are also a component of this service. The inclusion of physical, occupational and speech therapy services, and nursing services as components of adult day health services does not require the Managed Care Plan to contract with the adult day health provider to deliver these services when they are included in an enrollee's plan of care. The Managed Care Plan may contract with the adult day health care provider for the delivery of these services or the Managed Care Plan may contract with other providers qualified to deliver these services pursuant to the terms of this Contract.

16. The petitioner is currently approved for 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 terminating the petitioner’s adult day care services under the LTC Program. The basis for the termination was that the adult day care services are not benefitting the petitioner. However, conflicting evidence on this issue was presented by the parties. The petitioner’s daughter testified her mother participates in all day care activities. The respondent’s witness testified the petitioner is unlikely to benefit from these services due to her dementia and she needs more 1 on 1 assistance than is available at the day

care. There was no testimony or written statement from anyone at the day care facility to support the respondent's position. Since the respondent bears the burden of proof in this case, the hearing officer resolves this conflict in the testimony in favor of the petitioner. Accordingly, the petitioner's adult day care services should not be terminated at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, and the petitioner's adult day care services shall not be terminated 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 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.)
17F-01192
PAGE -9

DONE and ORDERED this 08 day of May, 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

May 11, 2017

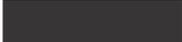
Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01197

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 
UNIT: 88249

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 19, 2017, at 9:15 a.m., in , Florida.

APPEARANCES

For the Petitioner: .

For the Respondent: Cynthia Haynes, DFC supervisor.

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Qualified Medicare Beneficiary (QMB) under the Medicare Savings Plan (MSP) is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By Notice of Case Action dated February 6, 2017, the Department informed the petitioner that her January 4, 2017 application for QMB was denied due to “value of your assets is too high for this program”. On February 22, 2017, the petitioner timely requested an appeal challenging the Department’s action.

██████████ petitioner’s friend, appeared as an observer.

The petitioner did not submit any exhibits. The respondent submitted eight (8) exhibits, which were accepted and marked as Respondent’s Exhibits “1” through “8”.

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 previously submitted and application requesting benefits and reported assets in excess of \$30, 000. The case was processed and petitioner was approved for the FAP. Her Medically Needy and QMB benefits were denied due to excess assets.
2. The petitioner is 79 years old ██████████ and is receiving Medicare benefits. On January 4, 2017, the petitioner submitted an application requesting Food Assistance, Medicaid and Medicaid/Medicare Buy-in assistance with Medicare Part B premiums. On the application, she listed having a CD with a balance over \$5,000.
3. The asset limit for QMB Program benefits is \$7,280. The application was processed and it was determined that the petitioner’s assets exceeded the asset limit for the QMB Program. The Medically Needy benefits were denied due to not signing a financial consent form, which would have authorized the Department to access her bank

information. On February 6, 2017, a notice was sent to the petitioner informing her of the action, see Respondent's Exhibits 1 & 2. Only the QMB issue is being challenged.

4. The respondent's representative explained that petitioner's QMB application was denied because of assets information reported on the previous application. The petitioner did not dispute the facts reported by the respondent. She acknowledged having balances over the limit, but explained that it not new money. She explained that she moves her money from one bank to another based of the interest rate offered to her. Petitioner maintains that the monies were in her accounts for her needs and expressed desire to close her case entirely. However, she did not withdraw her appeal.

CONCLUSIONS OF LAW

5. 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.

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

7. Fla. Admin. Code R. 65A-1.702, Special Provisions explains MSP and in part states:

(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.)...

8. 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., with the following exceptions:

9. The Fla. Admin. Code R. 65A-1.303, Assets, sets forth:

(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.

10. In accordance with the federal regulations, eligibility standards for SSI-Related Program appear in the Department's Program Policy Manual (The Policy Manual), CFOP 165-22, at Appendix A-9. Effective April 2016, the resource limit for a one-person assistance group applying for Medicaid/Medicare Buy in Program is \$7,280.

11. At the time of the application, the petitioner's assets exceeded the \$7,280 asset limit for the petitioner to be eligible for QMB. By her own admission, the assets in question still exist to date. The petitioner acknowledged having bank accounts linked to

her with balances higher than the established amount. A review of the rules did not find any exceptions to meeting the asset limit. It is concluded that the respondent's action to deny the petitioner's application for QMB benefits was within the rules of the Program, as petitioner's assets exceed the resource limit for the Program the petitioner is seeking.

12. In careful review of the cited authorities 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 SSI-Related Medicaid and MSP (QMB) is proper.

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.

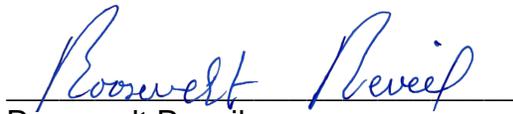
FINAL ORDER (Cont.)

17F-01197

PAGE -6

DONE and ORDERED this 11 day of May, 2017,

in Tallahassee, Florida.



Roosevelt Reveil

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

Jun 23, 2017

Office of Appeal Hearings
Dept. of Children and FamiliesSTATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 17F-01213

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 15 
UNIT: AHCARESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on May 23, 2017, at 10:45 a.m.

APPEARANCES

For the Petitioner:  M.S.W.
Case Manager
 Health Center

For the Respondent: Mindy Aikman
Grievance and Appeals Specialist
Humana

STATEMENT OF ISSUE

Did the respondent, Humana, demonstrate by a preponderance of the evidence that it correctly denied 48 of the 120 units of mental health Targeted Case Management services requested by the petitioner? The petitioner requested 120 units of Targeted Case Management services for the period January 19, 2017 through April 19, 2014 and the respondent approved 72 units.

PRELIMINARY STATEMENT

██████████ may sometimes hereinafter be referred to as the petitioner's "representative".

The following individuals appeared as witnesses on behalf of Humana: Vanessa Ramirez, L.M.H.C., Director of Utilization Management at Beacon Health Options; Simone Lazarus, R.N., L.M.H.C., Manager of Utilization Management at Beacon Health Options; and Sherrie Bieniek, M.D., Medical Director of Beacon Health Options. Dianne Soderlind, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration ("AHCA" or "Agency"), was present solely for the purpose of observation.

The petitioner introduced Composite Exhibit "1" at the hearing, which was accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "4" at the hearing, which were also accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on May 30, 2017 for the petitioner's representative to submit the petitioner's most recent clinical progress note and for both parties to submit their closing statements in writing. Once received from the petitioner's representative, the progress note was accepted into evidence and marked as petitioner's Exhibit "2". The hearing record was closed on May 30, 2017 after receipt of the closing statements from both parties.

At the respondent's request, the hearing officer took administrative notice of the Florida Medicaid Mental Health Targeted Case Management Handbook at the hearing.

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 47-year-old male. He resides in ██████████ County.
2. The petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. The Agency for Health Care Administration is responsible for administering the Florida Medicaid Program.
4. The petitioner is an enrolled member of Humana.
5. Humana is a health maintenance organization (“HMO”) contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in the State of Florida.
6. The petitioner resides in an assisted living facility.
7. Humana approved 120 units of Targeted Case Management services for the petitioner for the certification period directly prior to this request.
8. The purpose of mental health Targeted Case Management services is to assist individual recipients in gaining access to needed medical, social, educational, and other services.
9. The primary goal of mental health Targeted Case Management services is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs,

goals, and abilities of each recipient and must not simply reflect the Medicaid maximum allowable for the service.

10. Targeted Case Management services are measured in quarter-hours.

One unit is equivalent to 15 minutes.

11. On January 19, 2017, [REDACTED] Health Center, the petitioner's Targeted Case Management provider, submitted a prior authorization request for 120 units of Targeted Case Management services to be approved for the period January 19, 2017 through April 19, 2017.

12. Humana has contracted Beacon Health Options to be its behavioral health vendor. One of Beacon Health Option's responsibilities as behavioral health vendor is to review and make final determinations on prior authorization requests submitted by Humana members for behavioral health services.

13. In a Notice of Action dated January 23, 2017, Beacon Health Options informed the petitioner that it was denying a portion of his request for Targeted Case Management services. The Notice of Action states, in part:

We made our decision because:

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 individualized, specific, consistent with symptoms or diagnosis of illness or injury, and not be in excess of the patient's needs.

14. The Notice of Action goes on to explain:

The facts that we used to make our decision are: [REDACTED] Health Center Inc. asked for Outpatient Mental Health for dates 1/19/17 – 4/19/17. A Beacon Physician Advisor (Doctor), a board certified

psychiatrist, looked at the request. The doctor also looked at all the medical information we received. The doctor used this information to decide if the services are necessary for your health. We are sorry, but Beacon will not cover all of this service. [REDACTED] Health Center Inc. has been told of this decision. You may want to talk to your doctor about this decision.

The services asked for are to treat sadness and trouble with daily things. This is through ongoing targeted case management services (TCM). According to the information we got from your provider, you are doing okay. You have been getting TCM since 2014. You do not need the services because the 120 units of TCM asked for are more than needed to meet goals. You are approved for 72 units of TCM.

This decision is based on Florida Mental Health Level of Care Clinical Criteria for Outpatient Mental Health....

15. The petitioner has been receiving case management services through [REDACTED] Health Center since October 1, 2014. From October 1, 2014 through May 25, 2015, he was participating in Intensive Case Management services. From May 26, 2015 until the present, he was authorized to receive Targeted Case Management services.

16. The petitioner may be characterized as a long-term mentally ill patient with a [REDACTED] and [REDACTED] limitations.

17. The petitioner's current diagnoses include the following [REDACTED]. The petitioner was also previously diagnosed with [REDACTED] disorder and [REDACTED].

18. The petitioner's traumatic brain injury is the result of a motorcycle accident that occurred when he was 18-years-old.

19. A consequence of the expressive aphasia is that the petitioner often does not speak coherently.

20. The petitioner does not always understand people speaking to him due to the severity of his injury.

21. The petitioner is unable to use the telephone.

22. The petitioner's psychiatric history includes episodes of psychotic paranoid behavior which resulted in him being involuntarily committed under the Florida Baker Act statute on multiple occasions.

23. The petitioner is prescribed [REDACTED].

24. [REDACTED] is an injectable antipsychotic drug used to treat certain mental and mood disorders such as [REDACTED] and [REDACTED] disorder.

25. The petitioner's understanding of money is rudimentary. He is unable to make change accurately.

26. The petitioner's case manager assists the petitioner with shopping and paying his bills.

27. The petitioner consistently neglects his personal hygiene.

28. The petitioner is unable to execute any adult daily living functions without assistance.

29. The petitioner's case manager assists the petitioner with the following activities of daily living: bathing; oral care; nail care; dressing; and laundry.

30. The petitioner has [REDACTED]. The petitioner's [REDACTED] may be the result of his past poor hygienic activity. The practice of the petitioner's representative bathing the petitioner helps curb the petitioner's [REDACTED].

31. The petitioner has made some limited progress. The petitioner is much less combative than he was previously. The frequency of the petitioner's paranoid and violent

behavior has decreased substantially in the past one-and-a-half years. While the petitioner used to be very guarded and would avoid everyone entirely, he now interacts sporadically with unfamiliar people.

32. Consistent, frequent home visits by the petitioner's case manager are necessary to assist the petitioner in maintaining his progress.

33. As a result of his [REDACTED], the petitioner cannot be expected to make significant progress.

34. The petitioner's case manager has worked with the petitioner since October 2014.

35. The petitioner's case manager provides additional services to the petitioner for the purpose of ensuring his health and safety which he does not document so as to not exceed the allowable services approved by the respondent.

36. The petitioner is not eligible for placement in an assisted living facility.

37. The petitioner does not have any family that can assist with his care.

38. The petitioner's progress notes indicate a consistent need for services.

CONCLUSIONS OF LAW

39. 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.

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

41. The Florida Medicaid Program is administered by the Agency for Health Care Administration.

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

43. In the present case, the respondent is denying a portion of the petitioner's request for Targeted Case Management services. Since this represents a reduction of this type of services from the previous certification period, the burden of proof is hereby assigned to the respondent in accordance with Fla. Admin. Code R. 65-2.060 (1).

44. 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.).

45. 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, on Page 1-27, states:

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

...

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

46. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include community mental health services.

47. 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."

48. In order for Targeted Case Management services to be approved, the services must be medically necessary and meet all requirements set forth in the Florida Medicaid Mental Health Targeted Case Management Handbook (“Handbook”).

49. Fla. Admin. Code R. 59G-1.010(166), defines medical necessity as:

(166) “Medically 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.

50. 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.

51. 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.

52. The Florida Medicaid Mental Health Targeted Case Management Handbook is incorporated by reference in the Medicaid Services Rules by Fla. Admin. Code R. 59G-4.199.

53. The Florida Medicaid Mental Health Targeted Case Management Handbook, on Page 1-1, explains as follows:

The purpose of mental health targeted case management services is to assist individuals (recipients) in gaining access to needed medical, social, educational, and other services.

The primary goal of mental health targeted case management is to optimize the functioning of recipients who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. Services and service frequency should accurately reflect the individual needs, goals, and abilities of each recipient and must not simply reflect the Medicaid maximum allowable for the service.

54. The Florida Medicaid Mental Health Targeted Case Management Handbook sets forth the certification criteria for adult mental health Targeted Case Management on Pages 2-4 and 2-5. It states as follows:

In order to be certified to receive adult mental health targeted case management services, documentation must be provided in the recipient's

case record indicating that the recipient:

1. Is enrolled in a DCF adult mental health target population (18 years and older);
2. Has a mental health disability (i.e., severe and persistent mental illness) that requires advocacy for and coordination of services to maintain or improve level of functioning;
3. Requires services to assist in attaining self-sufficiency and satisfaction in the living, learning, work, and social environments of choice;
4. Lacks a natural support system for accessing needed medical, social, educational, and other services;
5. Requires ongoing assistance to access or maintain needed care consistently within the service delivery system;
6. Has a mental health disability (i.e., severe and persistent mental illness) that, based upon professional judgment, will last for a minimum of one year;
7. Is not receiving duplicate case management services from another provider; and
8. Meets at least one of the following requirements:
 - a. Is awaiting admission to or has been discharged from a state mental health treatment facility;
 - b. Has been discharged from a mental health residential treatment facility;
 - c. Has had more than one admission to a crisis stabilization unit (CSU), short-term residential facility (SRT), inpatient psychiatric unit, or any combination of these facilities within the past 12 months;
 - d. Is at risk of institutionalization for mental health reasons; or
 - e. Is experiencing long-term or acute episodes of mental impairment that may put him at risk of requiring more intensive services.

55. The Agency for Health Care Administration eligibility criteria for Mental Health Targeted Case Management also appear on the Agency's internet website at http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/behavioral_health_coverage/bhfu/Mental_Health_TCM.shtml. They explain as follows:

All Medicaid recipients who meet the following criteria may receive mental health targeted case management services:

- Not receiving case management services under a home and community-based service waiver.
- Not in a hospital, nursing home, intermediate care facility for the developmentally disabled or institution for mental diseases.

- 17 years of age or younger and require advocacy for and coordination of services to maintain or improve level of functioning, or
- 18 years of age or older and require advocacy for and coordination of services to maintain or improve level of functioning, or
- 18 years of age or older and resides in the community and, due to mental illness, exhibits behavioral or symptoms that could result in long-term hospitalization if frequent interventions for an extended period of time were not provided.

56. The Beacon Health Options Level of Care Guidelines for Continued Care of

Targeted Case Management set forth the following prerequisites for continued care:

- The participant continues to meet criteria for specialized case management services.
- The participant has made some progress toward more independent functioning, but evidences an ongoing inability to obtain or coordinate services without program support at this time.
- The treatment plan clearly defines the expected treatment goals and the time frame for achieving these specific activities.

57. The Beacon Health Options Level of Care Guidelines for Targeted Case

Management set forth the following exclusions relating to the receipt of services:

- The participant has an axis I diagnosis which is not reasonably expected to improve or successfully respond to therapeutic interventions. The member is unable to show any positive improvement given their baseline behavior.
- Ongoing services are for the primary purpose of providing support which can be obtained through other services or a lower level of care.
- The participant does not meet criteria for specialized case management services.

58. The Beacon Health Options Level of Care Guidelines for Targeted Case

Management contain exclusions not found in the guidelines of the Agency for Health

Care Administration. Since the services offered by a health maintenance organization may not be more restrictive than those offered by the Medicaid State Plan administered by the Agency for Health Care Administration, this appeal will be evaluated in accordance with the Agency's standards.

59. In the present case, the respondent did not provide any testimony or evidence demonstrating a change in the petitioner's circumstances which would make the Targeted Case Management services it denied no longer medically necessary. The respondent relied almost exclusively on its position that the services being provided to the petitioner are primarily supportive in nature and, thus, should be denied in accordance with the Beacon Health Options Level of Care Guidelines. By their very nature, these services are supportive. In addition, this exclusion does not appear in the guidelines of the Agency for Health Care Administration. The respondent also argued the services should be denied because there will be no improvement in the petitioner's ability to take care of himself or to manage his day to day affairs. However, testimony at the hearing reflects that the petitioner has not only made progress but maintenance of this progress is dependent upon the continuation of his Targeted Case Management services.

61. Pursuant to the above, the respondent has not met its burden of proof to demonstrate by a preponderance of the evidence that it correctly denied a portion of the petitioner's request for Targeted Case Management services.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is 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 23 day of June, 2017,

in Tallahassee, Florida.

Peter J. Tsamis

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

FILED

May 01, 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-01244

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 66292

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:49 p.m. on March 3, 2017.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Sylma Dekony, ACCESS
Economic 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

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 10 exhibits, entered as Respondent Exhibits "1" through "10". The record was closed on March 3, 2017.

FINDINGS OF FACT

1. On September 19, 2016, the petitioner (age 42) submitted a Medicaid application for herself (Respondent Exhibit 2). The petitioner was employed as a Human Resources (HR) Director at a Long Term Rehabilitation Health Facility until May 2016.
2. For the petitioner to be eligible for Medicaid, she must have minor children in the home, be pregnant, elderly or considered disabled by the Social Security Administration (SSA) or DDD.
3. DDD is responsible for determining disability eligibility on behalf of the Department.
4. The petitioner does not have minor children in the home, is not pregnant or elderly and has not been considered disabled.
5. The petitioner applied for disability through the SSA in June 2016 and was denied. The petitioner is unsure of the date she applied with the SSA or the reason she was denied.
6. Ms. Miller stated that the SSA system does not indicate that the petitioner was denied for medical reasons. Therefore, Ms. Miller "believes" that the petitioner was denied for technical reasons, such as income and or resources.
7. The petitioner described her medical conditions as having a pacemaker and poor circulation in both legs, which causes her legs to fall asleep. The petitioner's cardiologist referred her to a vascular doctor for her poor circulation.
8. The vascular doctor diagnosed the petitioner with [REDACTED]
[REDACTED] in her legs.

9. In November 2015, the vascular doctor performed surgery on the petitioner and placed a large stint in her abdomen, to open the circulation in her left leg. The stint is hitting nerves in the center of the petitioner's body, which creates excruciating pain throughout her body.

10. The petitioner tried working after the November 2015 surgery. Her employer allowed her to work a few hours a day. However, the surgery caused [REDACTED] in the petitioner's legs, which prevented her from working. In May 2016, she was "released" by her employer.

11. After the surgery, the petitioner's internal medicine doctor referred her to a vascular surgeon. The petitioner asserts that after the vascular surgeon completed many tests, he determined that the November 2015 surgery was not required. And the procedure is irreversible, because the stint is in a very dangerous place near a major artery.

12. The vascular surgeon referred the petitioner to a pain management doctor. The petitioner is taking three different opiates, anti-inflammatory, [REDACTED] and [REDACTED].

13. DDD reviewed the petitioner's medical records from [REDACTED], Doctor [REDACTED] and Florida Cardiology, between 2015 and 2016 (Respondent Exhibit 5). And determined that the petitioner's primary diagnosis is [REDACTED] and the secondary diagnosis is [REDACTED]. DDD also listed "other alleged impairments" as [REDACTED] and varicose veins (Respondent Exhibit 7).

14. The petitioner disagrees with the medical records DDD reviewed. The petitioner asserts that [REDACTED] and Florida Cardiology are places where she had some of her surgeries. And Doctor [REDACTED] is the vascular surgeon that told her that the stint was not required and cannot be removed.

15. The petitioner also disagrees with DDD's determination that [REDACTED] is the primary diagnosis and [REDACTED] is the secondary diagnosis. The petitioner argued that her disability is the excruciating pain caused by the stint in her abdomen that is hitting the nerve, not fibromyalgia or mitral valve prolapse.

16. Ms. Miller contends that the order of the diagnosis is not relevant. That DDD looks at all of the alleged disabilities and reviews the petitioner's medical records and "weighs everything equally".

17. DDD utilizes a federally regulated 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?

18. DDD concluded the five-step evaluation process in step four. The following are the petitioner's results (in bold) of DDD's five-step evaluation (Respondent Exhibit 6):

- 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? **Yes**
- Step 5: Is the claimant able to perform other work? **N/A**

19. Although step one is part of the five-step sequential evaluation process, Ms. Miller said DDD does not determine step one. Step one was referred to the Department.

20. The respondent's representative stated since the petitioner was last employed in May 2016 she is not engaging in SGA.

21. In step two, DDD determined the petitioner's mental MDI [REDACTED] was not severe and her physical MDI's [REDACTED] were severe.

22. In step three, DDD evaluated the petitioner's physical MDI level of severity from a federal regulation list of disability impairments. The petitioner's physical MDI's are in the body system category 4.00 Cardiovascular System, section 4.12 [REDACTED]

23. Ms. Miller said there are no listings for [REDACTED] or the pain the petitioner is suffering due to the stint. And mitral valve prolapse and [REDACTED] fall in the [REDACTED] section.

24. Ms. Miller stated that the petitioner's physical MDI did not meet or equal the listing, because it was not determined by "appropriate medically acceptable imaging, causing intermittent claudication, had a blood pressure ratio test or decrease in systolic blood pressure on an exercise test".

25. In step four, DDD evaluated whether the petitioner was capable of returning to her PRW as a HR Director. DDD's Physical Residual Functional Capacity Assessment (Respondent Exhibit 7), determined that all of the petitioner's recent physical exams are within normal limits with normal gait and no neurological deficits. Therefore, the petitioner is capable of:

- Occasionally lift and/or carry 20 pounds.
- Frequently lift and/or carry 10 pounds.
- Stand and/or walk (with normal breaks) about 6 hours in an 8-hour workday.
- Sit (with normal breaks) about 6 hours in an 8-hour workday.

26. DDD determined, in step four, that the petitioner can return to her previous job as a HR Director. DDD stopped the sequential evaluation in step four.

27. DDD's Case Analysis, dated December 1, 2016, (Respondent Exhibit 6) in part states:

DATA:

42 year old alleging [REDACTED], fatigue, depression. 12th grade education and PRW as a human resource director. The claimant has a medical history of [REDACTED], varicose veins and mitral valve prolapse and regurgitation. Last EF was 60-648, and all recent physical exams are WNL with normal gait and no neurological deficits.

ADLS:

The claimant is not working at this time and has PRW as a human resources director. The claimant needs assistance with her personal care tasks and her daughter-in-law assists with that. The claimant is able to prepare simple meals, she lives alone and her daughter in law checks on her daily. The claimant does not do housework, she does not drive due to her medications and does not go grocery shopping. She holds onto things or people when walking and is looking into getting a wheelchair. She is able to sit for about 10-15 minutes before needing to get up and is able to stand or walk 10-15 minutes before needing to sit. She is on medications for pain at this time.

Mental:

[REDACTED] Ph.D. reviewed the file and provided a PRTF. The claimant has a diagnosis of [REDACTED] which is well controlled. He reported that there is no evidence of a severe mental impairment at this time.

Summary:

At this time it is felt that the claimant is able to perform PRW as a human resources director.

28. DDD denied the petitioner Medicaid Disability on December 1, 2016 with code N31-NON-PAY Capacity for SGA - customary past work, no visual impairment.

29. On December 5, 2016, the Department mailed the petitioner a Notice of Case Action, denying the September 19, 2016 Medicaid application, "Reason: you or a member(s) of your household do not meet the disability requirement" (Respondent Exhibit 3).

30. The petitioner disagrees with DDD's evaluation. The petitioner said she has letters from her cardiologist, vascular surgeon, internal medicine doctor and pain management doctor that verify she is disabled and unable to work.

31. Petitioner asserts that medical records from her internal medicine doctor and pain management doctor should be reviewed, not from [REDACTED], Florida Cardiology or Doctor [REDACTED].

32. Ms. Miller said that "there is no rule that they have to obtain every medical record" on the petitioner. That DDD is only required to review recent medical records, which were reviewed. And the petitioner's pain caused by the stint was reviewed from medical records provided by Doctor [REDACTED].

33. The Hearing Officer offered to leave the record open for the petitioner to submit medical records from her doctors. However, Ms. Miller refused to review the medical records, stating that DDD's review is more than 90 days old. And the only way DDD will review the petitioner's medical records from her doctors is if the petitioner submits another Medicaid application.

34. The petitioner elected to submit another Medicaid application and submit her doctors' medical records, rather than having the Hearing Officer leave the record open for the medical records.

35. The respondent's representative explained that the petitioner must also provide verification that she has applied for disability through the SSA.

36. The petitioner agreed to also reapply for disability through the SSA and to provide all her medical records to SSA.

CONCLUSIONS OF LAW

37. 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.

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

39. Medicaid eligibility is based on federal regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents, children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 or older.

40. *Florida Administrative Code* R. 65A-1.703, Family-Related Medicaid Coverage Groups, in part states:

(1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule...

(5) Medicaid for pregnant women...

41. The evidence submitted establishes that the petitioner has no minor children in the home and is not pregnant. Therefore, the petitioner is not eligible for Family-Related Medicaid.

42. The evidence submitted also establishes that the petitioner is not age 65 or older and has not been considered disabled by the SSA. Therefore, the Department considered the petitioner for SSI-Related Medicaid.

43. 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.) ...

44. 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).)...

45. In accordance with the above authority, DDD utilized the five-step sequential evaluation process in determining the petitioner's disability.

46. 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 May 2016, when she was employed part-time as a HR Director. Therefore, the petitioner is not engaging in SGA.

47. The evidence submitted establishes that DDD reviewed the petitioner's medical records from [REDACTED], [REDACTED], between 2015 and 2016. And determined that the petitioner's primary diagnosis is [REDACTED] and the secondary diagnosis is [REDACTED]. DDD also listed "other alleged impairments as [REDACTED] and varicose veins.

48. The petitioner argued that DDD reviewed incorrect medical records to determine her disability, because [REDACTED] [REDACTED] are places where she had some of her surgeries. And Doctor [REDACTED] is the vascular surgeon that told her that the stint was not required and cannot be removed.

49. In Step two of the evaluation process, DDD determined that the petitioner's mental MDI (anxiety) is not severe and her physical MDI's [REDACTED] and [REDACTED] [REDACTED] are considered severe.

50. Step three of the evaluation process evaluates whether the petitioner's physical MDI severity meets or equal a list of disability impairments in Title 20 of the Code of Federal Regulations, Appendix 1.

51. The findings show that the petitioner's [REDACTED] and [REDACTED] fall in the body system category [REDACTED]

52. Title 20 of the Code of Federal Regulations § 404 Subpart P, Appendix 1, identifies [REDACTED], and in relevant part states:

4.00 Cardiovascular System...

A. General

1. What do we mean by a cardiovascular impairment?

a. We mean any disorder that affects the proper functioning of the heart or the circulatory system (that is, arteries, veins, capillaries, and the lymphatic drainage)...

3. What do the following terms or phrases mean in these listings?...

d. Appropriate medically acceptable imaging means that the technique used is the proper one to evaluate and diagnose the impairment and is commonly recognized as accurate for assessing the cited finding...

C. Using Cardiovascular Test Results...

16. What details should exercise Doppler test reports contain? The reports of exercise Doppler tests must describe the level of exercise; for example, the speed and grade of the treadmill settings, the duration of exercise, symptoms during exercise, and the reasons for stopping exercise if the expected level of exercise was not attained. They must also include the blood pressures at the ankle and other pertinent sites measured after exercise and the time required for the systolic blood pressure to return toward or to the pre-exercise level. The graphic tracings, if available, should also be included with the report. All tracings must be annotated with the standardization used by the testing facility.

17. How must exercise Doppler tests we purchase be performed? When we purchase an exercise Doppler test, you must exercise on a treadmill at 2 mph on a 12 percent grade for up to 5 minutes. The reports must include the information specified in 4.00C16...

G. Evaluating Peripheral Vascular Disease

1. What is peripheral vascular disease (PVD)? Generally, PVD is any impairment that affects either the arteries (peripheral arterial disease) or the veins (venous insufficiency) in the extremities, particularly the lower extremities. The usual effect is blockage of the flow of blood either from the heart (arterial) or back to the heart (venous). If you have peripheral arterial disease, you may have pain in your calf after walking a distance that goes away when you rest (intermittent claudication); at more advanced stages, you may have pain in your calf at rest or you may develop ulceration or gangrene. If you have venous insufficiency, you may have swelling, varicose veins, skin pigmentation changes, or skin ulceration.

2. How do we assess limitations resulting from PVD? We will assess your limitations based on your symptoms together with physical findings, Doppler studies, other appropriate non-invasive studies, or angiographic findings...

5. When will we purchase exercise Doppler studies for evaluating peripheral arterial disease (PAD)? If we need additional evidence of your PAD, we will generally purchase exercise Doppler studies...

6. Are there any other studies that are helpful in evaluating PAD? Doppler studies done using a recording ultrasonic Doppler unit and strain-gauge plethysmography are other useful tools for evaluating PAD. A recording Doppler, which prints a tracing of the arterial pulse wave in the femoral, popliteal, dorsalis pedis, and posterior tibial arteries, is an excellent evaluation tool to compare wave forms in normal and compromised peripheral blood flow. Qualitative analysis of the pulse wave is very helpful in the overall assessment of the severity of the occlusive disease...

7. How do we evaluate PAD under 4.12?

a. The ankle blood pressure referred to in 4.12A and B is the higher of the pressures recorded from the posterior tibial and dorsalis pedis arteries in the affected leg. The higher pressure recorded from the two sites is the more significant measurement in assessing the extent of arterial insufficiency. Techniques for obtaining ankle systolic blood pressures include Doppler (See 4.00C16 and 4.00C17), plethysmographic studies, or other techniques. We will request any available tracings generated by these studies so that we can review them...

4.12 Peripheral arterial disease, as determined by appropriate medically acceptable imaging (see 4.00A3d, 4.00G2, 4.00G5, and 4.00G6), causing intermittent claudication (see 4.00G1) and one of the following:

A. Resting ankle/brachial systolic blood pressure ratio of less than 0.50.

OR

B. Decrease in systolic blood pressure at the ankle on exercise (see 4.00G7a and 4.00C16-4.00C17) of 50 percent or more of pre-exercise level and requiring 10 minutes or more to return to pre-exercise level...

53. In accordance with the above authority, “appropriate medically acceptable imaging” (several different tests) are required to evaluate and diagnose the petitioner’s physical MDI.

54. Ms. Miller argued that the petitioner’s physical MDI did not meet or equal the listing because it was not determined by “appropriate medically acceptable imaging, causing intermittent claudication, had a blood pressure ratio test or decrease in systolic blood pressure on an exercise test”.

55. The findings do not indicate that the required testing, in accordance with the above authority, were performed on the petitioner.

56. In step four, DDD determined that the petitioner can return to her previous job as HR Director. DDD stopped the sequential evaluation in step four.

57. The evidence submitted establishes that all of the petitioner’s recent physical exams are within normal limits with normal gait and no neurological deficits.

58. The petitioner argued that her disability is from the pain the stint in her abdomen is causing, not [REDACTED] and [REDACTED].

59. Ms. Miller argued that the petitioner’s pain caused by the stint was reviewed from medical records provided by Doctor [REDACTED].

60. The petitioner argued that DDD’s evaluation is incorrect because they did not review medical records from her cardiologist, vascular surgeon, internal medicine doctor and pain management doctor that verify she is disabled and unable to work.

61. Ms. Miller argued that “there is no rule that they have to obtain every medical record” on the petitioner. And DDD is only required to review recent medical records, which were reviewed.

62. Title 42 of the Code of Federal Regulations § 435.541, Determinations of disability, in part states:

- (c) Determinations made by the Medicaid agency...
- 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.

63. The ACCESS Program TRANSMITTAL NO.: I-03-05-0025, Disability Reminders, dated May 23, 2003, in part states:

Adoption of Previous DDD Decision

There has been some confusion among staff regarding the DDD decision itself. The following should address the most common misunderstandings.

1. If an individual reapplies for Medicaid within 90 days of a disability denial from DDD, the eligibility specialist:
 - must not submit a new disability packet unless the client has a condition that DDD has not already considered, and
 - must advise the applicant that the DDD decision must be adopted...

64. In accordance with the above authority (#62) and Department Transmittal (#63), DDD is required to make a disability determination within 90 days.

65. Ms. Miller argued if the petitioner wants to submit different medical records, the petitioner must submit another Medicaid Disability application because her September 19, 2016 application is more than 90 days old.

66. *Florida Administrative Code* R. 65A-1.702, Special Provisions, in part states:

- (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

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...

67. The ACCESS Program TRANSMITTAL NO.: I-03-05-0025, Disability Reminders, dated May 23, 2003, in part states:

Requirement to Apply for Social Security Disability Insurance (SSDI) Payments

Staff often approve Medicaid without obtaining evidence of an application for SSDI payments. If an individual under age 65 applies for Medicaid based on being disabled, they must provide verification they have already applied for SSDI before any Medicaid benefits may be authorized. This fulfills the requirement to apply for and pursue to completion any application for benefits to which the individual may be entitled.

An appointment with the Social Security Administration (SSA) is not sufficient evidence that an application has been filed with SSA. The client must provide verification that an application has been filed or that SSA has refused to consider an application for benefits. The only exception is for those individuals applying for Emergency Medicaid for Aliens, and children under age 18 (unless a parent is deceased, aged, or disabled)...

68. In accordance with the above authority (#66), and the above Department Transmittal (#67), the petitioner is required to apply for disability through the SSA.

69. The petitioner agreed to submit another Medicaid Disability application and provide different medical records. And also to apply for disability through the SSA with the appropriate medical records.

70. 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 respondent'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.

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 May, 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

FILED

May 16, 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-01246

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 14 [REDACTED]
UNIT: 88113

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 6, 2017 at 1:13 p.m.

APPEARANCES

For the Petitioner: [REDACTED], sister of petitioner

For the Respondent: Christine Frier, Senior Human Services
Program Specialist, Northwest Region

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 23, 2016 denying her application for Institutional Care Program (ICP) Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner is deceased and represented by her sister, [REDACTED].

The petitioner submitted documentation prior to the hearing which was entered as Petitioner's Exhibit 1. The Department submitted evidence prior to hearing which was entered as Respondent's Exhibit 1.

The record was held open for the petitioner's representative to review the Department documentation and submit any written rebuttal no later than April 17, 2017. The petitioner submitted an additional statement and documentation on April 13, 2017, which was entered as Petitioner's Exhibit 2.

The record closed on April 17, 2017.

FINDINGS OF FACT

1. The petitioner filed an application for Institutional Care Program (ICP) Medicaid on November 22, 2016.
2. The petitioner, with the assistance of an attorney, signed a Durable Power of Attorney (DPOA) on November 22, 2016.
3. A Qualified Income Trust (QIT) was executed by the power of attorney for the petitioner on November 22, 2016.
4. The Department explained all DPOA and QIT documentation must be reviewed by the Department's legal staff prior to approval of ICP Medicaid.
5. The petitioner died on December 8, 2016.
6. The Department explained as the petitioner had income that exceeded the income limit for ICP Medicaid, the petitioner needed a QIT.
7. The Department maintains that paragraph 15 (shown below) of the durable power of attorney (Respondent Exhibit 1, page 5B-C) specifically is contested. There is only one signature of the petitioner following paragraph 15.

15. Obtain and Maintain Eligibility for Public Health Care Benefits. If my Agent in my Agent's sole discretion has determined that I need nursing home or other long-term medical care and that I will receive proper medical care whether I privately pay for such care or if I am a recipient of Title XIX (Medicaid) or other public benefits, then my Agent shall have the power: (1) to take any and all steps necessary, in my agency's judgment, to obtain and maintain my eligibility for any and all public benefits and entitlement programs, including, if necessary, creating and funding a qualified income trust or special needs trust for me, my spouse or disabled child, if any; (2) to transfer with or without consideration my assets to my spouse and/or my descendants (if any), or to my natural heirs at law or to the persons named as beneficiaries under my last will and testament or a revocable living trust which I may have established, including my Agent; and (3) to enter into a personal services contract for my benefit, including entering into such a contract with my Agent, even if doing so may be considered self-dealing. Such public benefits and entitlement programs shall include, but are not limited to, Social Security, Supplement Security Income, Medicare, Medicaid and Veterans Benefits.

8. The Department argues this paragraph combines creating and funding an income trust with the transfer of assets and a personal services contract. The Department determined that the power of attorney combined items that are required to be separated with individual sign-off provided.

9. The Department maintains that because the DPOA cited above was not completed correctly, the QIT is also invalid.

10. The petitioner's representative argues the intent was to create the power of attorney to handle all business for the petitioner.

11. The petitioner's representative stated they were unaware of the problem with the DPOA until after December 12, 2016 when a contact letter was sent to her stating the power of attorney was insufficient.

12. The petitioner's representative is concerned DCF Legal staff is being more particular on this power of attorney document than other power of attorney documents

prepared by the same attorney for other nursing home residents. The representative believes this is an unfair practice by the Department.

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. Florida Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states:

The Department covers all mandatory coverage groups and the following optional coverage groups:

...

(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.

16. 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:

...

(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.

17. Section 709.2102, Florida Statutes, Definitions, states in part: As used in this part, the term: ... (9) "Power of attorney" means a writing that grants authority to an agent to act in the place of the principal, whether or not the term is used in that writing.

18. Section 709.2105, Florida Statutes, Qualifications of agent; execution of power of attorney, states:

(1) The agent must be a natural person who is 18 years of age or older or a financial institution that has trust powers, has a place of business in this state, and is authorized to conduct trust business in this state.

(2) A power of attorney must be signed by the principal and by two subscribing witnesses and be acknowledged by the principal before a notary public or as otherwise provided in s. 695.03.

(3) If the principal is physically unable to sign the power of attorney, the notary public before whom the principal's oath or acknowledgment is made may sign the principal's name on the power of attorney pursuant to s. 117.05(14).

19. Section 709.2106(1), Florida Statutes, Validity of power of attorney, states "A power of attorney executed on or after October 1, 2011, is valid if its execution complies with s 709.2105."

20. Section 709.2108(1), Florida Statutes, When power of attorney is effective, states "Except as provided in this section, a power of attorney is exercisable when executed."

21. The above Florida Statutes explain that the principal is an individual who gives his or her authority to an agent in a power of attorney. A power of attorney gives an agent the authority to act as the principal. A Power of attorney that has been executed on or after October 1, 2011 is valid if it has been signed and acknowledged by

the principal in order to be valid. Based on the statutes, the undersigned concludes the power of attorney in the petitioner's case became exercisable on November 22, 2016.

22. Section 709.2202, Florida Statutes, Authority that requires separate signed enumeration, effective October 11, 2011, states in relevant part:

- (1) Notwithstanding s. 709.2201, **an agent may exercise the following authority only if the principal signed or initialed next to each specific enumeration of the authority**, the exercise of the authority is consistent with the agent's duties under s. 709.2114, and the exercise is not otherwise prohibited by another agreement or instrument:
 - (a) Create an inter vivos trust;
 - (b) With respect to a trust created by or on behalf of the principal, amend, modify, revoke, or terminate the trust, but only if the trust instrument explicitly provides for amendment, modification, revocation, or termination by the settlor's agent;
 - (c) Make a gift, subject to subsection (4);
 - (d) Create or change rights of survivorship;
 - (e) Create or change a beneficiary designation;
 - (f) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan; or
 - (g) Disclaim property and powers of appointment.(emphasis added)

23. The above controlling authority requires that the power granted regarding creation of a trust or distribution of assets must be specifically and individually signed off on by the principal (or party granting the power of attorney) when giving the agent to ability to act on the principal's behalf. Prior to October 2011, the authority was quite vague and did not require specified signature or initialing for each power granted as it does following the October 11, 2011 rule change. The rule regarding power of attorney now limits the agent's authority to those actions specifically granted to them by the principal as indicated by initials or signature. The undersigned concludes the petitioner initialing or signing each specific action is required by the law.

24. In the instant case, paragraph 15 of the Durable Power of Attorney (DPOA) (Respondent's Exhibit 1, pages 5B-C) grants three powers. The undersigned concludes each power requires a specified initialing or signature. Following the paragraph there is a single signature line which the petitioner signed. The undersigned reviewed the document carefully and found other initialing of specific powers listed in the paragraph. The undersigned concludes the DPOA is invalid as related to the ability to create an income trust or dispose of assets as those items were not individually specifically signed or initially by the petitioner.

25. The findings show the Department notified the petitioner on December 12, 2016 that the DPOA is insufficient. The findings also show the petitioner passed away on December 8, 2016. The undersigned concludes there is no method by which the petitioner's representative could remedy the insufficient DPOA as the petitioner was deceased when the Department notified her of the problem.

26. 42 U.S.C. § 1396p. Liens, adjustments and recoveries, and transfer of assets states:

(d) Treatment of trust amounts states:

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a 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 such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) 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.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

27. The Department's Program Policy Manual, CFOP 165-22, section 1840.0110, Income Trusts (MSSI) states:

The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does not apply to Community Hospice.

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-9 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

1. it is established on or after 10/01/93 for the benefit of the individual;
2. it is irrevocable;
3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and
4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The eligibility specialist must forward all income trusts to their Region or Circuit Program Office for review and submission to the Circuit Legal Counsel for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A-22.1, Guidance for Reviewing Income Trusts, for instructions on processing income trust cases...
(emphasis added)

28. The findings show the Qualified Income Trust (QIT) was executed by the petitioner's representative, and presumed DPOA on November 22, 2016 (Respondent's Exhibit 6, page 6A-O). The QIT does not contain a signature by the petitioner approving the establishment of the QIT. The undersigned concludes as the petitioner's representative did not have a valid durable power of attorney when the QIT was executed, the QIT is invalid as well.

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 16 day of May , 2017,

in Tallahassee, Florida.



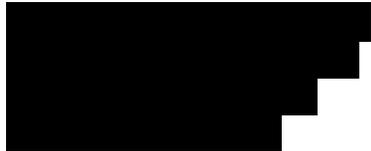
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Copies Furnished To: [REDACTED], Petitioner
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[REDACTED]

Jun 02, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 17F-01249

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 13 
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on May 23, 2017, at 1:45 p.m.

APPEARANCES

For the Petitioner: 
Petitioner's mother

For the Respondent: Carlene Brock, L.P.N.
Quality Operations Nurse
Amerigroup

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her 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, Amerigroup: Lauren Hernandez, Complaints and Grievances Specialist with DentaQuest; and Susan Hudson, D.M.D., Dental Consultant with DentaQuest. Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration ("AHCA" or "Agency"), and Karla Ibarra, Complaints and Grievances Specialist with DentaQuest, were present solely for the purpose of observation.

██████████, Interpreter ██████████ with Cyracom International, provided English-Spanish translation at the hearing.

The respondent introduced Exhibits "1" through "10" 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 female. She resides in ██████████ County.
2. The petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. The petitioner is an enrolled member of Amerigroup. Amerigroup 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 Amerigroup was June 1, 2014.

5. Amerigroup 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. Amerigroup has contracted DentaQuest to be its dental vendor. DentaQuest completes prior authorization reviews of requests for dental services submitted to it by members of Amerigroup.

7. On or about January 14, 2017, the petitioner's dental provider submitted a prior authorization request 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; and
5. D9230 – inhalation of nitrous oxide/analgesia, anxiolysis.

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 26, 2017, Amerigroup denied the petitioner's request for services. 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 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 goes on to explain:

The facts that we used to make our decision are:

- 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.

The DentaQuest guideline or policy used to support this decision was:

- DentaQuest Clinical Criteria for Surgical Extraction

11. In a separate Notice of Action, also dated January 26, 2017, Amerigroup also denied the petitioner's request for relaxation gas citing that "[T]he requested **service is not a covered benefit** [emphasis in original]."

12. The Notice of Action goes on to explain:

The facts that we used to make our decision are:

- Your dentist asked to give you a drug to help you relax while you get a service. We can only approve the drug if the service to be done is approved. The service was not approved. So the drug to help you relax cannot be approved. We have also told your dentist. Please talk to your dentist.

13. 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.

14. Shortly after receiving notification of the denial, the petitioner requested an internal reconsideration of the decision to deny the extractions and surgical anesthesia.

15. DentaQuest subsequently completed an internal review of its decision and, in an updated Authorization Determination mailed to the petitioner's dentist on February 10, 2017, DentaQuest approved the removal of Tooth #17 and Tooth #32 and associated intravenous sedation.

16. The Dental Consultant Review Form completed on February 9, 2017 states as follows:

After a re-review of the member's x-ray and the provider's narrative and documented appeal the denial is OVERTURNED and the procedure is APPROVED for the extraction of teeth #17 and 32 and associated IV Sedation. We received and reviewed all submitted documentation (radiographs and narrative) for requested appeal determination. The denial(s) are UPEHLD for extraction(s) of teeth #1 and 16 (D7240). To qualify for this benefit under this plan, a case must demonstrate evidence of current pathology, infection, aberrant position, and/or continuous and/or reoccurring pain beyond normal eruption. This/These service is/are DENIED because documentation submitted does not demonstrate the required criteria have been met at this time.

17. Some pain is to be expected as the natural consequence of the eruption of any tooth into the mouth.

18. 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.

19. The dentist appearing as a witness for Amerigroup testified that in order for DentaQuest to approve the extraction of teeth due to pain, severe pain would have to be documented by the provider as well as what treatment has been given for the pain.

20. The narrative provided by the petitioner's dentist in the Dental Claim Form states as follows: "emergency patient in pain needs EXT of 1,16,17,32 due to perioconitis."

21. Perioconitis is found in the lower wisdom teeth, not the upper wisdom teeth.

22. There is no evidence of pathology or infection associated with the petitioner's upper wisdom teeth.

23. The petitioner's upper wisdom teeth appear to have space to erupt into the mouth normally.

24. The petitioner's mother expressed her concern about the petitioner feeling pain in her mouth.

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. The DentaQuest criteria for the approval of extractions indicate that the extraction of a tooth must be supported by a demonstrable need and documentation of medical necessity.

47. Amerigroup 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 proffered no testimony or evidence to support a conclusion that the extraction of her two upper wisdom teeth is medically necessary. The infection noted in the narrative of the prior authorization request is found only in the two lower wisdom teeth. The petitioner also provided no documentation to support the existence of pain associated with her two upper wisdom teeth over that which is normally expected with the eruption of teeth into the mouth.

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 her request for the removal of Tooth #1 and Tooth #16, her 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

FINAL ORDER (Cont.)

17F-01249

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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 June , 2017,

in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
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
AHCA, Medicaid Fair Hearings Unit
Amerigroup Hearings Unit

FILED

May 10, 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-01298

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION

CIRCUIT: 13 [REDACTED]

UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on April 4, 2017, at 2:45 p.m. The hearing officer reconvened the hearing on April 13, 2017, at 12:45 p.m.

APPEARANCES

At both hearings:

For the petitioner: [REDACTED], pro se

For the Respondent: Marc Kaprow, D.O.
Executive Director
Long-Term Care Program
United Healthcare

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for an additional five hours per week of Homemaker Services and five hours per week of Adult Companion Services?

PRELIMINARY STATEMENT

Christian Laos, Senior Compliance Analyst with United Healthcare, appeared as a witness on behalf of the respondent, United Healthcare. Lisa Sanchez, Medical Health Care Program Analyst with the Agency for Health Care Administration (“Agency”), was present solely for the purpose of observation. [REDACTED], Operator [REDACTED] with Language Line Solutions, provided Spanish-English translation at the first hearing and [REDACTED], Operator [REDACTED] with Language Line Solutions, provided Spanish-English translation at the second hearing.

The respondent introduced Exhibits “1” through “5” at the first hearing, which were accepted into evidence and marked accordingly. At the request of the hearing officer at the first hearing, the respondent forwarded the United Healthcare Community Plan Health and Home Connection Enrollee Handbook. Once received, the hearing officer accepted the Handbook into evidence and marked it as respondent’s Exhibit “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. The petitioner is a 56-year-old male.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. The petitioner is an enrolled member of the United Healthcare Community Plan. United Healthcare 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 United Healthcare was January 1, 2017.

5. The petitioner is a participant of the Long-Term Care Program.

6. The petitioner's medical history is remarkable for the following: [REDACTED]

[REDACTED]

[REDACTED]

7. The petitioner was previously approved to receive the following services through United Healthcare: 10 hours per week of Personal Care Services; five hours per week of Homemaker Services; seven Home-Delivered Meals per week (31 per month); and incontinence supplies consisting of at least two packages of wipes and one box of gloves per month.

8. On or about January 5, 2017, the petitioner submitted a prior authorization request to United Healthcare for an additional five hours per week of Homemaker Services and five hours per week of Adult Companion Services.

9. The United Healthcare Community Plan Health and Home Connection Enrollee Handbook ('member handbook') defines Personal Care Services as: "Assistance with eating, bathing, dressing, and personal hygiene."

10. The United Healthcare member handbook defines Homemaker Services as: "General household activities such as meal preparation and routine household tasks provided by a trained homemaker."

11. The United Healthcare member handbook defines Home-Delivered Meals as: "Nutritionally sound meals delivered to your place of residence."

12. The United Healthcare member handbook defines Adult Companion Services as: “Non-medical care, supervision and socialization. This service does not include hands-on nursing care.”

13. United Healthcare sent the petitioner a Notice of Action dated January 12, 2017 advising him that his request for an additional five hours per week of Homemaker Services was denied. The Notice of Action states, in part:

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 individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs.

The Notice of Action goes on to state:

The facts that we used to make our decision are: You asked for 5 more hours of homemaker care at home. Your care plan is based on your needs. Your needs are being met. The hours you asked for are in excess of your needs. Hours in excess of your needs are not medically necessary.

14. In a second Notice of Action, also dated January 12, 2017, United Healthcare also informed the petitioner that it was denying his request for five hours per week of Adult Companion Services. The Notice of Action states, in part:

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 individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient’s needs.

The Notice of Action goes on to state:

The facts that we used to make our decision are: 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. The request is denied.

15. The petitioner requested an administrative hearing to dispute the denials and this proceeding ensued.

16. As indicated above, the petitioner is presently allocated 10 hours per week of Personal Care Services and five hours per week of Homemaker Services.

17. The petitioner receives his presently allocated services on Monday through Friday. He receives assistance for approximately three hours on each of those days.

18. The petitioner does not presently receive any services on Saturday and Sunday.

19. The petitioner rents a room in a house. None of the other residents in the house are related to the petitioner.

20. The petitioner weighs approximately 380 pounds.

21. The petitioner's [REDACTED] causes him to lose his breathe easily when he attempts to walk.

22. The petitioner requires the use of a wheelchair for ambulation. He has an electric wheelchair.

23. The petitioner testified his cardiac rhythm is irregular. This results in an insufficient amount of oxygen reaching his brain and places him at risk of falling.

24. The petitioner requires supplemental oxygen 24-hours per day.

25. The petitioner uses eight liters of oxygen per minute. This is a very high amount and requires the petitioner to travel with multiple oxygen tanks.

26. The petitioner requires assistance with toileting. He is unable to clean himself after using the toilet.

27. The petitioner requires assistance with bathing, shaving, and dressing.

28. The petitioner is unable to do his own laundry. He requires assistance with laundry.

29. The petitioner is unable to do any of his own housework.

30. The petitioner is able to prepare a shopping list but is unable to participate in any shopping activities.

31. The petitioner presently receives three Home-Delivered Meals on Friday of each week – one for Friday, one for Saturday, and one for Sunday.

32. The petitioner's Homemaker Services provider is responsible for preparing all of the petitioner's meals other than those provided by United Healthcare.

33. The petitioner has medical appointments on a regular basis. One of the reasons the petitioner requested Adult Companion Services is so that he has someone to accompany him to his doctor's appointments to assist with his oxygen tanks.

34. The petitioner uses a medical transportation service to get to and from his medical appointments.

35. It was the position of the respondent's representative at the hearing that the petitioner's current services allow him to reside in a sanitary environment and to eat regular meals and that any additional services would not provide an additional benefit to the petitioner and should therefore be denied. The representative also testified that services are not based on a recipient's diagnoses but rather on a member's functional abilities.

36. It is the petitioner's position that he is diabetic and cannot only eat one meal per day; he requires assistance with meal preparation, laundry, and housework; he needs someone to accompany him to and from his doctor's appointments for the purpose of helping him with his oxygen tanks; and that the currently approved services do not provide him with all of the help that he needs.

CONCLUSIONS OF LAW

37. 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 Chapter 120.80, Fla. Stat.

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

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

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

41. 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.).

42. 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.

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. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

45. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 440.180.

46. Section 409.978, Florida Statutes, 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. Fla. Stat. § 409.981(1), authorizes AHCA to solicit bids from and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is United Healthcare.

47. The definition of medically necessary is found in the 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.

48. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states 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.

49. 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.”

50. Section 400.462(7), Fla. Stat. defines a companion as follows:

“Companion” or “sitter” means a person who spends time with or cares for an elderly, handicapped, or convalescent individual and accompanies such individual on trips and outings and may prepare and serve meals to such individual. A companion may not provide hands-on personal care to a client.

51. The United Healthcare member handbook defines Adult Companion Services as: “Non-medical care, supervision and socialization. This service does not include hands-on nursing care.”

52. Companion services are approved, in part, to increase a patient’s interaction with other individuals.

53. Section 400.462(16), Fla. Stat. defines a homemaker as follows:

“Homemaker” means a person who performs household chores that include housekeeping, meal planning and preparation, shopping assistance, and routine household activities for an elderly, handicapped, or convalescent individual. A homemaker may not provide hands-on personal care to a client.

54. The United Healthcare member handbook defines Homemaker Services as: “General household activities such as meal preparation and routine household tasks provided by a trained homemaker.”

55. Section 400.462(24) defines personal care as follows:

“Personal care” means assistance to a patient in the activities of daily living, such as dressing, bathing, eating, or personal hygiene, and assistance in physical transfer, ambulation, and in administering medications as permitted by rule.

56. The United Healthcare Community Plan Health and Home Connection Enrollee Handbook (‘member handbook’) defines Personal Care Services as: “Assistance with eating, bathing, dressing, and personal hygiene.”

57. United Healthcare's services are not more restrictive than those of the Agency for Health Care Administration.

58. The petitioner participates in the Long-Term Care Program. The Long-Term Care Program is designed to provide recipients with the services they need in order to continue living independently in the community. It is a nursing home diversion program.

59. In the present case, the petitioner requested an increase in his Homemaker Services from five hours per week to 10 hours per week. The petitioner's homemaker is responsible for doing the petitioner's grocery shopping, preparing approximately fourteen meals per week for the petitioner, doing the petitioner's laundry, cleaning the petitioner's living quarters, including his bathroom, and doing any additional homemaking services the petitioner requires. Five hours per week of Homemaker Services is not adequate to complete the aforementioned tasks; even the 10 hours per week the petitioner requested is conservative given the amount of assistance he requires in this area.

60. The petitioner also requested five hours of Adult Companion Services per week. The petitioner provided credible testimony concerning his need for assistance with his oxygen tanks when he leaves his home for medical appointments. Additionally, the Long-Term Care Program is not only about providing a subsistence level of services but also maintaining a recipient's quality of life. In the present case, the petitioner receives his currently approved services Monday through Friday. It is inhumane to expect a person with limited mobility to remain in a room alone from Friday afternoon until the following Monday when his aide returns.

61. After careful consideration, the hearing officer concludes the petitioner has demonstrated by a preponderance of the evidence that the respondent incorrectly denied

his request for an additional five hours per week of Homemaker Services and five hours per week of Adult Companion Services.

DECISION

The 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 10 day of May, 2017,

in Tallahassee, Florida.

Peter J. Tsamis

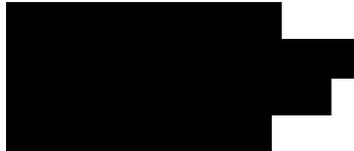
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Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

May 30, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 17F-01352

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 13 [REDACTED]
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in this matter telephonically on May 22, 2017, at 10:30 a.m.

APPEARANCES

For the petitioner: [REDACTED]
Petitioner's daughter

For the Respondent: Sloan Karver, M.D.
Long-Term Care Medical Director
United Healthcare

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for an additional eight hours per week of Adult Companion Services?

PRELIMINARY STATEMENT

Christian Laos, Senior Compliance Analyst with United Healthcare, appeared as a witness on behalf of the respondent, United Healthcare. Cindy Henline, Medical Health Care Program Analyst with the Agency for Health Care Administration (“Agency”), was present solely for the purpose of observation.

The petitioner introduced Exhibits “1” through “5” at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits “1” through “12” at the hearing, which were accepted into evidence and marked accordingly. At the respondent’s request, the hearing officer took administrative notice of Fla. Admin. Code Rule 59G-1.010. 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 the Long-Term Care member handbook. Once received, this information was accepted into evidence and marked as respondent’s Exhibit “13”. The hearing record was then closed.

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 92-year-old female.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. The petitioner is an enrolled member of the United Healthcare Community Plan. United Healthcare 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 United Healthcare was August 1, 2014.

5. The petitioner is a participant of the Long-Term Care Program.

6. The petitioner is diagnosed with [REDACTED] disease and suffers from [REDACTED]

7. The petitioner's cognitive abilities have decreased significantly in the recent past. She frequently does not recognize her daughter and is not cognizant of the home where she has resided for the past 50 years.

8. The petitioner resides in the family home with her adult daughter. There are no other people living in the home.

9. The petitioner's daughter works from 5:00 a.m. to 1:00 p.m., Monday through Friday. She was previously working from 9:00 a.m. to 5:00 p.m., Monday through Friday, but adjusted her work schedule so she can spend more time at home with the petitioner while the petitioner is awake.

10. The petitioner used to sleep until about 10:30 a.m. or 11:00 a.m. but is now waking up before 9:00 a.m.

11. The petitioner is alone for approximately one to two hours in the morning before her aide arrives.

12. The petitioner requires monitoring and supervision to ensure her health and safety. The petitioner's daughter expressed concern about the petitioner getting hurt while she is alone after her daughter leaves for work in the morning and before her aide arrives.

13. The petitioner's daughter has installed locks on the doors to prevent the petitioner from eloping.

14. The petitioner's daughter has devised a system of cameras throughout the house so she can monitor the petitioner while she is at work.

15. The petitioner has experienced a reduction in her physical abilities in addition to the reduction in her cognitive abilities.

16. The petitioner was previously approved to receive the following services through United Healthcare: seven hours per week of Personal Care Services; 13 hours per week of Adult Companion Services; and one hour per week of Homemaker Services.

17. Personal Care Services provide assistance with eating, bathing, dressing, and personal hygiene.

18. Adult Companion Services provide non-medical care, supervision, and socialization. This service does not include hands-on nursing care.

19. Homemaker Services provide assistance with general household activities such as meal preparation and routine household tasks provided by a trained homemaker.

20. In addition to the above services, the petitioner was approved to receive 60 hours per year of Respite Care Services.

21. Respite Care Services provide assistance to a recipient, on a short-term basis, when family or caregivers normally providing care to the recipient are absent.

22. Respite Care Services are normally intended to provide a caregiver with time to attend to personal responsibilities unrelated to the care of a recipient.

23. The petitioner's daughter uses the petitioner's respite services to provide additional coverage in the morning in order to reduce the amount of time the petitioner is alone.

24. The petitioner uses all of her currently approved services Monday through Friday. The petitioner's daughter is solely responsible for the petitioner's care and supervision in the evening, overnight, and on the weekends.

25. On or about August 24, 2016, the petitioner submitted a prior authorization request to United Healthcare for an additional eight hours per week of Adult Companion Services. The additional services were to be used to provide coverage in the mornings.

26. In a Notice of Action dated August 29, 2016, United Healthcare informed the petitioner that it was denying her request for an additional eight hours per week of Adult Companion Services.

27. 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 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 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.

X 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.)

28. The Notice of Action goes on to state:

You have asked for 26 hours of care at home a week.

You are getting 18 hours of care a week.

Your care plan for help is based on how much you [*sic*] help you need. Needs in Florida Medicaid are defined by the law. For a service to be needed it must treat a problem. It must also be a common practice. It must also be just for you. It must also not be in excess of your needs. It must also be safe. It must also be the least costly treatment in the state that meets your needs. It must also not be for the convenience of you or another person. The fact that a doctor orders a service does not make it needed or covered.

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 numbers 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 18 hours a week.

29. The petitioner requested an internal reconsideration of the decision by United Healthcare to deny the increase in Adult Companion Services on or about October 4, 2016.

30. In a letter dated November 11, 2016, United Healthcare informed the petitioner that it was upholding its original decision to deny her request for an additional eight hours per week of Adult Companion Services.

31. The letter states, in 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 (includes personal care, homemaker care, and companion care) 26 hours a week. She needs help with daily personal care. We cannot approve 26 hours because it is not medically necessary. We used an assessment tool and the doctors' review. This tool tells us her needs. Eighteen hours a week can meet her needs and is approved by the Health Plan. This is why we cannot approve what you asked for. Please talk about this with her doctor/case manager.

32. The Functional Assessment completed by United Healthcare on August 24, 2016 supports the testimony of the petitioner's daughter at the hearing regarding the petitioner's need for assistance with her activities of daily living and the presence of dementia. It also explains the petitioner has trouble concentrating or making decisions on a daily basis, the petitioner is severely impaired and rarely makes her own decisions, and has memory lapses resulting in an inability to perform routine tasks on a daily basis.

33. The United Healthcare Long-Term Care Medical Director appearing at the hearing testified the petitioner's request for additional Adult Companion Services was denied for a multitude of reasons but did not go into detail about the reasons.

34. The United Healthcare Long-Term Care Medical Director appearing at the hearing offered two alternatives to the petitioner's request for additional Adult Companion Services – enrolling the petitioner in an adult day care program or placing the petitioner in an assisted living facility.

35. The petitioner's daughter offered concrete examples of why she feels adult day care is not a good option for the petitioner. She also shared her position that she can provide a higher level of care to the petitioner than an assisted living facility.

36. The petitioner's daughter emphasized the importance of having adequate monitoring and supervision for the petitioner. She provided detailed examples of her concerns associated with leaving the petitioner unsupervised.

CONCLUSIONS OF LAW

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

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

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

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

41. 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.).

42. 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.

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. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state’s Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

45. Home or community-based services include personal care services, habilitation services, and other services that are “cost effective and necessary to avoid institutionalization.” See 42 CFR § 440.180.

46. Section 409.978, Florida Statutes, 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. Fla. Stat. § 409.981(1), authorizes the Agency to solicit bids from and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is United Healthcare.

47. The definition of medically necessary is found in the 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.

48. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code

Chapter 59G-4. In accordance with the above Statute, the Handbook states 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.

49. 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.”

50. Section 400.462(7), Fla. Stat. defines a companion as follows:

“Companion” or “sitter” means a person who spends time with or cares for an elderly, handicapped, or convalescent individual and accompanies such individual on trips and outings and may prepare and serve meals to such individual. A companion may not provide hands-on personal care to a client.

51. The United Healthcare Community Plan Health and Home Connection Enrollee Handbook (‘member handbook’) defines Adult Companion Services as: “Non-medical care, supervision and socialization. This service does not include hands-on nursing care.”

52. United Healthcare policy with respect to Adult Companion Services is not more restrictive than that of the Agency for Health Care Administration.

53. The petitioner participates in the Long-Term Care Program. The Long-Term Care Program is designed to provide recipients with the services they need in order to continue living independently in the community. It is a nursing home diversion program.

54. In the present case, the petitioner's daughter provided credible testimony regarding the petitioner's need for monitoring and supervision. She provided concrete examples of her concerns associated with the petitioner being left unsupervised. The additional services requested are medically necessary to ensure the petitioner's health and safety.

55. After careful consideration, the hearing officer concludes the petitioner has demonstrated by a preponderance of the evidence that the respondent incorrectly denied her request for an additional eight hours per week of Adult Companion Services.

DECISION

The 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.

FINAL ORDER (Cont.)
17F-01352
PAGE - 12

DONE and ORDERED this 30 day of May, 2017,
in Tallahassee, Florida.

Peter J. Tsamis

Peter J. Tsamis
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

FILED

May 05, 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-01415
APPEAL NO. 17F-01416

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 27, 2017 at 1:04 p.m., and reconvened on April 25, 2017 at 8:38 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Mary Triplett, supervisor

STATEMENT OF ISSUE

The petitioner's issues are:

(A) The respondent's action to terminate SSI-Related Medicaid benefits due to his assets being over the limit for the program.

(B) The respondent's action to terminate her Special Low-Income Medicare Part B benefits under the Medicare Savings Program (MSP). The respondent carries the burden of proof by preponderance of evidence in both appeals.

PRELIMINARY STATEMENT

At the hearing on March 27, 2017, the burden of proof was assigned to the petitioner, but after careful consideration it is reassigned to the respondent.

A continuance was granted to the petitioner for a prior scheduled hearing.

At the hearing the respondent submitted three exhibits, a Statement of Matters, a print of the Data Exchange Inquiry and the Notice of Case Action. The exhibits were marked as Respondent's Exhibits 1, 2 and 3 respectively. At the hearing on March 27, 2017, the petitioner did not present any exhibits. The record was held open until the end of business on March 27, 2017, for the respondent to provide the petitioner's bank statements. The petitioner's bank statements were received, entered into evidence and marked as Respondent's Exhibit 4. The record was closed on March 27, 2017.

The undersigned found it necessary to reconvene, therefore a hearing was set for April 25, 2017 at 8:30 a.m. The record reopened and testimony was taken. The record was held open until April 27, 2017, for the petitioner to provide his credit card statement. He provided a balance transfer disclosure which was received, entered into evidence and marked as Petitioner's Exhibit 1. The record closed on April 27, 2017.

FINDINGS OF FACT

1. On January 30, 2017, the petitioner submitted an application for additional benefits. He was applying for SSI-Related Medicaid benefits in the Medically Needy Program. He was previously approved for Special Low-Income Medicare Part B Medicare (SLMB) benefits under the MSP. He was 65 years old at the time of his application. He receives monthly Social Security Disability income (SSDI) of \$1,060.

2. On February 2, 2017, the respondent received a response from its data exchange system indicating that the petitioner was the owner of two checking accounts at Bank of America, one account ending in 4625 with a balance of \$50.35 and another ending in 3275 with a balance of \$9,461.69 (Respondent's Exhibit 2).
3. The respondent determined that the petitioner was over the asset limit by \$2,511 (after the allowance for a burial plot). The maximum assets limit for an individual who is disabled is \$5,000. The respondent denied the petitioner's request for SSI-Related Medicaid benefits and MSP based on the Data Exchange alert it received.
4. On February 6, 2017, the respondent mailed the petitioner a Notice of Case Action informing him that his Medically Needy benefits will end on February 28, 2017. The same notice informed him that he was no longer eligible for the Special Low Income Medicare Part B Program effective February 28, 2017. Additionally, it informed him that the state will no longer pay his Medicare Part B premiums because the value of his assets was too high for the program (Respondent's Exhibit 3).
5. On February 10, 2017, the petitioner requested a hearing to challenge the respondent's action.
6. The petitioner stated that last August, he took a Cash Advance on his credit card for which he is making payments of \$151 monthly. The bank deposited the Cash Advance money of \$8,000 into a checking account ending in [REDACTED] so he can use it to pay his monthly expenses. He argued that the money in his checking account 3275 was the money he owed on his credit card and it is not an asset, it is a liability since he owes the credit card company that money.

7. The petitioner provided his bank statements to the respondent as verification of his assets. He is the sole owner of the accounts. The bank statements showed the beginning balance on February 7, 2017 for Bank of America Core checking account ending in 4625 was \$772.93 and ending balance on March 10, 2017 as \$545.78 and Bank of America Core checking account ending in [REDACTED] beginning balance on February 7, 2017 was \$9,461.69 and ending balance on March 10, 2017 was \$2,795. The petitioner's bank statement shows several withdrawals. On February 23, 2017, there was a withdrawal of \$5,888 causing the petitioner's assets to be below the asset limit of \$5,000 for an individual. Prior to February 23, 2017, his bank balance was above the asset limit of \$5,000 (Respondent's Exhibit 4).

8. The petitioner provided a balance transfer disclosure dated August 5, 2016, indicating that \$13,000 was deposited into his Bank of America Account.

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.

The Medically Needy benefits will be discussed first.

10. Federal regulations at 20 C.F.R. §416.1201 addresses, Resources and 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. 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.)

11. The regulation 20 C.F.R. §416.1208 addresses, How funds held in financial institution accounts are counted and states in part:

(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**, (emphasis added) 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.

12. The above authority states that if an individual is the sole owner of an account, that account is presumed owned by the individual, and the funds are considered the resource(asset) of the individual regardless of the source of the funds.

13. Fla. 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. 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.

14. Fla. Admin. Code R. 65A-1.303, Assets, states in part:

(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.

15. Fla. Admin. Code 65A-1.716, Income and Resource Criteria, sets forth the Medically Needy monthly asset limit for an individual at \$5,000 for a single-individual household.

16. The above cited authorities define assets, establishes rules set for determining availability of assets and where it is considered countable in determining eligibility. The petitioner does not dispute being the owner of the checking accounts at issue or having full access to the accounts. He argued that the money in his checking account [REDACTED] is a liability rather than an asset because the money in it was from a cash advance from his credit card and he still owes the credit card company. His bank statements showed that the both accounts are core checking accounts with a combined balance in excess of \$5,000 at the time of the respondent's denial on February 6, 2017.

17. Fla. Admin. Code R.65- 1.205 Eligibility Determination Process, states in the pertinent part:

...(5) The Department can substantiate, verify or document information provided by the applicant/recipient as part of each determination of eligibility. For any program, when there is a question about the validity of the information provided, the Department will ask for additional documentation or verification as required. The term verification is used generically to represent this process.

(a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.

(b) Verification confirms the accuracy of information through a source(s) other than the individual. The Department can secure verification electronically, telephonically, in writing, or by personal contact.

(c) Documentation establishes the accuracy of information by obtaining and including in the case record an official document, official paper or a photocopy of such document or paper or electronic source that supports the statement(s) made by the individual.

(6) The Department conducts data exchanges with other agencies and systems to obtain information on each applicant and recipient. It uses data exchanges to validate or identify social security numbers, verify the receipt of benefits from other sources, verify reported information, and obtain previously unreported information...

(b) The Department compares information found through the data exchanges with the information already on file. If the data exchange identifies new or different information than was previously available, the Department conducts a partial eligibility review to determine whether it must change benefit levels.

18. The Department's Policy Manual (The Policy Manual), at Passage 0240.0108 MEDS-Aged/Disabled (MSSI) defines the asset limit for an individual as \$5,000.

19. The Policy Manual at passage 1640.0560.01 Evaluating Loans (MSSI, SFP) states:

Loans may be formal (written) or informal (verbal). The individual must provide information on the type, amount, purpose, and unpaid balance of the loan. The loan contract can be used as the source of this information. Any loan agreement must be legally binding under state law to be considered a bona fide loan for Medicaid purposes.

A bona fide agreement is an agreement that is legally valid and made in good faith. A bona fide loan must meet all of the following requirements:

1. The loan must be enforceable under State law ; and
2. The loan agreement was in effect at the time the cash proceeds were provided to the borrower; and
3. The lender and the borrower both acknowledge the lender has an obligation to repay the loan; and
4. The loan includes a plan or schedule for repayment by pledging real or personal property or anticipated income; and
5. the repayment plan must be feasible.

A negotiable agreement is an agreement where the legal title to the instrument itself and the whole amount of money expressed on its face can be transferred from one person to another.

Loans by verbal agreement that will affect an individual's eligibility must be reviewed by Circuit Legal Counsel to determine if the loan is negotiable/bona fide. When the loan is an informal verbal loan, information such as the type of the loan, parties involved, and the commitment to repay, must be obtained to determine if the loan is legally binding.

When the individual is the borrower:

1. The loan agreement itself is not an asset.
- 2. Cash proceeds of a loan may be an included asset if retained into the month following the month of receipt (emphasis added)**
3. Cash proceeds of a bona fide loan are not income in the month of receipt.
4. When the loan is not bona fide, cash proceeds are income in the month of receipt.

20. The above directs the Department to include cash proceeds of a loan as an asset if retained in the month following the month of receipt. The petitioner's cash advance is considered a loan therefore; its proceeds following the month it was received are counted as an asset.

21. In accordance with the above cited authority and policy manual, the respondent used an electronic Data Exchange system to verify the petitioner's asset value in his checking account. The Data Exchange showed the account balances in account [REDACTED] as \$9,461.69 for February 2017. The respondent determined the petitioner's assets were over the asset limit.

22. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent met its burden of proof. The respondent's action to deny the petitioner SSI-Related Medicaid benefits for being over the asset limit is proper.

The MSP/Special Low-Income Medicare Part B will now be discussed.

23. The Policy Manual, Appendix A-9 sets forth the MSP monthly asset limit for an individual at \$7,390.

24. The petitioner acknowledged ownership of all of the above-mentioned accounts. However, he feels he should be entitled to benefits because the money in the account was from his credit card account as a cash advance. He provided a balance transfer disclosure indicating that \$13,000 was deposited in his Bank of America as cash advance, however, he did not provide proof of his credit card statements showing the outstanding balance owed on his credit card account or proof of any money he paid back. The policy manual above directs the Department to include the cash proceeds from a loan as an asset following the month it was received.

25. The undersigned concludes that the petitioner is the sole owner of checking [REDACTED] and he has access to the money (funds); therefore, the money is available to him and it is considered his asset regardless of the source. The respondent terminated his MSP due to his asserts being over the program's asset limit. The respondent has met its burden of proof and correctly terminated both the Medically Needy benefits and the MSP benefits. The petitioner may wish to reapply at any time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the respondent's action is 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 05 day of May, 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

FILED

May 09, 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-01422

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: 88297

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:20 a.m. on March 6, 2017.

APPEARANCES

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

For the Respondent: Jennie Rivera, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to terminate the petitioner's full Medicaid benefits and instead approve Medically Needy (MN) with a Share of Cost (SOC), is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present at the hearing and did not provide testimony. The petitioner did not submit exhibits. The respondent's representative submitted eight exhibits, entered as Respondent Exhibit "1" through "8". The record remained open through end of business day on March 6, 2017, for the respondent's representative to submit another exhibit. The exhibit was received timely and entered as Respondent Exhibit "9". The record was closed on March 6, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received full SSI-Related Medicaid benefits.
2. On January 24, 2017, the petitioner submitted a redetermination Food Assistance and SSI-Related Medicaid application for himself (Respondent Exhibit 2). Medicaid is the only issue.
3. For the petitioner to be eligible for full SSI-Related Medicaid the petitioner's income cannot exceed the SSI-Related Medicaid income limit of \$864 in January 2017 through March 2017 and \$885 in April 2017 (Respondent Exhibit 8, pages 51 and 52).
4. The petitioner receives \$895 Social Security Disability Income (SSDI) and works part time at FedEx, paid weekly (Respondent Exhibit 4). The Department calculated the petitioner's income from FedEx using the following four weekly pays (Respondent Exhibit 4, page 21):

<u>DATE</u>	<u>GROSS AMOUNT</u>
12/30/16	\$315.84
01/06/17	\$151.20
01/13/17	\$161.28
01/20/17	\$147.84
Total	\$776.16

5. The petitioner's total household income (\$895 + \$776.16) income exceeds the income limit (#3) for full SSI-Related Medicaid. The next available program is the MN with a SOC.

6. The following is the Department's calculation of the petitioner's SOC (Respondent Exhibit 5, page 24):

\$ 895.00	SSDI
<u>-\$ 20.00</u>	<u>unearned income disregard</u>
\$ 875.00	countable unearned income
\$ 776.16	earned income
<u>-\$ 65.00</u>	<u>earned income disregard</u>
\$ 711.16	divided by 2 = \$355.58
\$ 355.58	countable earned income
<u>+\$ 875.00</u>	<u>countable unearned income</u>
\$1,230.58	total countable income
<u>-\$ 180.00</u>	<u>MN income limit (MNIL)</u>
\$1,050.00	SOC (cents dropped)

7. On February 10, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying his application dated January 24, 2017, was approved for MN with a \$1,050 SOC, effective March 2017 (Respondent Exhibit 6, page 27).

8. During the hearing, the respondent's representative determined that the petitioner's \$315.84 pay (December 30, 2016) pay was not representative of the petitioner's weekly pay. The following is the recalculation of the petitioner's income, excluding \$315.84 (Respondent Exhibit 9):

<u>DATE</u>	<u>GROSS AMOUNT</u>
01/06/17	\$151.20
01/13/17	\$161.28
01/20/17	\$147.84
Total	\$460.32

\$460.32 divided by 3 weeks = 153.44 multiplied by 4 weeks = \$613.76

9. The following is the Department's recalculation of the petitioner's SOC excluding \$315.84 (Respondent Exhibit 9, page 3):

\$ 895.00	SSDI
<u>-\$ 20.00</u>	<u>unearned income disregard</u>
\$ 875.00	countable unearned income
\$ 613.76	earned income
<u>-\$ 65.00</u>	<u>earned income disregard</u>
\$ 548.76	divided by 2 = \$274.38
\$ 274.38	countable earned income
<u>+\$ 875.00</u>	<u>countable unearned income</u>
\$1,149.38	total countable income
<u>-\$ 180.00</u>	<u>MNIL</u>
\$ 969.00	SOC (cents dropped)

10. On March 7, 2017, the respondent's representative mailed the petitioner another NOCA, notifying his SOC was reduced from \$1,050 to \$969 (Respondent Exhibit 9, page 4).

11. The petitioner's representative stated that the petitioner has \$800 monthly in prescriptions which is less than the \$969 SOC. Therefore, the petitioner will "quit" his job and will be submitting a change request with verification notifying the Department he is no longer working.

12. The respondent's representative stated that the petitioner's \$895 SSDI minus the \$20 unearned income disregards "barely" qualifies the petitioner for full Medicaid.

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. *Florida Administrative 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...

(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", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service...To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months...

16. The above authority explains to be eligible for full SSI-Related Medicaid, income cannot exceed 88 percent of the federal poverty level (FPL). And MN provides coverage for individuals who do not qualify for full Medicaid, due to income.

17. The Department's Program Policy Manual, CFOP 165-22, appendix A-9, identifies \$864 (January 2017) and \$885 (April 2017) as 88 percent of the FPL for an individual.

18. The petitioner's \$1,149.38 household income (SSDI and FedEx) exceeds the \$864 and \$885 income limits to be eligible for full Medicaid.

19. Title 20 of the Code of Federal Regulations § 416.1124 explains 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..."

20. Title 20 of the Code of Federal Regulations § 416.1112 explains earned income we do not count and states in part "(c) Other earned income we do not count. We do not count as earned income... (5) \$65 of earned income in a month (7) One-half of remaining earned income in a month..."

21. *Florida Administrative Code R. 65A-1.716* sets the MNIL at \$180 for a family size of one.

22. In accordance with the cited authorities, the Department deducted \$20 unearned income from the petitioner's \$895 SSDI, \$65 earned income from the petitioner's \$613.76 earned income, divided the earned income by half and deducted the \$180 MNIL to arrive at a \$969 SOC.

23. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent met its burden of proof. The respondent's action to terminate the petitioner's full Medicaid and instead approve MN with a 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 09 day of May, 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

May 01, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01452

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 15 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on April 6, 2017, at 2:30 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner's daughter

For the Respondent:

Mindy Aikman
Grievance and Appeals Specialist
Humana

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request to be exempt from enrollment in the Statewide Medicaid Managed Care Program?

PRELIMINARY STATEMENT

The petitioner's daughter may sometimes hereinafter be referred to as his "representative".

Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration, was present for observation.

The petitioner introduced petitioner's Exhibit "1" at the hearing, which was accepted into evidence and marked accordingly. The respondent introduced respondent's Exhibit "1" at the hearing, which was accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on April 7, 2017 for Ms. Latson to provide the applicable law in this matter. The hearing officer did not receive this information within the allotted time frame, and the record was closed.

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 76-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 dually eligible for Medicare and Medicaid.
4. The petitioner receives straight Medicare; he is not assigned to a Medicare plan.

5. The petitioner was assigned to the Humana Managed Medical Assistance (“MMA”) plan for receipt of his Medicaid benefits effective January 1, 2017.

6. The petitioner requested disenrollment from the Humana Managed Medical Assistance plan, explaining his desire to receive his Medicaid benefits directly through the Medicaid State Plan.

7. Humana denied the petitioner’s request for disenrollment.

8. The petitioner requested an administrative hearing to dispute the denial of his disenrollment from the Humana Managed Medical Assistance plan. This proceeding ensued.

9. The petitioner was previously enrolled in the Humana Health Maintenance Organization (“HMO”) for receipt of his Medicaid benefits in or around 2015.

10. The petitioner was dissatisfied with his enrollment in the Humana Health Maintenance Organization. Many of his existing medical providers were outside of the Humana network.

11. The petitioner is diagnosed with [REDACTED]. He requires frequent visits to his chemotherapist, radiation therapist, and cardiovascular physician.

12. The petitioner’s current primary care physician, as well as many of his other medical providers, are outside of the Humana network.

13. The petitioner’s representative testified that “[w]e absolutely cannot have him on Humana HMO because he is simply going to die if he has that health plan.” She also expressed her belief that the “Humana HMO is killing him.”

14. Because of his medical condition, the petitioner requires greater flexibility than that which is traditionally available with a health maintenance organization so that he is able to consult with different specialists.

15. However, the petitioner is enrolled in the Humana MMA plan, not the HMO.

16. Since the petitioner is dually eligible for Medicare and Medicaid, his primary insurance provider is Medicare.

17. The purpose of the petitioner's Medicaid MMA coverage is to pay for the 20 percent (20%) of his medical expenses which are not covered by Medicare.

18. Since the petitioner is Medicare-eligible and not enrolled in a Medicare plan, he should be able to consult with and receive services from any physician or institution which accepts Medicare, regardless of whether that physician or institution is a part of the Humana network.

19. The physician or institution from which the petitioner receives services should bill the Humana Managed Medical Assistance plan for the 20 percent (20%) of the petitioner's medical expenses not covered by Medicare.

20. The petitioner has not received any bills for medical services received since he was enrolled in the Humana Managed Medical Assistance plan in January 2017.

21. The State of Florida requires most Medicaid recipients be assigned to and receive services through a managed care organization.

22. The Florida Legislature has enacted a limited number of exceptions under which a Medicaid recipient is exempt from participation in the Statewide Medicaid Managed Care Program.

23. The petitioner does not meet any of the exceptions which would allow him to be exempt from participation in the Statewide Medicaid Managed Care Program.

CONCLUSIONS OF LAW

24. 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.

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

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

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

28. 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.).

29. 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.

30. In June 2013, the federal government approved Florida’s request to move nearly all Medicaid beneficiaries and services into managed care beginning in 2014.

31. In preparation for the State's transition to a managed care paradigm, the Florida Legislature enacted Section 409.965, Fla. Stat. mandating the enrollment of all Medicaid beneficiaries into managed care. It explains as follows:

409.965 Mandatory enrollment. - All Medicaid recipients shall receive covered services through the statewide managed care program, except as provided by this part pursuant to an approved federal waiver. 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.

32. Section 409.972, Fla. Stat. carves out an exception for certain individuals who may choose to opt out from mandatory enrollment into managed care. It states, in part, as follows:

409.972 Mandatory and voluntary enrollment. -

- (1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. [409.965](#), and may voluntarily choose to participate in the managed medical assistance program:
 - (a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.
 - (b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. [394.455](#)(47).
 - (c) Persons eligible for refugee assistance.
 - (d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.
 - (e) Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.
 - (f) Medicaid recipients residing in a group home facility licensed under chapter 393.
 - (g) Children receiving services in a prescribed pediatric extended care center.

33. The petitioner does not meet the requirements for any of the exceptions to mandatory enrollment into managed care. Therefore, he is not exempt from enrollment in

the Statewide Medicaid Managed Care Program. Accordingly, the respondent correctly denied his request.

34. However, as noted above, the petitioner's primary insurance provider is Medicare. Therefore, he is able to receive services from any provider who accepts Medicare. The sole purpose of his Humana Managed Medical Assistance coverage is to pay the 20 percent (20%) deductible not paid by Medicare. If his Medicare providers are unsure of how to bill Humana for the deductible, they may contact the Agency for Health Care Administration provider helpline discussed by the Agency's representative at the hearing for assistance.

35. 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 to be exempt from enrollment in the Statewide Medicaid Managed Care Program.

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.

FINAL ORDER (Cont.)
17F-01452
PAGE - 8

DONE and ORDERED this 01 day of May, 2017,
in Tallahassee, Florida.



Peter J. Tsamis
Hearing Officer
Building 5, Room 255
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Copies Furnished To: , Petitioner
AHCA, Medicaid Fair Hearings Unit
Humana Hearings Unit

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

FILED

May 09, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01521

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 22, 2017 at 3:00 p.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 submitted a letter from her daughter and her physician as evidence for the hearing (as part of her hearing request), 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'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-five (88) years of age and lives with her daughter and son-in-law. Her medical conditions include [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 by United Healthcare for the following services under the LTC program: 26 hours weekly of personal care assistance, 9 hours weekly of homemaker care services, 5 hours weekly of companion care, and consumable medical supplies.

5. On December 30, 2016, United Healthcare sent a notice of action to the petitioner which stated her 5 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. The request is denied.

By a separate notice also on December 30, 2016, United Healthcare informed the petitioner her homemaker care hours would be reduced to 4 hours weekly based on medical necessity considerations. That notice of action 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.

6. The petitioner's daughter stated her mother consumes a liquid diet and it takes her 1.5 hours to eat a meal. She stated her mother is at risk for elopement from the home and the family has installed cameras in the home to monitor her. She also stated her mother cannot use the telephone. Her mother takes insulin, which is administered by the daughter. Her mother utilizes a wheelchair and a hospital bed. The daughter stated she herself has her own physical limitations. She also stated the home health aide only assists her mother, not any other family members.

7. The respondent's witness, Dr. Kaprow, stated the petitioner is aware of her name, location, and situation and is able to make simple decisions. The home health hours are being utilized Monday to Friday when the other family members are at work, and the family provides the care needed on Saturday and Sunday. He also stated the petitioner was receiving 24 hours weekly of assistance before she experienced a fall and broken arm in approximately July 2016, at which time the home health hours were increased to 40 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 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 needs assistance with activities of daily living (ADLs) such as walking, bathing, toileting, and meal preparation. However, she is currently approved for 30 hours weekly of assistance to help her with these activities. The family is able to provide care on the weekends, so the 30 hours weekly can provide assistance for 6 hours per day on Monday to Friday. The petitioner had been approved for 24 hours weekly prior to her fall and broken arm in July, 2016; therefore, the currently approved 30 hours weekly represents an increase from those previously approved 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 09 day of May, 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

66STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

May 03, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01559

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 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 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 submitted her daughter's letter and a letter from her physician 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 the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Case System Screenshots, and a Medical Assessment Form.

FINDINGS OF FACT

1. The petitioner is ninety-three (93) years of age and lives with her daughter, although she was in the hospital at the time of the hearing. She suffers from

[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 is currently approved for 16.5 hours weekly of home health services (12.5 hours of personal care and 4 hours of homemaker services) through United Healthcare. These hours are currently being utilized for approximately 2 hours per day beginning at around 1:30 p.m.

5. On or about December 21, 2016, the petitioner made a request to United Healthcare for home-delivered meal services. On December 28, 2016, United denied the request for home-delivered meals based on medical necessity criteria. The denial notice stated the following:

You have asked for home delivered meals. The health plan covers delivered meals when no one in the home can prepare meals. Your caregivers are able to prepare three meals daily. Delivered meals are in excess of your needs. Services in excess of your needs are not medically necessary. The health plan will not approve delivered meals.

6. The petitioner's daughter stated her mother previously received home-delivered meals through a program sponsored by the City of [REDACTED] but this service was discontinued once she became covered by the United Healthcare LTC program. The daughter stated she herself is 67 years old and she receives one home-delivered meal daily for herself from the City of [REDACTED] program. The daughter is retired from employment and she is undergoing radiation treatments for [REDACTED]. She makes a simple breakfast for her mother and sometimes will make a sandwich for dinner. She also stated she was informed by her mother's home health agency that the aide is not allowed to prepare a hot meal for her mother.

7. The respondent's witness, Dr. Kaprow, stated that the petitioner did not meet the criteria for home-delivered meals due to the assistance she is already receiving in

the home both from her daughter and the home health aide. He stated home-delivered meals are usually provided only for individuals who live alone and cannot cook for themselves. He also stated the petitioner's daughter's belief that the home health aide cannot prepare a hot meal is incorrect, and the scope of homemaker services includes meal preparation.

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 16.5 hours of home health services weekly to assist her with daily living activities. Homemaker services are part of these services, which include assistance with meal preparation. In addition, the petitioner's daughter is able to provide some assistance with regard to meal preparation. The fact the petitioner was approved for home-delivered meals previously by a different program does not necessarily mean she is entitled to the same service from United Healthcare, since each program contains its own requirements and criteria.

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 03 day of May , 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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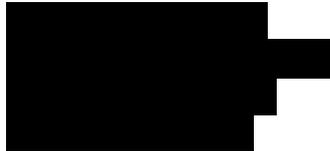
Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS
UNITED HEALTH CARE HEARINGS UNIT

FILED

May 22, 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-01614

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 April 24, 2017, at 8:30 a.m.

APPEARANCES

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

For the Respondent: Monica Otolora, Senior Program Specialist - AHCA

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

At the conclusion of the hearing, the record was left open for 10 days to allow the petitioner to submit any documentary evidence. On or about May 2, 2017, the petitioner submitted a handwritten note or letter from someone at [REDACTED] Memorial Hospital describing her medical conditions and requesting adjustments to her wheelchair. This document was 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, Case System Screenshots, and Medical Assessment Form.

FINDINGS OF FACT

1. The petitioner is sixty-three (63) years of age and is currently living with one of her daughters. She also has two other daughters who assist her, but one of these other daughters will be relocating. The petitioner is [REDACTED] and uses a power wheelchair for mobility. She is able to feed herself. She needs assistance with activities of daily living such as bathing, dressing, and meal preparation.

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: 7 hours weekly of personal care assistance and 7 hours weekly of homemaker services.

5. On or about January 17, 2017, the petitioner made a request to United Healthcare for 21 additional hours weekly of personal care services. On February 3, 2017, United sent a letter to the petitioner denying her request for the additional personal care services as not being medically necessary. The denial notice stated the following:

You asked for 14 more hours of personal care at home. Your care plan is based on your needs. You are getting 14 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.

6. The petitioner's daughter stated one of her sisters is relocating and will be unable to assist with her mother's care. Her remaining sister (the one with whom her mother lives) has rheumatoid arthritis. That sister is also employed. The petitioner's

daughter is also employed and has 2 children. She stated the home health aide is currently assisting her mother 4 hours per day on the weekdays (1 hour in the morning, 1 hour in the afternoon, and 2 additional hours during the day) and 2 hours per day on the weekend (1 hour in the morning and 1 hour in the afternoon). The aide helps her with activities such as bathing, dressing, and meal preparation. She stated her mother receives some home health services from the Medicare program as well as Medicaid.

7. The respondent's witness, Dr. Kaprow, stated United's position is that the currently approved hours of service are sufficient to meet the petitioner's needs. He stated any additional service hours would be in excess of her needs.

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 personal care 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.

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, dressing, and meal preparation. However, she is currently receiving approximately 24 hours weekly to assist with these activities (including the services provided by Medicare). These services are being provided for 4 hours daily on the weekdays and 2 hours daily on the weekends. Although one of her daughters is relocating, she will still have some assistance from her two other daughters.

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-01614

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 22 day of May, 2017,

in Tallahassee, Florida.



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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

May 12, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01617

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 April 24, 2017 at 1:12 p.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Dr. Brittany Vo, dental consultant

STATEMENT OF ISSUE

Whether the petitioner is eligible to receive deep gum cleaning, a dental service, 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. The Agency contracts with numerous health care maintenance organizations (HMOs) to provide medical services to Medicaid enrollees. United Healthcare (United) is the contracted HMO in the instant case.

By notice dated February 6, 2017, United informed the petitioner that her request for deep gum cleaning was denied because “[t]he requested service is not a covered benefit.”

The petitioner timely requested a hearing to challenge the denial decision.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

Present as witnesses for the respondent from United: Christian Laos, senior compliance analyst and Arlene Carrion, 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.

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 39) is a Florida Medicaid recipient. The petitioner is enrolled with United HMO. (Respondent's Exhibit 1)

2. On February 3, 2017, the petitioner's dental provider, [REDACTED] Dental Center, submitted a request to United for deep gum cleaning, all four quadrants of the mouth, under dental code D4341. (Respondent's Exhibit 1)

3. United denied the request as a non-covered benefit on February 6, 2017. (Respondent's Exhibit 1)

4. The petitioner timely requested a hearing to challenge the denial decision.

5. The petitioner asserted that deep gum cleaning is medically necessary because she suffers from numerous health issues, including periodontal (gum) disease, calcium deposits, and bone loss due to vitamin D deficiency. She is concerned about infection and worsening of her overall health if she does not have the deep gum cleaning prescribed by her dentist. (Petitioner testimony)

6. The petitioner asserted that Medicaid coverage is the only option for her because the procedure costs hundreds of dollars. She is not employed and cannot pay out-of-pocket for the procedure. (Petitioner testimony)

7. The respondent explained that deep gum cleaning is not a covered benefit for Medicaid recipients over age 20, even if the procedure is prescribed by a physician. (Testimony of Dr. Brittany 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 Dental Services Policy (May 2016) explains that Medicaid will only reimburse for dental services that are 1) medical necessary and 2) a covered benefit. Section 2.0 of the dental policy reads, “If a service is limited to recipients under the age of 21 years, it is specified in section 4.0.” Section 4.0 reads: “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.”

15. Medicaid publishes covered dental procedures in the Dental Fee Schedule by code numbers. The schedule contains a column which specifies the coverage age limit for each procedure code. Deep gum cleaning is coded as D4341 on the fee; the age limit for this procedure code is listed as 20.

16. The respondent denied the petitioner’s request for a deep gum cleaning as a non-covered benefit because the petitioner is 39 years old. Medicaid only covers this procedure if the recipient is under age 21.

17. The petitioner argued that an exception should be made due to her health issues.

18. Medicaid provides limited dental services for individuals over age 20; these services are limited to emergency services to alleviate pain and denture preparation services. There is no evidence that the circumstances in instant case rise to the level of an emergency service.

19. Medicaid rule does not cover deep gum cleaning for recipients over age 20. There are no noted exceptions to this coverage limitation. The petitioner is 39 years old. Per Medicaid rule, deep gum cleaning is not a covered benefit.

20. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent’s decision in this matter was correct.

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 12 day of May , 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

FILED

May 05, 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-01621

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 [REDACTED]
UNIT: 12DDD

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 28, 2017 at 10:24 a.m.

APPEARANCES

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

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

ISSUE

At issue is the respondent's action on January 31, 2017 to deny his application for SSI-Related Medicaid on its contention that he did not meet the disability requirement.

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

PRELIMINARY STATEMENT

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

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. The petitioner (date of birth July 8, 1969) applied for SSI-Related Medicaid on January 26, 2017 for himself only. The petitioner has no children.

2. The Department reviewed the petitioner's application for SSI-Related Medicaid and forwarded it to the Division of Disability Determination (DDD) for review.

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 (*Respondent's Exhibit 2, page 9*). 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 suffers from a [REDACTED]

[REDACTED] The petitioner contends that he cannot sit more than 15 minutes at a time and cannot stand. The petitioner explained that his girlfriend and family support him. The petitioner explained that his mother assisted in buying his medication but can no longer afford to do so. The petitioner argues that his medical coverage under the Affordable Care Act (ACA) has expired and that he would need to pay \$400 each month in order to renew his expired

health insurance policy. The petitioner contends that he is unable to work and is homeless.

5. The petitioner applied for disability with the SSA in 2015 and was denied in August 2015. The petitioner believes that all of his medical conditions reported during the hearing were reviewed by the SSA. The petitioner contends that he has no new medical conditions. However, petitioner reported during the hearing that his current medical conditions have worsened.

6. The Department contends that the petitioner was denied by the SSA on August 5, 2015 with a denial code of N43. The Department's record show that an SSA appeal was filed in December 2015 and is currently pending (*Respondent's Exhibit 2, page 10*). The Department explained that the code N43 is defined as: "Nonpay. Capacity for substantial gainful activity-other work, visual impairment." The Department adopted the SSA disability denial.

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. 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...

10. 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**).

11. The Department's ACCESS Florida Program Policy Manual, CFOP 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)

12. 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.

13. In this case, the petitioner is under age 65 and has several medical conditions such as a [REDACTED]. [REDACTED] The findings show that the petitioner's medical conditions were reviewed by the SSA in its disability determination. The petitioner reports a worsening of the medical conditions reported to the SSA. 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.

DONE and ORDERED this 05 day of May, 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

May 12, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01660

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 28, 2017 at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's son

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent United Healthcare's denial of the petitioner's request for home health aide (HHA) visits was correct. The respondent bear the burden of proving its 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 Dr. Marc Kaprow, Medical Director, and Susan Frishman, Senior Compliance Analyst, for United Healthcare, which is the petitioner's managed health care plan.

The respondent, United Healthcare, submitted the following documents into evidence, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Case System Screenshots, Authorization Request and Plan of Care (with attached medical records), HHA visit reports, and United Healthcare Community Plan provisions.

FINDINGS OF FACT

1. The Petitioner is a seventy-two (72) 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 through United Healthcare.
2. The Agency for Health Care Administration (AHCA) is responsible for management of the managed 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.
3. On or about February 3, 2017, the petitioner's home health services provider submitted an authorization request to United Healthcare for continuation of approval of

one home health aide (HHA) visit daily. The petitioner had previously been approved for one HHA visit daily.

4 On or about February 6, 2017, United Healthcare informed the petitioner by written notice that her request for home health aide visits had been denied. The denial notice stated the following:

You have [REDACTED]. You are asking for help in daily care. Based on the health plan guidelines, home health can be approved when skilled nursing care is needed. There is no specific medical problem where nursing care is needed. Therefore, home health care is not approved.

5. The respondent's witness, Dr. Kaprow, stated there was a change in policy after the adoption of a new AHCA Home Health Services Handbook in 2016. United Healthcare's position is that an individual over age 21 can only be approved for an HHA visit if it is incidental to a skilled nursing need. He referred to Section 4.2.2 of the new AHCA Handbook which refers to ADL (activities of daily) support for individuals under age 21.

6. The petitioner's son confirmed his mother only needs assistance with ADLs and does not need nursing care at home.

7. Home health services under the Medicaid State Plan in Florida are provided in accordance with the respondent AHCA's Home Health Visit Services Coverage Policy ("Home Health Visits Policy"), effective November, 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. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the petitioner was previously approved for HHA visits. 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.).

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 Home Health Visits Policy is incorporated by reference in Chapter 59G-4, Florida Administrative Code.

13. Section 409.973, Florida Statutes, sets forth the various services which must be offered by Medicaid MMA plans. “Home health agency services” and “nursing care” are among the required services.

14. The Home Health Visits Policy describes home health services as follows:

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), private duty nursing, and personal care services.

15. The Home Health Visits Policy describes intermittent home health aide visits as follows:

Medically necessary skilled nursing and home health aide services that are provided at intervals for the length of time necessary to complete the service.

16. The Home Health Visits Policy also states the Medicaid Program will provide up to three intermittent home health visits daily for non-pregnant recipients over age 21. Individuals under age 21 and pregnant individuals are entitled to up to four intermittent home health visits daily. The amount of visits is determined by medical necessity criteria.

17. Fla. Admin. Code R. 59G-1.010 defines medical necessity as follows:

(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 ...

18. Section 4.2.2 of the Home Health Visits Policy states the following:

Florida Medicaid reimburses for home health aide visits for recipients under the age of 21 years who have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs.

19. The United Healthcare plan provisions concerning home health care exclude coverage for “custodial care”, which is defined as “[n]on-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring, ambulating and companion services).”

20. The United Healthcare plan provisions also state the following:

This Coverage Determination Guideline provides assistance in interpreting United Healthcare benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersedes this Coverage Determination Guideline.

21. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the respondent has not met its burden of proof in demonstrating it was correct in denying the petitioner’s request for home health visits. The respondent’s position is that the new AHCA Home Health Visits policy limits HHA visits for ADL support only to individuals under age 21 unless an individual over age 21 also has a skilled nursing need. The respondent relies on Section 4.2.2 of the Policy for its position.

22. Although the undersigned agrees that Section 4.2.2 may create an ambiguity with regard to the scope of covered services, there is no reference in the Home Health

Visits Policy which denies HHA visits to individuals over 21 if the individual only requires ADL support. The Policy defines Home Health Visits as being both skilled nursing services as well as home health aide services. The applicable statute also requires MMA plans to offer both home health agency services as well as nursing care. As stated in the United Healthcare plan provisions, if there is a conflict between the plan provisions and state coverage requirements, the state requirements must prevail.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the petitioner is entitled to continuation of one home health visit daily.

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 12 day of May, 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255

FINAL ORDER (Cont.)

17F-01660

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1317 Winewood Boulevard

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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

Jun 23, 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-01663

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 [REDACTED]
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter June 13, 2017 at 1:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's daughter

For the Respondent: John Cater, M.D.
Long-Term Care Medical Director
Sunshine Healthcare

STATEMENT OF ISSUE

At issue is whether the Agency properly denied Petitioner's request for five days of Adult Day Care.

PRELIMINARY STATEMENT

The Agency for Healthcare Administration (AHCA or Agency) is responsible for administering Florida's Medicaid Program AHCA contracts with Health Maintenance

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

Petitioner was not present but represented by his daughter. Petitioner's daughter testified on Petitioner's behalf. Petitioner's 88-page composite document was entered into evidence as Petitioner's Composite Exhibit 1.

Respondent's 101-page composite document was entered as Respondent's Composite Exhibit 1. Serving as Respondent's witnesses from Sunshine Health were:

- Andrea Metcoff, Case Management Supervisor
- Melandy Catalino, Case Coordinator
- Kimberly Bouchet, Clinical Appeal Coordinator
- Cassie Alleyne, Paralegal
-

Cindy Henline, Health Care Program Analyst, was present for the Agency for Health Care Administration for observational purposes only

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. Petitioner is 70 years of age and resides with his wife. The wife is Petitioner's primary caregiver. There are no other individuals in the household.
2. Petitioner is enrolled in respondent's Long Term Managed Care Program (LTMC Program).
3. Petitioner uses a walker at all times to ambulate long distances but is able to ambulate around the home by "furniture cruising." (Resp. Com. Exh. 1, pg. 5)

4. Petitioner's functional abilities were assessed on November 18, 2016. The purpose of the assessment is to plan his service needs. Regarding the Petitioner, the assessment provided the following information:

- Some assistance with bathing
- Able to use the bathroom without assistance
- Able to transfer without assistance
- Able to ambulate on his own with the assistance of a walker

5. Additional information in the assessment case notes includes:

- Wife assists with meal prep, shopping financial management and transports Petitioner in her own vehicle.
- Can feed himself but requires assistance with food cutting.
- Petitioner is aware of person and time.
- Petitioner was diagnosed with [REDACTED]
- Member is able to express any discomfort

5. Petitioner requested adult day care services, five days per week, because the family is concerned about Petitioner's isolation and refusal to leave the house. The goal is for Petitioner to socialize with other people in the community but is limited based on his cognitive and physical limitations. The Long-Term-Care Plan of Care states this goal will be achieved by participation in day care for socialization. (Resp. Comp. Exh. 1 pg. 11)

6. The Agency, through its contracted managed care plan Sunshine Health, partially denied Petitioner's request for five days per week of adult day care services by notice dated November 22, 2016. It approved two days per week of adult day care services to permit socialization.

5. On November 22, 2016, Petitioner was notified his request for five days weekly of adult day care was denied. Petitioner was approved to receive two days weekly of adult day care. The notice stated:

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)

Other authority: Based on the assessment, the member's currently approved services are adequate to meet the member's care needs. The member's present care plan includes 2 days/Week ADC/Adult Day Care Services +3 hours/week Homemaker Services. (Resp. Comp. Exh. pg. 4)

6. Sunshine denied Petitioner's request for additional three days of service because the medical director determined other days are in excess of his needs and not medically necessary. The main reason for adult day care would be to provide socialization. The Respondent concluded that socialization is a valid reason for adult day care but not to the level Petitioner is requesting.

7. On January 13, 2017 the Office of Appeal Hearings timely received the Petitioner's request for a fair hearing.

8. During the hearing, Dr. Carter confirmed that Petitioner is now receiving three (3) full days of Adult Day Care, eight (8) hours of personal care services and four (4) hours of homemaker services to total number of 12 hours a week of home services. This was an increase of five (5) hours of personal care services, one (1) hour of homemaker services, and one full day of Adult Day Care. This increase was due to subsequent assessments showing Petitioner declined in mobility.

9. Dr. Carter testified that based on the most recent assessment, in his medical opinion, the current services were adequate to meet the Petitioner's medical needs.

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 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

11. Florida Medicaid State Plan is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency.

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

13. As this matter involves a request for a more intense level of service and Petitioner is asserting the affirmative of the issue, the burden of proof was assigned to the Petitioner pursuant to Florida Administrative Code Rule 65-2.060(1).

14. 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).

15. Section 409.978, Florida Statutes, provides that the "Agency shall administer the long-term care managed care program." The Agency is required to do this through a managed care model. *Id.* It does this by contracting with eligible plans to provide provider service networks. Section 409.981(1), Florida Statutes.

16. The Medicaid program only covers "medically necessary" services. See Sections 409.905(4)(c) and 409.913(7) Florida Statutes. Florida Administrative Code Rule 59G-1.010(166) states:

“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 sure care, goods or services medically necessary or a medical necessity or a covered. Service.

17. For Additional Adult Day Care services to be approved, the request must satisfy each condition of medical necessity. Medical necessity is not subject to a personalized definition. Rather, the definition in Fla. Admin. Code R 59G-1.010 is the controlling authority.

18. It is noted the Petitioner does require some supervision but is relatively independent in most activities of daily living. The Petitioner is receiving a total of eight (8) hours of personal care to assist with bathing and dressing. Further, the Petitioner is receiving a total of four (4) hours of homemaker to assist with homemaking and laundry. The Petitioner’s wife is able to assist Petitioner with shopping, financial and transportation needs.

19. The undersigned must consider all evidence; judge the creditability of witnesses; draw permissible inferences from the evidence; and reach findings of fact based on

competent substantial evidence. After reviewing all evidence and testimony on a comprehensive basis, Petitioner has not demonstrated two additional days a week of Adult Day Care are medically necessary. The greater weight of the evidence does not demonstrate the following conditions of medical necessity have been satisfied:

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;
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.

20. This Order is not to be construed as suggesting Petitioner does not require assistance to address his needs. This Order only concludes that based on the evidence submitted, Petitioner has not met his legal requirements to establish that 2 additional days of Adult day care is medically necessary. If Petitioner's health declines further, Petitioner is encouraged to apply for additional services as needed.

21. Therefore, the undersigned concludes Petitioner failed to meet his burden of proof to show, by the greater weight of the evidence, that 2 additional days of Adult Day Care is medically necessary.

DECISION

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

DONE and ORDERED this 23 day of June, 2017,

in Tallahassee, Florida.



Stephanie Twomey
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
[REDACTED]
Sunshine Hearings Unit

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

FILED

May 04, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01688

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 [REDACTED]
UNIT: 88656

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 20, 2017 at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

For the Respondent: Miguelina Jovane, Operations & Management Consultant
for the Economic Self-Sufficiency program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll her in the Medically Needy program with an assigned share of cost. On the record, the hearing officer assigned the burden of proof to the petitioner. However, upon subsequent review of the record, the hearing officer has determined that the burden of proof must be assigned to the respondent. The standard of proof at a Fair Hearing is a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner's Composite Exhibit 1 was admitted into evidence.

Respondent's Exhibits 1 through 4 were admitted into evidence.

By way of a Notice of Case Action dated January 30th, 2017, the respondent informed the petitioner that she would be enrolled in the Medically Needy program with an estimated share of cost (SOC) of \$710 effective January 2017. On February 15th, 2017, the respondent issued another Notice of Case Action informing the petitioner that her share of cost would increase from \$710 to \$910 effective March 1 of 2017. On February 21st, 2017, the petitioner filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. On January 26th, 2017, the petitioner submitted an application for recertification for food assistance, cash assistance and family Medicaid for herself and her two children.
2. On the application, the petitioner listed one source of employment and no assets. The petitioner also listed multiple expenses such as rent, utilities and medical bills (Respondent Exhibit 3).
3. The petitioner submitted into evidence a composite exhibit which shows her increased rent, and expenses such as utilities. She expressed difficulty in meeting her SOC after those obligations. The petitioner contends that those expenses should entitle her for full Medicaid instead of enrollment in the Medically Needy program (Petitioner's Composite Exhibit 1).

4. Previously, the respondent certified the petitioner for Extended Medicaid due to her earned income (ME I). When the petitioner contacted the call center on January 17th, 2017, to inquire about her Medicaid, she was advised by the agent to reapply since her Medicaid period has ended (Respondent Exhibit 4).

5. The respondent processed the petitioner's application using the earned income of \$1,196.80 from the previous certification period. After a Medically Needy Income Level (MNIL) deduction of \$486 for a Standard Filing Unit (SFU) of 3 (the petitioner and her 2 children), the petitioner was enrolled in the medically needy program with an estimated SOC of \$710.

6. When the respondent used the petitioner's verified earned income of \$1,396.62 (using two bi-weekly checks of \$711.72 on 01/20/2017 and \$684.90 on 02/03/2017), the petitioner's SOC increased from \$710 to \$910 effective April 2017 (Respondent Exhibit 1).

7. The respondent presented into evidence the "Family Related Medicaid Income Limit" chart which shows that for a family size of 3, the maximum income limit for a parent to qualify for Medicaid is \$303 a month. Once the parent fails \$303 threshold, the only applicable deduction available is a MNIL of \$486, which the petitioner was afforded. No other expenses such as shelter or utilities (except allowable medical expenses) are allowed in the Medically Needy budget calculation.

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 120.80, Fla.

Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

10. Fla. Admin. Code R. 65A-1.707 and 65A-1.716 list the Family-Related Medicaid Income and Resource Criteria. These authorities set forth full Medicaid coverage groups available for the household member.

11. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria states in part:

(1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows.

(a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources.... For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.

12. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria continues:

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
1	\$180
2	\$241

3

\$303 *[emphasis added]* ...

13. The authority cited sets forth the income limits for full Medicaid. The undersigned concludes petitioner's total countable income of \$1,196.80 and \$1,396.62 exceeds the income standard for a household size of three of \$303. Therefore, the petitioner is not eligible for full Medicaid.

14. Federal Regulation 42 C.F.R. § 435.831 Income eligibility, explains:

The agency must determine income eligibility of medically needy individuals in accordance with this section.

(b) Determining countable income. The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than the applicable income standard under §435.814, the individual or family is eligible for Medicaid...

15. The above authority explains Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income.

16. The ACCESS Florida Program Policy Manual Appendix A-7, Family-Related Medicaid Income Limits chart sets forth a \$486 MNIL for a household size of three.

17. The respondent subtracted the \$486 MNIL from \$1,196.80 and \$1,396.62 to arrive at the \$710 and \$910 share of cost respectively for the petitioner.

18. The ACCESS Florida Program Manual at 2030.1400, Medically Needy Coverage

(MFAM) sets forth:

The Medical Needy Program coverage is for individuals who meet the technical requirements of the above coverage groups but whose income exceeds the income limit. If the household's income is great than the income limit, the exceeding amount is determined as the share of cost. The individual is enrolled but is not eligible until the share of cost is met. Medically Needy provides month-to-month coverage when individuals have incurred medical bills that meet their share of cost.

19. A review of the rules and regulations did not find any exception to this formula.

Based on a review of the evidence in its totality, the hearing officer concludes that the respondent's action to enroll the petitioner in a Medicaid Medically Needy Program and determine a share of cost of \$710 initially and \$910 afterwards was within the rules of the program.

DECISION

Based on the foregoing Findings of Fact and Conclusions 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 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 May, 2017,

FINAL ORDER (Cont.)
17F-01688
PAGE -7

in Tallahassee, Florida.



Sajan George
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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

May 12, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01695

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 [REDACTED]
UNIT: 66292

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:56 a.m. on April 3, 2017.

APPEARANCES

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

For the Respondent: Jennie Rivera, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Medicaid, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

[REDACTED] Language Solutions, appeared as an interpreter. The petitioner was present and did not testify. The petitioner submitted one exhibit, entered as

Petitioner Exhibit "1". The respondent's representative submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on April 3, 2017.

FINDINGS OF FACT

1. On February 3, 2017, the petitioner's mother submitted a Food Assistance and Medicaid redetermination application for her household, the petitioner (age 22) is one of four household members (Respondent Exhibit 2). Medicaid for the petitioner is the only issue.
2. The application lists the petitioner as a full-time university student, not employed or disabled. The petitioner does not have children.
3. To be eligible for Family Medicaid, the petitioner must be under age 21, or have minor children living in the home.
4. To be eligible for Adult Medicaid, the petitioner must be age 65 or older, or considered blind or disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD is responsible for Medicaid disability determinations.
5. The petitioner does not have minor children, is not age 65 or older, and has not been considered blind or disabled by the SSA or DDD.
6. The petitioner's mother explained that the petitioner has a medical condition, which if not treated, will cause him to "die".
7. The petitioner applied for disability through the SSA on March 30, 2017.
8. The petitioner is required to submit a Medicaid Disability application to the Department while waiting for the SSA decision. Once the new application is submitted, disability eligibility will be referred to DDD for review.

9. On April 4, 2017, the Department mailed the petitioner a Notice of Case Action, notifying he was denied Medicaid (Respondent Exhibit 4).

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. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents and children, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 or older.

13. *Florida Administrative Code* R. 65A-1.703 - Family-Related Medicaid Coverage

Groups in part states:

(1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule.

(a) **Children under the age of 21 living with a specified relative** (emphasis added) who meet the eligibility criteria of Title XIX of the Social Security Act. Included in this coverage group are children who are under age 21 in intact families, provided that the children are living with both parents, unless a parent is temporarily absent from the home.

14. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Passage 1430.0500, Age (MFAM) states, "Children in the assistance group must meet

requirements for the factor of age in order for the assistance group to be eligible. A child must be under age 21 to be eligible for assistance.”

15. 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.

Children ages 19 to 21 may be eligible for Medicaid based on the same MAGI federal poverty level of a parent or caretaker relative.

A child is eligible to receive assistance on the factor of age through the month of the child’s appropriate birthday unless born on the first day of the month. Eligibility then ceases effective the birth month.

16. The above authority and Policy Manual provide potential Family-Related Medicaid coverage group for a child under age 21.

17. *Florida Administrative Code R. 65A-1.711 - SSI-Related Medicaid Non Financial Eligibility Criteria* states “for MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905...”

18. Title 20 of the Code of Federal Regulations § 416.903 - Who makes disability and blindness determinations in part states “the Social Security Administration will make disability and blindness determinations...”

19. In accordance with the above authorities, to be eligible for Medicaid an applicant age 21 and older, must have children, be age 65 or older, or considered disabled or blind.

20. The evidence submitted establishes that the petitioner does not have children, is not blind, nor age 65 or older. And has not been determined disabled by the SSA or

DDD. Additionally, the February 3, 2017 application does not indicate that the petitioner is disabled.

21. In careful review of the cited authorities 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, 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 12 day of May, 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
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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

May 08, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01706

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 [REDACTED]
UNIT: 88701

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 18, 2017, at 10:57 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Phyllis Barnes-Thermezi, DCF senior worker.

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 an estimated share of cost (SOC). The burden of proof was originally assigned to the petitioner at the hearing. Upon further review and in accordance with Fla. Admin. Code R. 65-2.060 (1),

the burden of proof is assigned to the respondent as for the termination of Medicaid benefits.

PRELIMINARY STATEMENT

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The respondent submitted evidence, which was accepted and marked as Respondent's Composite 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. Prior to the action under appeal, petitioner has been receiving full Medicaid benefits for her household. The son's last month of full Medicaid eligibility was February 2017.
2. On January 18, 2017, the petitioner submitted an application to continue Food Assistance and Medicaid benefits for her family. Her household consists of herself, her son (age 19) and her two daughters (ages 12 & 16). The petitioner is a tax filer, with her two daughters as her dependents. The son and employed, files his own taxes and is not listed as dependent on anyone's tax return.
3. The petitioner is employed and gets paid weekly. The son is employed and gets paid biweekly.
4. The case was processed and a pending notice was sent to the petitioner requesting verification of income. The petitioner provided the following paystubs for herself: 1/6/17 (\$32.20), 1/12/17 (\$34.43) and 1/19/17 (\$32.40). She also provided two

paystubs for her son: 12/28/16 (\$378) & 1/11/17 (\$327.40). Based on the information listed on the application, petitioner was approved for FAP and Medically Needy benefits.

5. On February 14, 2017, the respondent sent the petitioner a Notice of Case Action informing her she was approved for the Medically Needy Medicaid for her and her son. They were enrolled separately with a \$416 share of cost. Petitioner's daughters were approved for full Medicaid.

6. On February 21, 2017, the petitioner requested a hearing challenging the respondent's action. The petitioner was seeking full Medicaid for her household. Only the son's enrollment in the Medically Needy Program is under challenge.

7. To determine eligibility for Medicaid for the petitioner son's, his biweekly income was converted to a monthly amount by adding the two checks together to equal \$705.40 (\$378 + \$327.40). This amount is called modified adjusted gross income (MAGI). The respondent counted one member in his standard filing unit (SFU). His income was then compared to the income limit for an adult with a household size of one, \$180. As his income exceeded the maximum limit, he was found ineligible for full Medicaid benefits.

8. As the petitioner's son was determined ineligible for full Medicaid, the respondent enrolled him in the Medically Needy Program. To determine his estimated SOC, the respondent determined his MAGI to be \$705.40. The Medically Needy Income Level (MNIL) of \$289 for a standard filing unit size of one was subtracted from the MAGI, resulting to his estimated SOC of \$416.

9. Respondent's representative explained that son was no longer eligible for full Medicaid due to excess income. He had received continuous Medicaid for six months prior to the benefits being terminated on February 28, 2017. She explained how the

SOC works and promised to send a Medically Needy brochure to the petitioner for review.

10. The petitioner explained she was not aware that her son was eligible for Medicaid through end of February 2017. She did not dispute any facts presented by the respondent. She acknowledged the son's employment and his earnings, but disputed the MAGI used by the respondent. During the hearing, petitioner argued that her son has a skin disorder that requires continued care and he cannot afford the necessary medications necessary to keep his skin healthy. Petitioner stated that the son is not disabled. Petitioner argued she cannot afford to be responsible for \$416 each month in out-of-pocket expenses for her son's Medicaid coverage to be active. Petitioner explained that her household is basically homeless and cannot afford anything. She maintains that her son should be eligible for full Medicaid

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. The petitioner was seeking full Medicaid for her 19 year-old son. Federal regulation at 42 C.F.R §435.119 addresses Family-Related Medicaid income criteria for Individuals age 19 or older and under age 65 and states in part:

(a) *Basis*. This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.

(b) *Eligibility*. Effective January 1, 2014, the agency must provide Medicaid to individuals who:

(1) Are age 19 or older and under age 65;

(2) Are not pregnant;

(3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;

(4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and

(5) Have household income that is at or below 133 percent FPL for the applicable family size.

14. 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.

15. Federal regulation 42 C.F.R. § 435.603 Application of modified gross

income (MAGI) (f) defines a Household for Medicaid. It states:

(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.

16. The Department's Program Policy Manual CFOP 165-22 (The Policy Manual) at section 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.

17. In accordance with the above controlling authorities, when the son is being tested, the Medicaid household group only includes him. The findings show the Department

determined the son's eligibility with a household size of one for Medicaid. A more favorable outcome come not be found.

18. Federal regulation at 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (d) defines 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.

(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.

19. 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.

20. 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.

21. The above allows for the use of the conversion factor of 2 if income is received biweekly for Medicaid eligibility determination. The undersigned concludes that son's d income was correctly converted.

22. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the son. The undersigned concludes the son 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.

23. 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".

24. 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.

25. 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.

26. In accordance with the above controlling authorities, the respondent determined the petitioner's SFU as a household of one based on his own tax filing status. In this instant case, petitioner's son is 19 and is no longer eligible for **full Medicaid**. Additionally, he is has already received continuous Medicaid. No ex-parte was necessary, as the respondent was processing an active application.

27. 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 one is \$289.

28. To determine the estimated SOC for the son, household monthly income of \$705.40 was reduced by the MNIL of \$289 for a standard filing unit size of one, resulting in their estimated SOC of \$416. No computational errors were found. The hearing officer found that no exception to this calculation. It is concluded that a more favorable share of cost could be not determined.

29. 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 and his enrollment in the Medically Needy Program is correct. The respondent has met its burden that petitioner's son is no longer eligible for full 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 08 day of May, 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

FILED

May 08, 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-01721

PETITIONER,

Vs.

AMERIGROUP, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-styled matter on April 24, 2017 in [REDACTED] Florida, at approximately 10:30 a.m.

APPEARANCES

Petitioner:

[REDACTED]

For Amerigroup:

Carlene Brock
Quality Operations Nurse

STATEMENT OF ISSUE

At issue is whether or not Amerigroup's denial of her request for removal of exostosis and alveoloplasty was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner represented herself at the hearing. She gave oral testimony, but did not move any exhibits into evidence. She presented one (1) witness, her husband,

[REDACTED]

In addition to Ms. Brock, Lauren Hernandez, Complaints & Grievances Specialist with DentaQuest was present on behalf of Amerigroup. Respondent's Exhibits 1 – 7 were entered into evidence. No one from the Agency for Health Care Administration ("AHCA" or "Agency") attended the hearing.

FINDINGS OF FACT

1. Petitioner is a 56-year-old female. Petitioner is enrolled with Amerigroup as her Managed Medical Assistance ("MMA") plan. DentaQuest is Amerigroup's dental vendor.

2. On February 10, 2017, DentaQuest received a prior authorization request from Petitioner's oral surgeon, requesting:

- D7471 – removal of exostosis – Upper Arch x 1
- D7471 – removal of exostosis – Lower Arch x 1
- D7321 – alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant – Upper Right Quadrant.
- D7321 – alveoloplasty not in junction with extractions – one to three teeth or tooth spaces, per quadrant – Lower Left Quadrant.

3. On February 13, 2017, DentaQuest issued an Authorization Determination, denying the request in full, stating the same determination reason for each one: "Service is not covered." Please refer to your Office Reference Manual for definition of covered teeth/quad/arch, patient ages, and procedure codes." (Resp. Exh. 4). That same day, Amerigroup issued a Notice of Action denying the request, stating each procedure "is not a covered service." (Resp. Exh. 5).

4. Petitioner does not have any natural teeth. She previously received full dentures approximately 2.5 – 3 years ago. Her dentures are in a state of disrepair. She said that dentists have refused to repair them due to potential liability if something were to go

wrong. Her dentures are in such poor shape that she went so far as attempting to super glue them into her mouth, to no avail.

5. Petitioner has growths in her lower gums, which she refers to as her “gumballs.”

There was no dental expert at the hearing to explain specifically what the correct term is for the gumballs. However, Petitioner said she was told the reason she has been unable to have her lower dentures corrected is due to the presence of the gumballs.

6. Petitioner’s gums are disconnected from her jaw on both the lower left and lower right quadrant. At hearing, she was able to demonstrate her ability to put her finger under her gums and into her mouth.

7. Petitioner has a metal plate in her lower left quadrant, which she said is broken and needs replacement as part of the procedures. She stated she cannot chew on the right side of her mouth at all, so she is forced to chew everything on the left side. She said she can only eat soft foods, and that the pressure on her left side from constantly chewing on that side only is causing her gums to wear down, making the situation worse.

8. The left side of her face was visibly swollen at hearing, and both she and her husband testified that she was having a good day, and that she is usually more swollen than she was at that time. She said it hurts to sleep on the left side of her face.

9. Petitioner’s oral surgeon told her she was shocked that the current dentures were initially fabricated due to the presence of the gumballs. Petitioner said the requested surgery includes removal of the gumballs, and is designed to prepare her mouth for a new set of dentures. She said there are also problems with her upper dentures, which she is trying to live with. However, her oral surgeon told her that work also needs to be

done on the top of her mouth in order to fabricate a complete set of new dentures to solve all of the problems she is experiencing.

10. Ms. Hernandez testified that codes D7471 and D7321 are not covered in Amerigroup's adult dental benefits. She referred to Respondent's Exhibit 6, which confirms her testimony. She said the alveoloplasty is covered if there are four (4) or more teeth or spaces per quadrant, but that Petitioner's request is for one (1) to three (3) teeth or spaces. The procedure code for alveoloplasty not in conjunction with extractions for four (4) or more spaces is D7320. (Resp. Exh. 6).

11. Ms. Hernandez stated she did not know what exostosis means, but that D7471 is not listed as a covered benefit. Both codes D7472 and D7473, removal of torus palatinus and removal of torus mandibularis, respectively, are both listed as scheduled benefits, which "can only be billed for the preparation of dentures." (Resp. Exh. 6) (emphasis added).

12. For adults aged 21 and older, Amerigroup covers dentures and denture-related services. (Resp. Exh. 7). Ms. Hernandez stated the denial was made administratively because the procedures/codes requested are not covered services. She was unaware of any authority that provides exceptions regarding coverage. She said there was no medical necessity review of the request since it was determined that the procedures are not covered.

13. The Current Procedural Terminology, Fourth Edition ("CPT") code list is a registered trademark of the American Medical Association ("AMA"). The Current Dental Terminology ("CDT") is a registered trademark of the American Dental Association ("ADA"). (<https://www.medicaid.gov/license-agreement-ama-ada.html>).

14. The Centers for Medicare & Medicaid Services (“CMS”) uses CPT and CDT codes, as well as the Health Care Common Procedure Coding System (“HCPCS”) for “diverse health care functions, from billing to tracking public health.”

(<https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets/index.html>).

15. The states are required to report the annual performance of CPT and CDT codes to CMS regarding the Early and Periodic Screening, Diagnostic and Treatment (“EPSDT”) benefit for children under age 21 enrolled in Medicaid on Form CMS-416.

(<https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>).

16. Multiple codes can be potentially used to describe the same procedure. In order to assist the states with reporting, CMS publishes as a Crosswalk of CPT Codes to CDT Codes (“Crosswalk”). The current Crosswalk is published at:

<https://www.medicaid.gov/medicaid/benefits/downloads/cpt-to-cdt-crosswalk.pdf>.

17. According to the Crosswalk, CDT code D7321 translates to CPT code 41874. CDT code D7320 also translates to CPT code 41874. CDT code D7310 is an example of a situation where a CDT code can translate to more than one CPT code. It translates to code 41874 like the others, but also translates to CPT code 41870. Amerigroup covers codes D7310 and D7320. Code D7321 is not on the Florida Medicaid Dental General Fee Schedule (“Dental Fee Schedule”). Codes D7310 and D7320 are on the Dental Fee Schedule.

18. Regarding CDT code D7471, it translates to both CPT codes 21031 and 21032. Code D7472 translates to code 21032, and Code D7473 translates to code 21031.

Amerigroup covers codes D7472 and D7473. Code D7471 is not on the Dental Fee Schedule. Codes D7472 and D7473 are on the Dental Fee Schedule.

19. As to the CPT codes, code 41870 is not on the Florida Medicaid Dental Oral and Maxillofacial Surgery Fee Schedule (“Surgery Fee Schedule”). Code 41874 is on the Surgery Fee Schedule. On the Crosswalk, code 41874, when referring to code D7321, is “Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant.”

20. Both codes 21031 and 21032 are on the Surgery Fee Schedule. On the Crosswalk, when referring to code D7471, codes 21031 and 21032 are “Removal of lateral exotosis (maxilla or mandible).”

CONCLUSIONS OF LAW

21. 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.

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

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

24. 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.).

25. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Florida Statutes and Chapter 59G of the *Florida Administrative Code*. AHCA is the single state agency that administers the Medicaid Program.

26. The Florida Medicaid Dental Services Coverage Policy, May 2016 (“Dental Handbook”), and the Florida Medicaid Oral and Maxillofacial Surgery Services Coverage Policy, May 2016 (“Surgery Handbook”) are promulgated into law by Chapter 59G of the *Florida Administrative Code*. Their respective fee schedules are incorporated by reference in Fla. Admin. Code R.59G-4.002.

27. Section 4.2 of the Dental Handbook states, in pertinent part:

Specific Criteria

Florida Medicaid reimburses for the following services in accordance with the American Dental Association Current Dental Terminology Manual, the American Academy of Pediatrics Periodicity Schedule, and the applicable Florida Medicaid fee schedules(s), or as specified in this policy:

....

Surgical Procedures and Extractions

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.

(emphases added)

28. Section 1.1 of the Surgery Handbook states: “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.”

29. Section 4.2 of the Surgery Handbook states:

Specific Criteria

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
- 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

(emphases added)

30. In the instant-matter, Petitioner's request was administratively denied as not being covered services under the CDT codes. However, DentaQuest and Amerigroup did not consider the broader meaning of those codes. While the CDT codes submitted are not covered on Amerigroup's list, or on the Dental Fee Schedule, the CPT codes that correspond to the CDT codes *are* on the Surgery Fee Schedule. The Dental Handbook explicitly adopts CDT codes, and the Surgery Handbook explicitly adopts CPT codes. CMS provides guidance regarding the interchangeability of these codes via the Crosswalk.

31. Both the Dental Handbook and Surgery Handbook contemplate that a procedure may be on different fee schedules by stating "applicable Florida Medicaid fee schedule(s)." It should come as no great surprise that the procedures requested by

Petitioner are found on the Surgery Fee Schedule since they are oral surgery procedures submitted by an oral surgeon.

32. Further, the Dental Handbook explicitly covers “procedures essential to prepare the mouth for dentures.” The Surgery Handbook takes it a step further and explicitly covers “*Surgical* procedures essential to the preparation of the mouth for dentures.”

Petitioner’s problem centers entirely around preparing her mouth for dentures.

DentaQuest did not perform a medical necessity review, however, both Handbooks require that any procedure be medically necessary.

33. The definition of medically necessary is found in Rule 59G-1.010 of the *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.

34. Petitioner testified that she experiences pain. She testified that she has “gumballs” in her mouth, and that her oral surgeon said those should have been removed prior to receiving dentures. She testified that the metal plate in her mouth is broken. She arrived at hearing with the left side of her mouth visibly swollen. She testified that her gums are disconnected from her jaw, as well as demonstrated her ability to put her finger underneath her gums and into her mouth. No evidence was presented by Amerigroup and DentaQuest to rebut Petitioner’s substantial evidence that the procedures are medically necessary.

35. The undersigned concludes that the procedures are covered benefits under the Surgery Fee Schedule and that Petitioner has met her burden of proof to show they are medically necessary.

DECISION

Based upon the foregoing, Petitioner’s appeal is GRANTED. Amerigroup is directed to provide the requested procedures to Petitioner.

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-01721

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DONE and ORDERED this 08 day of May, 2017,

in Tallahassee, Florida.



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
AFCA, Medicaid Fair Hearings Unit
Amerigroup Hearings Unit

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

FILED

May 18, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01725

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 March 28, 2017 at 1:30 p.m.

APPEARANCES

For Petitioner: [REDACTED], Esq.

For Respondent, AHCA: Monica Otalora, Senior Program Specialist

For Respondent, Amerigroup: Craig Smith, Esq.

ISSUE

At issue is whether the respondent Amerigroup's denial of the petitioner's request for Botox treatment was correct. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for the petitioner were two physicians, Dr. [REDACTED]

[REDACTED] and Dr. [REDACTED].

The petitioner submitted the following documents as evidence for the hearing, which were marked as Petitioner Composite Exhibit 1: Curriculum Vitae for each of the two physician witnesses and eight medical journal articles concerning botulinum toxin (Botox) and its use in treating [REDACTED].

Appearing as witnesses for the respondent were Dr. Vincent Pantone, Chief Medical Officer, and Brian Hawkins, Director of Grievances, from Amerigroup, which is the petitioner's managed health care plan. The following individuals from Amerigroup were also present but did not testify as witnesses: Dana Gryniuk, Legal Counsel, Dr. Maribel Bravo, and Dr. Lynn Berger.

The respondent submitted the following documents as evidence for the hearing, which were marked Respondent Composite Exhibit 1: Sequence of Events, Authorization Request, Notice of Action, Peer to Peer Review, Internal Appeal Request, Third-Party Reviewer Referral Form, Appeal Determination Letter, and Medical Policy.

The respondent also submitted four documents consisting of Medical Policies and Guidelines addressing botulinum toxin and/or [REDACTED]. These documents were marked as Respondent Composite Exhibit 2.

FINDINGS OF FACT

1. The petitioner is a one (1) 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 Amerigroup. She suffers from [REDACTED] [REDACTED] also known as [REDACTED].

2. On or about December 7, 2016, the petitioner's treating physician submitted a prior authorization request to Amerigroup for approval of a treatment pertaining to the following medical procedure codes: (a) code 23700 – manipulation under anesthesia, shoulder joint, including application of fixation apparatus, and (b) code 64642 – chemodeneration of one extremity. This treatment involves the use of botulinum toxin (Botox).

3. On December 12, 2016, Amerigroup denied the requested treatment as not being medically necessary. The denial notice stated the following:

We cannot approve your child's treatment for her arm (manipulation under anesthesia for erbs palsy). This treatment is not approved for this problem. This is approved for a spine that is broke (Verterbral fracture, dislocation of the spine or acute traumatic incomplete dislocation of the spine).

4. After that denial, the petitioner's representative initiated an internal grievance/appeal procedure with Amerigroup. On or about February 2, 2017, Amerigroup upheld its initial denial for the same reasons set forth above. The petitioner thereafter requested a Medicaid Fair Hearing and this proceeding followed.

5. The petitioner's witness, Dr. [REDACTED], stated that Botox treatment can obviate the need for surgery and improve healing for individuals with [REDACTED]. He does not consider this treatment to be investigational. He did not know whether the FDA has

approved Botox for the treatment of [REDACTED], but stated this would be an off-label use of Botox.

6. The petitioner's second witness, Dr. [REDACTED], is also her treating physician. He stated he has treated thousands of infants with [REDACTED] conditions and has used Botox in many different situations. He stated the Botox is used to weaken the stronger muscles, which allows the weaker muscles to get stronger. He also stated this has helped some individuals avoid surgery for their condition. He stated Botox treatment is an effective treatment for this condition, but also stated it is an off-label use since the FDA has not approved the use of Botox to treat [REDACTED]. He stated the studies referenced in the supporting medical articles were not considered to be "phase 3 studies."

7. The respondent's witness, Dr. Pantone, stated Medicaid requirements for approval of a requested medication for an off-label use include the following: (a) trial and failure of a FDA-approved medication, (b) phase 3 clinical studies which support the off-label use, and (c) the off-label use must be supported by peer-review medical literature and listed in drug compendia. He stated the studies referenced in the medical articles submitted by the petitioner were not phase 3 studies. He also stated that Botox is not FDA-approved to treat [REDACTED]. He also admitted that Amerigroup has approved Botox treatment for other patients in the past with this condition, but that these approvals were made in error and Amerigroup has taken corrective action.

CONCLUSIONS OF LAW

8. 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.
9. This is a final order pursuant to § 120.569 and § 120.57, Fla. Stat.
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 by a preponderance of the evidence. (See Fla. Admin. Code R. 65-2060(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. 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. Managed care plans, such as Amerigroup, provide services to Medicaid recipients pursuant to a contract with AHCA.
13. The Florida Medicaid Provider Handbook (Provider Handbook) is incorporated by reference in the Medicaid Services Rules found in Florida Administrative Code Chapter 59G-4. In accordance with the above Statute, the Handbook states 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.

14. In this proceeding, Amerigroup is the health maintenance organization or managed care plan which provides the petitioner's Medicaid services.

15. Page 1-28 of the Provider Handbook lists HMO covered services. The service list includes prescribed drug services.

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

17. The Florida Medicaid Prescribed Drug Services Handbook has been promulgated into rule by reference in Fla. Admin. Code R. 59G-4.250. Relevant to this proceeding:

Page 1-4:

HMO prescribed drug services are defined the same as for the Medicaid fee-for-service program and include all legend drug products covered by fee-for-service Medicaid as defined in Chapter 2 of this handbook, Legend Drugs. Medicaid's contract with HMOs states that Medicaid HMOs may use prior authorization and/or step therapy to encourage compliance with the preferred drug list.

Page 2-2:

To be reimbursed by Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in accordance with Section 1927(k)(6) of the Social Security Act, or (b) prior authorized by a qualified clinical specialist approved by the Agency. Notwithstanding this rule, the Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.

18. The definition of "medically necessary" is found in Fla. Admin. Code R. 59G-1.010, which 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; 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. Addressing the Preferred Drug List (PDL), the Drug Services Handbook

continues by providing the following additional information:

Page 2-4:

The Preferred Drug List (PDL) is a listing of prescription products recommended by the Pharmaceutical and Therapeutics (P&T) Committee for consideration by AHCA as efficacious, safe, and cost effective choices when prescribing for Medicaid patients.

...

Products included on the PDL must be prescribed first unless the patient has previously used these products unsuccessfully or the prescriber submits documentation justifying the use of a none-PDL product.

...

Non- PDL drugs may be approved for reimbursement upon prior authorization.

20. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not demonstrated that Amerigroup should have approved the requested Botox treatment. Although the petitioner's witnesses presented

persuasive evidence that Botox is an effective treatment for [REDACTED], the evidence also establishes the use of Botox for that purpose is not FDA-approved and constitutes an off-label use. Accordingly, pursuant to the applicable Medicaid guidelines, Amerigroup correctly denied the requested Botox treatment.

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

DONE and ORDERED this 18 day of May, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard

FINAL ORDER (Cont.)

17F-01725

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Tallahassee, FL 32399-0700

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CRAIG SMITH, ESQ.
AMERIGROUP HEARINGS UNIT

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

FILED

May 18, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01806

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 05 [REDACTED]
UNIT: AHCA

AND

CHILDREN'S MEDICAL SERVICES

RESPONDENTS.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 26, 2017 at 3:13 p.m.

APPEARANCES

For the Petitioner: [REDACTED], mother

For the Respondent: Dr. Donald Fillips, Ped-I-Care medical director

STATEMENT OF ISSUE

Whether the respondent's decision terminating the petitioner's personal care services (PCS) was correct. The respondent 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 other agencies and organizations to administer medical services to Medicaid enrollees. AHCA contracts with the Department of Health's (DOH) Children's Medical Services (CMS) Division to provide services to children with special medical needs, under a health plan known as Ped-I-Care. Ped-I-Care is affiliated with the University Of Florida College Of Medicine's Department of Pediatrics.

By notice dated February 1, 2017, Ped-I-Care informed the petitioner that his request for continued PCS services, for the certification period January 29, 2017 – March 29, 2017, was denied.

The petitioner timely requested a hearing to challenge the decision. The PCS services have been continued at the prior level pending the outcome of the hearing.

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 Ped-I-Care: Holly Estep, assistant director of utilization management. Present as observers for the respondents: Laura Monday, utilization manager; Virginia Aiello, utilization management nurse; Karen Tillman, general counsel; Peaches Jackson, utilization manager; Tamara Zanders, unit director; Gene Gandy, general counsel; Selwyn Gossett, medical health care analyst.

The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibits 1 and 2.

The hearing record was closed on April 26, 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. (Respondent's Exhibit 1)
2. The petitioner "is a 6-year-old with a history of complex [REDACTED] [REDACTED] and corrective surgeries. (Respondent's Exhibit 1)
3. The petitioner's most recent corrective heart surgery occurred on November 14, 2016. Post surgery, the petitioner required assistance with the activities of daily living (bathing, toileting, dressing, grooming, etc.). The petitioner's treating physician submitted a request for PCS to Ped-I-Care, the petitioner's Medicaid health plan. Ped-I-Care approved 8 to 10 hours of PCS daily for three months, November 2016 – January 2017. (Respondent's Exhibit 1)
4. The petitioner's physician submitted a request for continued PCS to Ped-I-Care in late January 2017, for the certification period January 29, 2017 – March 29, 2017. Ped-I-Care concluded that ongoing PCS was not medically necessary and denied the request on February 1, 2017. (Respondent's Exhibit 1)
5. The petitioner timely requested a hearing to challenge the decision.
(Respondent's Exhibit 1)

6. Ped-I-Care reviews the request form(s) and all supporting documentation to make its decision. (Dr. Donald Fillipps testimony)

7. Dr. Donald Fillips, Ped-I-Care medical director, explained the denial decision in the instant case in a written Statement of Matters which reads:

[Petitioner] is post corrective heart surgery...November 14, 2016... [Petitioner] has been followed regularly by the Pediatric Congenital Heart Center at the University of Florida. Following two recent cardiology visits on 2/1/17 and again on 3/1/17, his treating cardiologist, Dr. [REDACTED] noted that [petitioner] has had a satisfactory post-operative course and he was cleared to return to normal activities. During a peer-to-peer call with the child's attending cardiologist Dr. [REDACTED] on 3/7/17, he told me that [petitioner] was cleared to resume all activities of daily living that would be expected for his age. Dr. [REDACTED] felt [petitioner] no longer had any medical needs that would require PCS services in the home.

We have also notes, in the records provided to us, that [petitioner] was diagnosed with an [REDACTED] in November 2016 during a hospitalization. He had a follow-up appointment with the UF Pediatric Surgery team on 12/5/16. At that visit, the pediatric surgeon felt that there was no urgency to performing the hernia repair stating that they wanted to delay performing the procedure until he was off a particular blood thinning medication. The surgery team did not put any restrictions on [petitioner's] activities while he is waiting to undergo the hernia repair.

Following our review of all the provided information, including a direct call to the treating cardiologist, it appears that [petitioner] has resumed normal age appropriate activity and mobility without any imposed restrictions. We therefore see no reason that the mother, even with her reported medical limitations, or other members of the family, could not provide age appropriate general routine care for [petitioner]. With cardiology clearing [petitioner] to resume normal activities for his age without need for special monitoring, or restrictions on his activity, PCS would no longer be medically necessary. The regular routine ADL care expected for a 6-year-old child such and laundry, meal preparation and other assistance, should be able to be provided by the mother or another responsible member of the family, who must already be doing these things in the home for the rest of the family. [Petitioner] should also be able to assist with bathing and grooming needs with only observational supervision and minimal directional assistance needed to complete these activities. (Respondent's Exhibit 1)

8. All Medicaid goods and services must be medically necessary as defined in the controlling legal authorities. Dr. Phillip's written Statement of Matters addressed the five bullets of medical necessity as they applied in the instant case:

Following our review of the records provided and our discussions with [petitioner's] treating cardiologist, we feel that there is no longer evidence to support the need for PCS service for [petitioner] and therefore we have made a decision to deny this service based on lack of medical necessity.

"medically necessary" or medical necessary" means that the medical or allied care, goods, or service furnished must:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

**The documentation provided does not support the needs for PCS services requested in order to prevent or alleviate further disability or illness progression for this member.*

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;

**The activities of daily living care required for this young man are routine and age appropriate and therefore can be provided by members of the family or a babysitter with observational supervision and minimal directional assistance being provided. Routine, age appropriate care can be provided by an untrained caretaker/guardian in a manner that is consistent with the member's age and current state of health.*

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

**Although PCS care qualifies as meeting generally accepted medical standard, in this case, home PCS care is not deemed to be medically necessary and would be in excess of the patient's needs.*

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;

**This member's care can be safely provided by the family, which would be a less costly alternative to PCS services, which are not deemed medically necessary at this time.*

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider;

**We maintain that authorizing PCS services for this member would be done solely for the convenience of the recipient's caretaker as it is determined that PCS services are no longer medically necessary for the child.*

(Respondent's Exhibit 1)

9. Dr. Fillips opined during the hearing that, for the reasons detailed in the above findings, it is not medically necessary for the petitioner to continue receiving PCS. Dr. Fillips recognized that Medicaid rule has an expanded definition of medical necessity for children under age 21 which includes a provision for goods and services needed to alleviate the medical condition, as long as the services are medically necessary. Dr. Fillips emphasized that, in his opinion, PCS, even under the expanded definition of medical necessity, are not medically necessary in the instant case because the petitioner has returned to his pre-surgery level of functioning. (Testimony of Dr. Donald Fillips)

10. The petitioner's mother acknowledged that he has recovered from the most recent heart surgery. However, like any 6-year-old child, he requires supervision, some physical assistance with ADLs, help with homework, chores, and other general tasks. The mother asserted that due to health problems of her own (fibromyalgia, arthritis, and degenerative cervical spine disease) and medication which causes drowsiness, she is not able to assist the petitioner's

CONCLUSIONS OF LAW

14. 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.

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

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

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

18. 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.).

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 all 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. As the petitioner is 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.

22. 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.

23. The petitioner received three months of PCS (late 2016 – early 2017) while recovering from heart surgery. His mother would like the PCS to continue because the petitioner continues to need care standard for his age; supervision, help with homework, some help with ADLs, and household chores. The mother is not able to help the petitioner with these tasks due to her own health problems.

24. The respondent determined that the requested service was not medically necessary as defined in the controlling legal authorities. The respondent concluded that a responsible lay caregiver could meet the petitioner's needs.

25. The undisputed evidence proves that the petitioner's treating physician has cleared him to return to his normal activities. The undisputed evidence further proves that the petitioner does not require the care of a medical professional or paraprofessional. The petitioner's need for supervision, help with homework, some help with ADLs, and household chores can be met by a responsible adult. Medical PCS is in excess of the petitioner's needs. Medicaid rule prohibits the provision of goods and services in excess of a recipient's needs.

26. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was correct.

DECISION

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

DONE and ORDERED this 18 day of May, 2017,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
AHCA, Medicaid Fair Hearings Unit
Children's Medical Services Hearings Unit

FILED

May 16, 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-01830

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 27, 2017 at 1:28 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 February 24, 2017 denying her application for SSI-Related Medicaid due to failure to complete an interview necessary to determine eligibility. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on March 13, 2017, which was entered as Respondent's Exhibit 1.

The record closed on March 27, 2017.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on January 24, 2017. The petitioner's household consists of herself only. The petitioner is 46 years old.

2. The petitioner expressed that she believes she is disabled. She has not been established as disabled as of the hearing by the Social Security Administration (SSA).

3. The petitioner stated she has not worked since April 2016.

4. The petitioner listed her conditions and onset dates as follows:

██████████ with onset date of May 2016. ██████████
with onset date of June 2016. ██████████ with onset date of November 2016. ██████████
██████████ diagnosed in 2017. The petitioner stated additional testing is being done, so more diagnosis may be on the horizon.

5. The Department issued a Notice of Case Action on January 27, 2017 informing the petitioner of the need for a telephonic interview. The Notice informed the petitioner the Department would call her on February 2, 2017.

6. The Department issued a Notice of Case Action on February 24, 2017 denying the petitioner's application for SSI-Related Medicaid due to failure to complete an interview necessary to determine eligibility for this program.

7. The petitioner stated she did not receive a call for a phone interview prior to her denial on February 24, 2017.

8. The petitioner filed a second application for SSI-Related Medicaid on February 27, 2017. The petitioner stated she completed this second application as instructed by the Department call center staff.

9. The Department issued a Notice of Case Action on February 28, 2017 informing the petitioner of the need for a telephonic interview on or before March 13, 2017 to determine her eligibility for benefits.

10. The Department submitted the Disability Determination and Transmittal to the Division of Disability Determinations (DDD) on March 13, 2017.

11. DDD returned the disability to the Department on March 16, 2017. DDD denied the petitioner's disability with code N32. They also notated the file as "Hankerson 3/17, same allegations)

12. The Department explained with the response from DDD coming back so quickly as well as the notation of "Hankerson, same allegations", they believe DDD adopted the disability determination made by Social Security which was made in March 2017.

13. The Department explained the N32 denial code means "Capacity for substantial gainful activity – other work, no visual impairment".

14. The Department issued a Notice of Case Action on March 20, 2017 informing the petitioner that her application for SSI-Related Medicaid dated February 27, 2017 was denied as "You or a member(s) of your household do not meet the disability requirement".

15. The petitioner believes she needs and qualifies for Medicaid due to her deteriorating health conditions.

16. The petitioner confirmed she did apply for Social Security benefits previously. The petitioner confirmed her Social Security application was denied. She has filed a reconsideration of the denial.

17. The petitioner advised she has retained an attorney to assist with the Social Security appeals. She has notified the attorney of all changes in her conditions. To her knowledge, Social Security has not refused to consider any of the new or worsened conditions.

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. The undersigned explored eligibility first under Family-Related Medicaid groups. The petitioner does not have a minor child in the home. The petitioner is not pregnant. The Family-Related Medicaid program benefit rules are set forth in the Florida Admin. Code 65A-1.705, Family-Related 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 or be pregnant. The undersigned

concludes the petitioner does not meet the criteria for Family-Related Medicaid program benefits.

21. 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.

22. 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).

23. 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.)

24. 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)

25. 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. She has not been established as disabled. In accordance with the above controlling authorities, the undersigned concludes as the petitioner is under age 65, she must meet the disability requirement for eligibility for Medicaid in the SSI-Related Medicaid program.

26. The findings show the petitioner has applied for Social Security and was denied in March 2017. The findings show the petitioner's report of appealing the denied Social Security decision with the assistance of an attorney. According to the above controlling authorities, a decision made by Social Security Administration (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 refuses to consider. In the instant case, the petitioner reports she has new conditions, but she has reported these to her attorney to share with SSA. There was no testimony or evidence presented to show that SSA has refused to consider new or worsened conditions.

27. 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

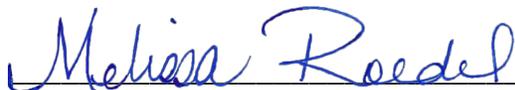
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

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 16 day of May, 2017,

in Tallahassee, Florida.



Melissa Roedel
Hearing Officer
Building 5, Room 255
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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

May 12, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01848

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 [REDACTED]
UNIT: AHCA,

And

SUNSHINE HEALTH PLANS,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 3, 2017, at 8:30 a.m.

APPEARANCES

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

For the Respondent: Monica Otolara, Senior Program Specialist

STATEMENT OF ISSUE

At issue is the respondent Sunshine Health Plan's action denying the petitioner's request for bathroom modification 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 Kizzy Alleyne, Paralegal, and Chantal Pierre, Appeals Coordinator, from Sunshine Health Plans, which is the petitioner's managed health care plan. Also present as witnesses for the respondent were Dr. Eladia Herrera-Jimenez, Medical Director, Tatiana Sam, Case Manager Supervisor, and Linda Albe, Case Management Director, from Little Havana Center, which is a provider of some of the petitioner's health services.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Fair Hearing Summary, Denial Notice, Plan of Care, Medical Assessment Form, and LTC Plan Policies and Procedures.

FINDINGS OF FACT

1. The petitioner is seventy-one (71) years of age and lives alone, although she stays at her daughter's house on the weekends.

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 Sunshine Health.

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 Sunshine Health provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner is currently approved for the following LTC plan services through Sunshine: 5 hours weekly of personal care assistance, 3 hours weekly of homemaker services, home-delivered meals, and incontinence supplies.

5. On or about January 24, 2017, the petitioner made a request to Sunshine Health for bathroom modification services. She requested that her bathtub be converted into a shower. On February 2, 2017, Sunshine sent a letter to the petitioner denying the requested service based on medical necessity considerations. The denial notice stated the following:

Client has a bath chair, is ambulatory, and currently receives 5 hours of personal care on a weekly basis which provides physical bathing assistance.

6. The petitioner's daughter stated her mother has difficulty stepping into the bathtub and is at risk for falling. The daughter works until 5:30 p.m. and is unable to assist her mother during the day. She goes to her mother's house after work and stays until 10:00 p.m. She stated the home health aide helps her mother with bathing, but she needs to be bathed more than once a day due to her incontinence. She also stated her mother has a bath chair and the bathtub has grab bars. The daughter has a bathtub in her own home and she helps her mother with bathing when her mother is there.

7. The respondent's witness, Ms. Sam, stated the petitioner has reported having dizzy spells so she is at risk whether she is bathing in a bathtub or a shower. She

stated the petitioner has a bath chair and grab-bars so that she can safely complete her bathing.

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 bathroom modification.

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 bathroom modification should have been approved by Sunshine Health. The petitioner’s bathing needs are currently being met with assistance from her home health aide and her daughter. She also has a bath chair and bathtub grab-bars. The conversion of the bathtub to a shower would be in excess of her needs and, therefore, not medically necessary according to the rule provisions outlined above.

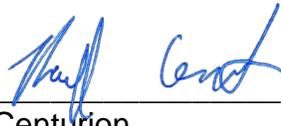
DECISION

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 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 12 day of May, 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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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
SUNSHINE HEARINGS UNIT

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

FILED

May 11, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01850

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 April 3, 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 United Healthcare's action to deny the petitioner's request for a cranial helmet was correct. The petitioner bears the burden of proof in this 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 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 the following documents as evidence for the hearing, which were marked as Respondent Exhibit 1: Statement of Matters, Denial Notice, Case System Screenshots, Authorization Request (with medical records), and Medicaid Handbook Provisions.

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 an eight (8) month-old infant and he is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan from United Healthcare.
2. On or about January 27, 2017, the petitioner's treating physician (hereafter referred to as "the provider"), submitted a prior authorization request to United Healthcare for a custom cranial remolding orthosis (a/k/a cranial helmet). United Healthcare denied this request on February 4, 2017 based on medical necessity criteria. The denial notice stated the following:

Your baby's doctor requested a head brace. This is for your baby. This is denied. Your baby's health plan requires certain conditions to be met.

There is no mention your baby did not get better with repositioning for six (6) months.

3. The petitioner's mother stated she experienced complications during childbirth and her son had to be pulled out with a vacuum device which caused a deformity on his head. She stated she has tried repositioning techniques to reshape his head since he was 1 month old, which has now been over 6 months, without success.

4. The respondent's witness, Dr. Kaprow, stated the request for the cranial helmet was initially denied because the requirement for 6 months of repositioning had not been met at that time. Due to the passage of time between the denial notice and the hearing date, this 6-month period may now have been satisfied with regard to the repositioning requirement. However, he stated an additional requirement for approval of a cranial helmet is a cephalic index (a measurement of head shape also known as the cranial index of symmetry) of less than 83. The petitioner did not meet this requirement since the submitted medical records contained a cephalic index of 87.9.

5. Durable medical equipment, including a cranial helmet, is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent AHCA's Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

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. Managed care organizations, such as United Healthcare, provide services to Medicaid recipients pursuant to a contract with AHCA.
11. The petitioner has requested DME services (a cranial helmet). As the petitioner is under 21 years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner’s eligibility for this service.
12. 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.
13. 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.

14. The service the petitioner has requested (DME services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Section 409.905, Florida Statutes, states, in part:

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.

15. 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:

¹ "You" in this manual context refers to the state Medicaid agency.

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.

16. Once a service has been identified as requested under EPSDT, Medicaid determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. The 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.

17. Based upon the information submitted by the petitioner's provider, United Healthcare completed a prior authorization review to determine medical necessity for the requested durable medical equipment (i.e., the cranial helmet).

18. In the petitioner's case, the health plan has determined that the cranial helmet is a covered service under the Medicaid state plan but is disputing the medical necessity for the cranial helmet.

19. 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 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.

20. 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.

21. The DME Handbook, on page 2-48, describes a cranial helmet as follows:

A custom cranial remolding orthosis is a non-invasive device used to correct the symmetry of an infant's skull.

22. The DME Handbook also sets forth the following requirements for approval of a cranial helmet:

Custom cranial remolding orthotic devices are covered by Medicaid when it is determined medically necessary to correct a moderate to severe craniofacial deformity. Supporting documentation, at a minimum, must include:

A prescription from an orthopedic or craniofacial surgeon; and
Clinical evidence, including measurements, indicating the infant's current cranial index of symmetry (CIS) is <83; and

Current color photographs of the infant's head, taken from the following views:

- Superior;
- Frontal;
- Posterior;
- Right and left lateral; and

A statement from a treating orthopedic or craniofacial surgeon, stating that treatment using a cranial remolding orthosis is recommended due to poor improvement in the infant's CIS, after a documented six (6) months trial period of active counter positioning has been completed; and

Six (6) month's worth of documentation regarding daily counter positioning therapy.

23. The petitioner's physician prescribed a cranial helmet, but it was not approved by United Healthcare. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

24. The respondent's witness stated the petitioner did not meet the requirements for the cranial helmet at this time since his cephalic index was not less than 83.

25. The petitioner's mother stated she has tried repositioning for over 6 months and it has not corrected the head deformity.

26. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not established by a preponderance of the evidence that the requested cranial helmet is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). The submitted medical evaluation shows a cephalic index of 87.9, and the applicable criteria require this index to be less than 83. Accordingly, the health plan correctly denied the requested cranial helmet based on the information currently available.

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

FINAL ORDER (Cont.)

17F-01850

PAGE - 10

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 11 day of May, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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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
UNITED HEALTH CARE HEARINGS UNIT

FILED

Jun 05, 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-01884

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 [REDACTED]
UNIT: 23013

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 24th, 2017 at 3:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Agency Representative for "Outreach Medical Assistance"

For the Respondent: Jennie Rivera, ESSSII for the ESS program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's denial of Medicaid application dated February 1st, 2017, based on an existing Child Support Enforcement (CSE) sanction against the petitioner. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner is deceased, but was represented as indicated above.

Appearing as a witness for the respondent was Ms. Sandra Fisher, Revenue Specialist-3 from the Child Support Enforcement (CSE), Department of Revenue.

Appearing as a witness for the respondent was Ms. Shawna Riles, Revenue Service Center Manager from the Child Support Enforcement (CSE). However, this witness exited from the call a few minutes into the hearing, and is not a participant to this proceeding.

The petitioner passed away on January 23rd, 2017. On February 1st, 2017, [REDACTED] from "Outreach Medical Assistance" designated himself as a representative for the petitioner and submitted a web application to the respondent requesting posthumous Medicaid for the petitioner from January 21st through 23rd, 2017. (Respondent Exhibit 6)

At the hearing, Ms. [REDACTED] appeared as the representative for the petitioner. The representative stated that she had never met the petitioner, nor did she know the petitioner's circumstances.

The respondent recognized the medical representative as the designated representative for the petitioner, and the hearing proceeded.

At the hearing, the petitioner did not submit any evidence.

At the hearing, the respondent submitted one composite exhibit, and six other exhibits which were marked and entered into evidence as Respondent's Composite Exhibit 1, and Respondent's Exhibits 1 through 6 respectively.

FINDINGS OF FACT

1. By way of a Notice of Case Action (NOCA) dated February 6th, 2017, the respondent informed the petitioner that it had denied the petitioner's Medicaid application due to an existing child support sanction (CSE) against the petitioner. (Respondent Exhibit 2)

2. The petitioner's designated representative did not contest the validity of the sanction; however, she contends that since the petitioner has already deceased, any child support sanction (CSE) should not exist. She argued that the petitioner had tried to comply with CSE in the past, and if she had still been alive, she would have cooperated. The representative also argued that the application was for SSI-related Medicaid; therefore, a CSE cooperation is not necessary. The representative further contends that the petitioner does not have custody of her children now since she has passed away.

3. The respondent stated that the CSE sanction was in effect since March 1st, 2015, and the petitioner was informed of the sanction and the need to cooperate as early as June 20th, 2015 by way of NOCA. (Respondent Exhibits 5 & 2 respectively)

4. The respondent stated that in order to be eligible for Medicaid, a parent or caretaker relative has to cooperate with child support enforcement, and failure to do so will result in a sanction. Once a child support sanction is imposed, it cannot be removed unless instructed by Child Support Enforcement.

5. The respondent stated that it does not matter whether the request was for Family-related or SSI-related Medicaid, a CSE sanction applies to all programs. For posthumous

Medicaid, the respondent has to determine eligibility for the individual as it existed prior to the individual's death. (Respondent Exhibit 1)

6. The respondent's witness testified that a CSE file was created for the petitioner as early as November 3rd, 2016, and judicial activity was created for the case to proceed forward. An appointment notice for a genetic testing was scheduled for December 12th, 2016 and a notice was generated and mailed to the petitioner on November 21st, 2016. The petitioner, did not appear for the genetic testing, stating that she was working on that day, but would walk in the next day. However, she did not appear on December 13th, 2016. After a seven-day procedural wait period, another notice was issued informing the petitioner that her case will be closed. The petitioner was never heard from again, and the case was moved to evaluate closure, and marked as non-cooperative as of January 1st, 2017. (Respondent Composite Exhibit 1)

7. The respondent's witness testified that a sanction cannot be removed just because the petitioner is now deceased. The petitioner was given ample opportunity to cooperate with the CSE requirement, but she failed to do so.

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...

15. 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...

13. 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.

14. 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.

15. In this instance, the petitioner was informed of the requirement to cooperate with CSE, both by the Department of Children and Families and by the Department of Revenue. The Department of Revenue (CSE) scheduled the petitioner for genetic testing and when the petitioner failed to appear, provided additional days to comply. The petitioner still failed to comply with the requirement.

16. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent’s action to deny the petitioner’s application for Medicaid based on existing child support sanction 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 05 day of June , 2017,

in Tallahassee, Florida.



Sajan George
Hearing Officer
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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

May 05, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-01927

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 April 18, 2017 at 9:35 a.m.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

Whether it was correct for Respondent to terminate Personal Care Services (PCS) for the certification period February 19, 2017 to August 17, 2017. Respondent is assigned the burden of proof for the termination of services. Petitioner also requested 2 additional hours of PCS on early release school days. Petitioner is assigned the burden of proof for the additional PCS service hours.

PRELIMINARY STATEMENT

Rakish Mittal, M.D., Physician Consultant with eQHealth Solutions, Inc., appeared as a witness for Respondent.

Respondent's 5 exhibits were entered into evidence.

Petitioner is currently receiving 4 hours of Personal Care Services (PCS) Monday through Friday, 6 hours of PCS on Saturday and Sunday, and an additional 4 hours of PCS on non-school days. He is administratively approved to continue receiving these PCS hours, pending the outcome of this 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 15-year-old Medicaid recipient diagnosed with [REDACTED], [REDACTED] and [REDACTED] which presents with passive-aggressive personality.
2. Petitioner lives with his mother, 10-year-old sister, and 12-year-old brother. The brother is diagnosed with [REDACTED], and [REDACTED]. The mother has medical limitations associated with a prolapsed disk and cannot lift more than 10 pounds.
3. The mother was working during the previous certification period but is not working at this time. She was attending school but due to financial constraints had to stop.
4. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PCS 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 February 14, 2017, Petitioner's provider submitted a request for Petitioner to continue receiving PCS with an increase of 2 additional hours of service on early school release days.

7. On February 22, 2017, an eQHealth Solutions physician consultant reviewed the request and denied the Personal Care Services. A "Notice of Outcome-Denial Private Duty Nursing/Personal Care Services" was issued to Petitioner on February 23, 2017, denying PCS services. The rationale for the denial was PCS services were not medically necessary as defined in 59G-1.010 (166) of the *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 February 23, 2017, a "Notice of Outcome" was issued to Petitioner's provider and gives the following clinical rationale:

The patient is a 15-year-old male with [REDACTED], passive-aggressive personality, aggressive behavior and [REDACTED]. The patient does not have a G-tube or a tracheostomy. The patient is on a regular diet. The patient's medications include [REDACTED]. The patient is ambulatory, non-verbal and incontinent. The patient requires assistance with activities of daily living. The patient attends school Monday to Friday from 9:15 a.m. to 3:15 p.m. The mother is the sole caregiver and has physical limitations with a 10 pound lifting restriction related to back and neck pain from [REDACTED]. The mother no longer works or attends school. There is a 10-year-old sibling that also lives in the house. Because the mother is no longer working or attending school and can provide care on Sundays, the clinical information provided does not support the medical necessity for any personal care services. Caregivers are expected to care for patients to the fullest extent possible. Constant monitoring and supervision are not covered benefits.

9. Petitioner did not request a reconsideration review.

10. Petitioner filed his request for a fair hearing on February 28, 2017.

11. Respondent's physician consultant opined that based on the mother's medical limitations and Petitioner's need for assistance with his activities of daily living, he was approving 4 hours of PCS Monday to Friday, and 6 hours on Saturday, Sunday, non-school days and early release school days. Petitioner arrives home at 1:00 p.m. on early release school days.

12. Petitioner's mother stated she needed 8 hours of PCS on non-school days. She explained her son becomes more aggressive with his siblings when he does not go out. When she takes him out he runs away often into the street. Recently, she took him to a doctor's appointment and he left the clinic and was found in the street. The mother stated she needs someone with her to help keep her son under control and out of danger.

13. Respondent's physician consultant explained that PCS services are for helping with Petitioner's activities of daily living (feeding, oral hygiene, toileting, bathing, etc.) and cannot be provided to address Petitioner's behavior issues, although these issues are a serious matter and a challenge for the mother.

14. Petitioner's mother responded she needs someone to stay with Petitioner when she takes the other children to therapy or she runs other errands. She explained she previously received 8 hours of PCS during the summer months when her son was not admitted to summer camp due to his aggressive behaviors. She is requesting 8 hours for non-school days in preparation for the summer months (June to August) when her son is not in school.

15. Respondent's physician consultant explained he could not approve 8 hours for the summer months because Petitioner may be accepted into summer camp. He also stated there has been no evidence, documentation, or testimony that supports the medical necessity for Petitioner to receive 2 additional hours of PCS on non-school days. Respondent's physician consultant explained Petitioner can submit a modification request when she has documentation in support of an additional 2 hours of PCS a day during the summer months if he is not accepted in a summer camp.

16. Petitioner's mother responded in the past she was approved for 8 hours of PCS for the summer months before she knew her son's summer camp status. She stated she later called when he was accepted to summer camp.

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

Chapter 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

18. 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.

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

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

21. 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*.

22. Rule 59G-1.010 (166) of the *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.

23. The Florida Medicaid Personal Care Services Coverage Policy, November 2016 (PCS Policy) is incorporated by reference in Rule 59G-4.215 of the *Florida Administrative Code*. The Rule states all providers must be in compliance with the provisions of this policy.

24. The PCS Policy states as follows:

Section 1.1.1

This policy is intended for use by providers that render personal care services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service specific and claim reimbursement policies with which providers must comply.

....

Section 4.2 Specific Criteria

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

....

Section 4.2.1, Parental Responsibility

Florida Medicaid reimburses for personal care services 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.

....

Section 4.3, 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.

....

Section 5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved plan of care (POC)
- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities
- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act

- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence
- Yard work, gardening, or home maintenance work

25. During the hearing, Respondent approved 4 hours of PCS Monday to Friday, and 6 hours on Saturday, Sunday, non-school days, and early release school days. This action approves the 2 additional hours Petitioner requested on early release school days. Respondent's action also reduces PCS services on non-school days from 8 hours to 6 hours.

26. Respondent's decision was based on the mother's availability to care for Petitioner since she is not currently working or attending school. The mother's medical limitations and Petitioner's aggressive behaviors were also considered in approving the PCS services. Respondent explained the PCS worker could not be used to supervise (or babysit) Petitioner while the mother took her other children to therapy sessions.

27. Petitioner's mother insisted she needs 8 hours of PCS on non-school days. She initially explained she needed the 8 hours of PCS because she needed someone to watch Petitioner while she took her other children to therapy sessions or ran other errands. She was unable to explain what PCS services would require 8 hours to

complete. She also stated she previously received 8 hours of PCS per day during the summer when Petitioner was not in a summer camp.

28. Rule 59G-1.010 (166) of the *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. Additionally, the services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

29. Respondent's decision is based on all the information provided by Petitioner, as well limitations cited in The Florida Medicaid Personal Care Services Coverage Policy. The PCS hours approved by Respondent are based on a determination of medical necessity.

30. Petitioner has failed to provide sufficient evidence or testimony to establish a medical need for an additional 2 hours of PCS on non-school days.

31. The undersigned has reviewed all the above cited authorities and applied these to the totality of the evidence.

32. Respondent has met its burden of proof in reducing PCS service hours on non-school days from 8 hours to 6 hours. At this time, Petitioner is approved 4 hours of PCS Monday to Friday, and 6 hours on Saturday, Sunday, non-school days, and early release school days.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is hereby DENIED and the Respondent's action, as amended during the hearing, 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 05 day of May, 2017, in Tallahassee, Florida.



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

Jun 27, 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-01979

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 88261

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 18, 2017 at approximately 8:04 a.m. CDT

APPEARANCES

For the Petitioner: [REDACTED] *pro se*, and [REDACTED], her son

For the Respondent: Jonathan Daniels, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 7, 2016 denying her November 22, 2016 application for Medicaid for the reason, "No household members are eligible for this program. 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".

On April 13, 2017, all parties met. Present were the petitioner, her son. Teshia Green was present for the respondent. After a pre-hearing conference, a continuance was requested. The hearing was rescheduled for May 18, 2017.

A packet of information was received from the petitioner containing medical records. This information was admitted into evidence and marked as Petitioner's Exhibit "1".

The record was left open for the respondent to provide information from the Division of Disability Determination (DDD) and from the Social Security Administration, (SSA) along with any new evidence. Nothing was received from the respondent. The record closed on May 25, 2017.

FINDINGS OF FACT

1. On November 22, 2016, the petitioner submitted an application to the respondent requesting Food Assistance Program benefits and Medicaid. This hearing deals only with Medicaid. On this application, the petitioner answered "no" to the question concerning her being disabled (Respondent's Exhibit 3).
2. The petitioner is a single female, age 61 at the time of application, who has no dependent minor children in her home, nor is she pregnant.
3. On December 7, 2016, the respondent mailed a notice of case action (NOCA) denying her November 22, 2016 application for Medicaid for the reason, "No household members are eligible for this program" (Respondent's Exhibit 5). At the time of this

denial, the respondent concluded that the petitioner had not claimed to be disabled on her application, had not been determined disabled by the Social Security Administration (SSA); therefore, her Medicaid application was denied as she did not meet the technical requirement of disability.

4. The respondent found that during preliminary contact concerning the hearing, the petitioner had attempted to advise the respondent that she was disabled. At that time, her case was reopened and she was requested to provide documentation of application with the SSA, financial and medical release forms and medical records (Respondent's Exhibit 6).

5. During the hearing, it was discovered that medical records provided by the petitioner were not included in the evidence. The respondent emailed the undersigned a copy of these records containing medical information received by the petitioner after the SSA denial of disability benefits.

6. Final action on the November 22, 2016 Medicaid application still awaits disposition.

7. The petitioner is requesting an independent disability determination be completed by DDD.

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.

9. 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. 65-1.203 Administrative Definitions (4) states: "Date of Application: The date the Department receives an application. If a web or facsimile application is received after business hours, the next business day following receipt is the date of application. Applications may be submitted in person, by the postal system, facsimile or electronically."

12. In accordance with the above cited authority, the date the department receives an application is considered the date of application for an application. The petitioner submitted her application requesting FAP and Medicaid benefits on November 22, 2016.

13. Fla. Admin. Code R. 65-1.205 Eligibility Determination Process (1)(a) states in pertinent part, "The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter."

14. The above cited authority explains that the department must determine an applicant's eligibility at application. The respondent acknowledges that the December 7, 2016 Medicaid eligibility determination based on the petitioner's November 22, 2016 application was denied in error and that no subsequent determination has been made.

15. Fla. Admin. Code R. 65-1.702 Special Provisions states in the pertinent part:

(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... Eligibility for Medicaid begins the first day of a month if an individual was eligible any time during the month...

(7) (e) If a case is re-opened and the department discovers that an error was made in the eligibility determination, benefits must be provided retroactively as follows:

1. If an application was denied, benefits will be awarded back to the date of eligibility provided all other eligibility requirements are satisfied.

16. The above cited authority explains the date of eligibility for Medicaid begins on the first day of the month of application. The authority further explains if a case is re-opened and it is determined a mistake has been made, the benefits will be awarded back to the original date of eligibility.

17. The petitioner's request for Medicaid has not been completed to date.

18. The petitioner has met her burden of proof. The action taken to deny her Medicaid benefits on December 7, 2016 is in error. The respondent is ordered to complete a determination of disability-related Medicaid protecting her November 22, 2016 date of application. Upon determination of eligibility, a notice of case action shall be issued to the petitioner, and such notice must contain appeal rights. If the petitioner disagrees with the decision, she will have the opportunity then to appeal it.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the Department for the corrective action described 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

FINAL ORDER (Cont.)

17F-01979

PAGE -6

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 27 day of June, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

May 25, 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-02024

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 05 [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 April 19, 2017 at 1:14 p.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Deborah Smith, United director of pharmacy services

STATEMENT OF ISSUE

Whether the petitioner proved by a preponderance of the evidence that it is medically necessary for him to receive the prescription drug [REDACTED]. The burden of proof was assigned to the petitioner.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. 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 February 10, 2017, United informed the petitioner that his request for the prescription drug Harvoni was denied. The notice reads in pertinent part: “the requested services are not medically necessary...”

The petitioner requested reconsideration.

By notice dated February 17, 2017, United informed the petitioner that the original denial decision was upheld.

The petitioner timely requested a hearing on March 3, 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 from United: Christian Laos, senior compliance analyst.
Present as an observer from AHCA: Stephanie Lang, 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 the close of business on the day of the hearing for the submission of additional evidence. Evidence was received from the petitioner and admitted as Petitioner’s Exhibit 2.

The hearing record was closed on April 19, 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 57) is a Florida Medicaid recipient. The petitioner is enrolled with United HMO. (Respondent's Composite Exhibit 1)

2. The petitioner's medical history includes [REDACTED]. The petitioner underwent a 12 week treatment with the prescription drug [REDACTED] July 31, 2015 – October 16, 2015. The petitioner asserted that the [REDACTED] treatment cured the virus. However, in late 2016, the virus returned. (Petitioner's testimony)

3. The petitioner's treating physician submitted a prior service authorization to United for retreatment with [REDACTED] 24 weeks. (Respondent's Composite Exhibit 1)

4. All Medicaid goods and services must be medically necessary. Specified goods and services, such as the prescription drug [REDACTED], require prior authorization. The respondent reviews the request form(s) and supporting documentation to make the coverage decision. (Respondent Composite Exhibit 1)

5. The respondent denied the petitioner request in a notice dated February 10, 2017. The notice reads: [REDACTED] is given to patients who have not taken certain medicines before. The facts given to us who you have taken these medicines before...."

6. The petitioner requested reconsideration. His treating physician included a letter of necessity with the reconsideration request. The letter reads in pertinent part:

[Patient] is a 57 year old male that has a diagnosis of [REDACTED] for which [REDACTED] is being prescribed....Patient is a candidate for a total of 24 weeks of therapy because the patient is treatment experienced with compensated [REDACTED]. My patient recently failed a 12 week regiment of [REDACTED], but that does not mean he cannot be retreated with [REDACTED]. Per AASLD, patients who have previously failed [REDACTED] can be retreated with [REDACTED] for a total of 24 weeks. My patient has [REDACTED] and cannot go untreated thus it is in his best interest to obtain approval so he can clear this virus and achieve desired SVR. If my patient's condition is not treated effectively, a liver transplant would be necessary in the future yielding a cost of about \$577,100....It is my responsibility as his physician to seek the best treatment option for my patient. Given my patient's clinical status, it is my professional opinion that [REDACTED] is medically necessary and appropriate. Delaying treatment any further could lead to risks, complications that lead to hospitalization, further liver compensation and possibly death associated with [REDACTED] (Respondent's Composite Exhibit 1)

7. The respondent upheld the original denial decision in a letter dated February 17, 2017. (Respondent's Composite Exhibit 1)

8. Deborah Smith, United director of pharmacy services, explained that all Medicaid HMOs are required to follow AHCA clinical guidelines which govern the provision of prescription drugs. The guidelines are published on AHCA's website. AHCA's retreatment guidelines for the drug [REDACTED] require the treating physician to submit clinical tests which prove the patient has not developed a resistance to the drug. The documentation submitted by the petitioner's treating physician did not include the required resistance testing results. Contrary to the petitioner's testimony that the initial 12 week [REDACTED] trial was successful, the documentation submitted by his treating physician concluded that the initial trial was not successful. Ms. Smith said it is not common for a treating physician to retry a drug that has previously failed. Industry standards recommend trial of a new drug. (Testimony of Deborah Smith)

9. During rebuttal testimony, the petitioner argued that his treating physician submitted two other prescription drug requests, for [REDACTED], prior to re-submission for [REDACTED] United denied both requests. The petitioner does not understand why the HMO has repeatedly denied multiple drugs his treating physician have determined are medically necessary. (Petitioner testimony)

10. Although the [REDACTED] denials were not at issue in the instant appeal, to address the petitioner's concerns, Dr. Smith explained that [REDACTED] and [REDACTED] contain one or more of chemical ingredients included in [REDACTED]. Accordingly, the same retreatment criteria applies. Patients must submit testing which proves they have not developed a resistance to the drug(s) or chemical ingredients contained in the drugs. The petitioner's treating physician did not file the required resistance tests. (Testimony of Deborah Smith)

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. 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.

18. The respondent denied the petitioner's request for the retreatment with prescription drug [REDACTED], to address his [REDACTED] because there was insufficient clinical data to determine if the drug was medically necessary. More specifically, the petitioner's treating physician did not file test results which proved the petitioner had not developed a resistance to the drug as a result of the previous 2015 failed [REDACTED] trial.

19. The petitioner argued that the appeal should be granted because the opinion of his treating physician, regarding the medical necessity of the requested drug, should carry greater weight than the opinion of a reviewing HMO.

20. Medicaid rules state that requested goods and services must be consistent with generally accepted professional medical standards as defined by the Medicaid program. For retreatment with the prescription drug [REDACTED] Medicaid requires testing which proves that the patient has not developed a resistance to the drug. The undisputed evidence in the instant case proves that the petitioner did not provide the required resistance tests. There is insufficient evidence to prove that retreatment with [REDACTED] is safe and/or the most effective course of treatment, as required by the controlling legal authorities. The petitioner's argument regarding the opinion of his treating physician taking precedence over the opinion of the HMO reviewer in this matter was considered. However, Medicaid rules state that the opinion of the treating physician is not controlling if the opinion is not supported by the required medical evidence.

21. 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 for him to receive the prescription drug [REDACTED]. The respondent's decision in this matter is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. 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 25 day of May, 2017,
in Tallahassee, Florida.



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Hearing Officer
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FINAL ORDER (Cont.)

17F-02024

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

FILED

May 23, 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-02046

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 April 4, 2017, at 1:30 p.m.

APPEARANCES

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

For the Respondent: Cindy Henline, Program Analyst - AHCA

STATEMENT OF ISSUE

At issue is the respondent's action terminating the petitioner's 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 guardianship documents 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 Notice, Case System Screenshots, Appeal Request, and Medical Assessment Form.

Also present for the hearing was a Spanish language interpreter [REDACTED]

[REDACTED], from Propio Language Services.

FINDINGS OF FACT

1. The petitioner is eighty-two (82) years of age and lives with her granddaughter. She also receives assistance from her daughter. She has been diagnosed with [REDACTED]

[REDACTED] She is incontinent and non-verbal. She is non-ambulatory and utilizes a wheelchair.

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: 15 hours weekly of personal care assistance, 7 hours weekly of homemaker care services, 10 hours weekly of companion care, incontinence supplies, and a nutritional supplement (food thickener).

5. On January 27, 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.

6. The petitioner's daughter stated her mother needs assistance 24 hours per day. Both the daughter and granddaughter work during the day and are unable to assist her during that time. She stated her mother also has [REDACTED] and can choke on her saliva. Her mother sometimes needs supplemental oxygen. The currently approved home health hours are being utilized for 4 hours daily on Monday to Friday

(from 8:00 a.m. to 12:00 p.m.) and 2 hours daily on the weekend. In addition, the daughter pays herself for the home health aide to stay with her mother until she returns from work at around 6:00 – 7:00 p.m.

7. The respondent's witness, Dr. Kaprow, stated the decision was made to terminate the companion 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 15 hours weekly. Companion services do not involve hands-on care since they are intended to assist with things such as supervision of the patient. The health plan determined that companion services were in excess of the petitioner's needs. He also stated the petitioner suffers from severe cognitive impairment.

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 not demonstrated it was correct in reducing or terminating the petitioner’s home health services under the LTC Program. The petitioner clearly needs assistance with activities of daily living (ADLs) such as ambulation, bathing, toileting, and meal preparation. The health plan approved an increase in personal care services to assist with these activities while terminating the companion care services. The reduction in total home health services was from 32 hours weekly to 28 hours weekly (21 hours of personal care and 7 hours of

homemaker). However, the evidence presented establishes the petitioner's services should not be reduced at this time. She suffers from severe cognitive impairment and her daughter and granddaughter are not available to assist her during the day when they are at work. The scope of companion services includes supervision of a functionally impaired adult.

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 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 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 May, 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer

FINAL ORDER (Cont.)

17F-02046

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

FILED

May 05, 2017

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-02076

PETITIONER,

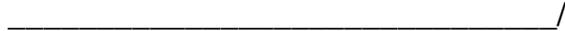
Vs.

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 May 1, 2017 at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent: Selwyn Gossett, Medical Program Analyst
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent Simply Healthcare's denial of the petitioner's request for 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.

Appearing as witnesses for the petitioner were three personal friends – [REDACTED]

Appearing as witnesses for the respondent were Deborah Zamora, Grievance and Appeals Team Lead, and Dr. Francisco Hernandez, Medical Director, from Simply Healthcare, which is the petitioner's managed health care plan. Also appearing as witnesses for the respondent were Charles Keiffer, Complaints and Grievance Specialist, and Dr. Susan Hudson, Dental Consultant, from DentaQuest, which reviews dental claims on behalf of Simply Healthcare.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Copy of Claim Payment, Authorization Request, Denial Notice, and Dental Director Review Form.

Also present for the hearing was a Spanish language interpreter, [REDACTED], Interpreter No [REDACTED], from The Language Line.

FINDINGS OF FACT

1. The petitioner is a forty-seven (47) 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 February 28, 2017, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Simply Healthcare and/or DentaQuest for approval of complete upper and lower dentures. Simply and DentaQuest denied the request for dentures on February 28, 2017 as not being a covered benefit.

3. The denial notice sent to the petitioner advised her of the following reason for the denial of her request for the dentures:

You can have this service once per lifetime. Our records show that you already got this service in the past. We have also told your dentist.

4. The petitioner stated her dentist removed all her teeth without her permission approximately one year ago. She believed only some of her teeth would be extracted so she could receive partial dentures. She thereafter received full dentures but she states they were not made correctly and they have damaged her mouth. She became depressed because of this, had difficulty eating, and lost 60 pounds. Her dentist submitted a request for a new set of dentures. However, at this point, she is not requesting new dentures – she is trying to obtain some compensation or redress from her dentist for removing all her teeth without her consent.

5. The petitioner's witnesses described all the problems she has experienced due to having all her teeth removed and not being able to wear her dentures.

6. The respondent's witness, Ms. Zamora, stated Simply Healthcare denied the 2017 request for the dentures because it exceeded the covered benefit of one set of dentures per lifetime. The petitioner received a complete set of dentures in December, 2015.

7. Mr. Keiffer from DentaQuest stated that DentaQuest reviewed the petitioner's complaint concerning her dentist and the original dentures, but no quality of care issues were found in that regard.

8. 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

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. 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.).

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, AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

14. 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.”

15. 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.

16. 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.

17. 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.

18. Managed care plans, such as Simply Healthcare, 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.

19. The petitioner's main concern appears to be in obtaining financial compensation or other redress from her dentist since she claims the dentist removed all her teeth without her permission. The petitioner is also seeking assistance regarding obtaining legal counsel to represent her in pursuing those claims.

20. As was explained to the petitioner during the hearing, those issues cannot be addressed as part of the Medicaid fair hearing process. The purpose of a fair hearing is to address the denial, reduction, or termination of Medicaid services and benefits. The hearing officer cannot provide legal advice or appoint legal counsel for the petitioner. The petitioner would need to pursue any professional complaint against the dentist through the appropriate licensing agency – the Florida Department of Health's Board of Dentistry. The petitioner would also need to obtain legal counsel on her own and she may be able to obtain assistance in that regard through any local legal services organizations or attorney referral services.

21. The respondent's witness stated the 2017 request for dentures was denied because the petitioner had already received dentures in 2015.

22. After considering the evidence and testimony presented, the undersigned concludes the respondent correctly denied the petitioner's request for the dentures. The Simply Healthcare dental plan provisions and the Florida Medicaid Dental Policy contain a limitation of one set of dentures per lifetime. Therefore, the petitioner is not

entitled to a new set of dentures through her Medicaid coverage. As stated above, the petitioner's other issues cannot be addressed as part of the Medicaid fair hearing process.

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 05 day of May, 2017,
in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
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AHCA, MEDICAID FAIR HEARINGS UNIT
SIMPLY HEARINGS UNIT

FILED

Jun 05, 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-02081

PETITIONER,

vs.

MANAGED CARE ORGANIZATION,
AND
AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, this matter convened for hearing before Hearing Officer Patricia C. Antonucci on May 16, 2017 at approximately 10:06 a.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's Daughter/Power of Attorney

For the Respondent, Sunshine Health: John M. Carter, M.D.,
Long Term Care Medical Director

STATEMENT OF THE ISSUE

At issue is a decision made by Respondent, the Agency for Health Care Administration (AHCA or "the Agency"), through its contracted health plan, Sunshine Health ("Sunshine"), to reduce Petitioner's Home Health Services (HHS), including: a reduction of Homemaker services from 56 hours/week to 7.5 hours/week, and a

reduction of Personal Care Assistance (PCA) from 56 hours/week to 53 hours/week.

Sunshine Health also proposes termination of Petitioner's Home-Delivered Meals (HDM) and Consumable Medical Supplies (CMS). As the proposed actions are reduction/termination of previously authorized services, Respondent bears the burden of proving, by a preponderance of the evidence, that its decisions are correct.

PRELIMINARY STATEMENT

Via a March 31, 2017 Notice of Hearing, all parties were informed that a telephonic hearing in this matter would convene on May 16, 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] his daughter, who holds Power of Attorney. Ms. [REDACTED] explained that Petitioner does not wish to contest the reduction on PCA services, nor challenge the termination of HDM or CMS; however, Petitioner asserts that he still requires the full allotment of 56 Homemaker hours, each week.

Respondent, Sunshine, was represented John M. Carter, M.D., Sunshine's Long Term Care Medical Director, who presented six additional witnesses: Maria Nieves, Care Coordinator/Case Manager; Kimberly Bouchette, Clinical Appeal Coordinator; Joerosa Davis, Senior Manager of Appeals and Grievances; Kizzy Alleyne, Paralegal;

Tammi Swan, Director of Case Management; and Kritzia Torres-Rodriguez, Supervisor of Case Management.

Bonnie Taylor, Program Administrator of the Agency's Jacksonville Field Office, observed the proceedings on behalf of AHCA. Respondent's Exhibits 1 through 8, inclusive, and Petitioner's Exhibits 1 and 2, inclusive, were accepted into evidence. Administrative Notice was taken of Fla. Admin. Code R. 59G-1.010. This Final Order follows.

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 79-year-old male, born in [REDACTED]. At all times relevant to this appeal, Petitioner has been eligible for and receiving services through Medicaid.
2. On or about October 1, 2015, Petitioner became a member of Sunshine Health, a managed care organization (MCO), contracted with AHCA to provide Long Term Care (LTC) services to eligible Medicaid recipients.

3. The Petitioner is diagnosed with multiple medical conditions including [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] He has a history of hallucinations and aggressive behavior. He requires oxygenation and suctioning several times per day.

As of the date of hearing, his prognosis was considered terminal.

4. Petitioner is incontinent of bladder and bowel. He requires total assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). He has become largely confined to his hospital bed, requiring wheelchair van transport to leave his home.

5. Following discharge from the hospital on February 15, 2017, the Petitioner has been on a thickened liquid diet, which is fed to him to prevent aspiration and ensure adequate nutrition. Nonetheless, he has lost approximately 10 pounds over the course of three months. The Petitioner also takes psychotropic medications, which are managed and administered by his daughter. He requires consistent, heightened supervision due to [REDACTED] and his declining physical health.

6. The Petitioner began receiving limited Hospice services in February of 2017. Hospice currently provides about 1-3 hours/week of PCA, nurse visits (as needed), monthly doctor visits, medication, and CMS.

7. The Petitioner lives at home with his wife, who once acted as his caregiver. In August of 2016, the Petitioner pushed his wife over and then fell on top of her, which resulted in her breaking multiple bones. The wife entered a rehabilitation facility, and was subsequently discharged back to the couple's shared residence. She has significant health issues of her own, receives her own HHS, and is now also afraid of the Petitioner, whose behavior towards her is unpredictable. As such, Petitioner's wife is unable to assist in meeting the Petitioner's care needs.

8. Approximately one week after Petitioner's February 15, 2017 hospital discharge, a Case Manager (CM) with Sunshine met with the Petitioner to conduct an updated, Comprehensive Assessment of his needs. Said Assessment (a "701-B") was

administered in the Petitioner's home environment. The report generated from the Assessment (dated February 22, 2017) notes that Petitioner's condition has gotten worse over the course of the last year. He has visited the hospital at least three times, after being found unresponsive or in respiratory failure. He is now unable to perform self-care, which is provided via a HHS worker while Petitioner remains in bed. His meals must be pureed, he utilizes incontinent briefs, and to mobilize, he must be pushed in a manual wheelchair.

9. As a result of the scoring on his 701-B, Sunshine's automated rating system recommended the following services as potentially beneficial towards meeting Petitioner's needs: assistance with meals, adult day care, caregiver support, medication review, respite services, CMS, a Personal Emergency Response System (PERS), companion care, home delivered meals/nutritional supplements, and medical referrals.

10. Via Notice of Action dated February 28, 2017, Sunshine informed Petitioner of its decision to reduce or terminate most of Petitioner's services. It is unclear why this notice references a review of "your [i.e., Petitioner's] request... which we received on 2/22/17" as there is no indication that Petitioner requested any change to his service array. More specifically, however, the Notice states:

After our review, this service has been: REDUCED, TERMINATED as of 3/10/17. We made our decision because:

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 individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

...

X Other authority: Sunshine Health looked at the member's present care needs, and provided home services and supplies. The member's present care plan with Sunshine Health includes 56 hours/week Companion Care Services + 56 hours/week Homemaker Services + 56 hours/week Personal Care Services, for a total of 168 hours/week combined home services... The member also receives home services and supplies from his Hospice Provider. Based on the assessment of the member's care needs and household and caregiver status, Sunshine Health will reduce Homemaker Services from 56 to 7.5 hours/week... **The updated care plan will include 56 hours/week Companion Care Services + 7.5 hours/week Homemaker Services + 53 hours/week Personal Care Services, for a total of 116.5 hours/week combined home services.** (emphasis original)

11. On March 7, 2017, Petitioner's daughter contacted the Office of Appeal Hearings to appeal this determination. She did not realize that by filing this request for hearing prior to Sunshine's proposed date of reduction implementation (i.e., March 10, 2017), Petitioner reserved the right to maintain his services at their current level, pending disposition of his appeal. Upon receipt of the hearing request, Sunshine Health did not confirm with Petitioner that his Homemaker services would remain at 56 hours/week.

12. Due to this confusion, Petitioner's daughter unilaterally reduced provision of his Homemaker services for approximately two weeks, informing his CM of same around March 10, 2017, and explaining that this reduction would be difficult to manage. The CM did nothing to correct this misunderstanding. As a result, Petitioner's daughter stopped staffing his Homemaker at the full 56 hours/week.

13. On or about March 19, 2017, Petitioner's daughter submitted a form to Sunshine's Appeal and Grievances Department to express her concerns. Within this form, the daughter noted, in part:

... at present his is getting 116.5 hours which is insufficient, it's not working out in the patient's best interest, he is being left for many hours without any help, he is coughing up a lot of secretion and needs to be suction[ed] frequently.

14. The daughter restored Petitioner's services to 56 hours/week (168 hours/week, total) when Sunshine informed her that said services were "reinstated."

15. At hearing, Sunshine Health testified with regard to its procedure for assessing a long term care member's needs, via the Comprehensive Assessment/701-B, and then comparing same to an internally-developed "LT.UM Criteria."

16. No prior Assessment (i.e., predating the February, 2017 701-B) was proffered into evidence for comparison as to Petitioner's past versus present needs; however, Sunshine does not contend that Petitioner's condition has improved.

17. Sunshine testified that its decision to reduce Homemaker was essentially based on duplication/overlap of services, in that: (1) Respite now covers a portion of Petitioner's care; and (2) Petitioner's wife receives 17 hours/week of LTC services (including 6 hours/week Homemaker), provided by the daughter, via the Participant Directed-Care Option (PDO). Sunshine argued that these latter hours, though designated to the wife and not authorized at a ratio other than 1:1, can be considered as coverage for both individuals.

18. Sunshine clarified that if an agency-based provider were authorized to provide the wife's services, Sunshine would not consider those hours to double as supervisory services for Petitioner; however, because it is the daughter who provides the service, Sunshine believes she can supervise her father while caring for her mother, too.

19. Petitioner's daughter argued that if she simultaneously provides services for her mother while also monitoring her father, one of her parents will end up receiving inferior care. Additionally, if there is an emergency that requires she attend to one parent, the other will be left alone. The daughter further explained that in her culture, it is improper

for a daughter to provide hygienic assistance to her father. As such, her father would not permit her to assist him with self-care. He requires agency-based staff to provide this service.

20. Respondent had no explanation as to why a PDO-participant member would be treated differently than a member receiving services from a provider agency.

Additionally, Sunshine could not explain how, even factoring in the wife's 17 hours of PDO *and* Petitioner's newly commenced Respite services of 3 hours/week (total of 20 hours/week) towards Petitioner's care could justify or offset a 48.5 hour reduction to Petitioner's Homemaker services

CONCLUSIONS OF LAW

21. 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.

22. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Fla. Stat., and in Chapter 59G, Fla. Admin. Code. Respondent, AHCA, administers the Medicaid Program.

23. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

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

25. The burden of proof in the instant case is assigned to Respondent, who proposes a reduction of Petitioner's previously authorized Home Health Services.

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

27. The Florida Statutes addresses mandatory Medicaid services under the State Medicaid Plan at § 409.905, which states:

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....
(emphasis added)

28. Also 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.

Additional exemptions are noted at § 409.972, Fla. Stat.

29. No evidence was presented to demonstrate that Petitioner may opt-out of managed care for his Long-Term Care needs.

30. 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, while § 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 Sunshine Health.

31. Respondent contends that its decision to reduce Petitioner's Homemaker was based, not on any improvement in Petitioner's medical condition – indeed, Sunshine agrees that Petitioner's condition is worsening – but on a change in the services that are provided to both the Petitioner and to his wife. For this reason, Sunshine contends that the previously authorized frequency of Homemaker services is not medically necessary because it is in excess of Petitioner's needs.

32. Medical necessity is defined by Fla. Admin. Code R. 59G-1.010(166), in part, 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:

...

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...

33. There is no evidence that Petitioner's medically necessary care needs have decreased, such that a reduction in total service hours is proper. Again, if anything, the totality of the evidence suggests that since Petitioner first became enrolled with Sunshine Health, his needs have increased, *and* his former caregiver (his wife)'s ability to provide assistance has decreased.

34. In a similar vein, Sunshine offered no evidence or explanation as to why the addition of 3 hours/week of PCA via Hospice, even if combined with the 17 hours of care per week authorized for Petitioner's *wife*, would justify a reduction of Petitioner's Homemaker services from 56 weekly hours to 7.5 weekly hours. At most, these

services (wife's 17 hours + 3 hours PCA) would suggest a potential overlap of 20 hours/week. However, Sunshine does not propose reducing Petitioner's services by 20 hours, but by 48.5 hours, each week. No explanation to justify this calculation was provided, nor did Sunshine demonstrate that any duplication of actual services is present.

35. Absent proof that Petitioner no longer requires the same frequency/hours of HHS, an overall reduction of the number of care hours -- specifically Homemaker services, which are directed towards Petitioner's task-based needs -- is not supported.

36. Sunshine Health's reduction of these services is not in keeping with the provisions of Medicaid. As such, Respondent has failed to meet its burden to show that the changes in Petitioner's service array are proper.

37. The Agency for Health Care Administration (AHCA) may wish to contact Sunshine Health in order to ensure contract compliance via guidance regarding the treatment of PDO versus agency-based providers.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is hereby GRANTED. Respondent is directed to continue the authorization of Petitioner's Homemaker services at 56 hours/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

FINAL ORDER (Cont.)

17F-02081

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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 05 day of June, 2017,

in Tallahassee, Florida.



Patricia C. Antonucci
Hearing Officer
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Copies Furnished To:

██████████, Petitioner
AHCA, Medicaid Fair Hearings Unit
Sunshine Hearings Unit

FILED

May 22, 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-02106

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 April 18, 2017 at 1:30 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent: Selwyn Gossett, Medical Program Analyst
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent United Healthcare's denial of the petitioner's request for home health aide (HHA) visits was correct. The respondent bears the burden of proving its 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 Dr. Ina Fishman, Medical Director, and Christian Laos, Senior Compliance Analyst, for United Healthcare, which is the petitioner's managed health care plan.

The respondent, United Healthcare, submitted the following documents into evidence, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Case System Screenshots, Authorization Request and Plan of Care (with attached medical records), HHA Visit Reports, and United Healthcare Community Plan provisions.

FINDINGS OF FACT

1. The Petitioner is a sixty-five (65) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan through United Healthcare.
2. The Agency For Health Care Administration (AHCA) is responsible for management of the managed 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.
3. On or about February 14, 2017, the petitioner's home health services provider submitted an authorization request to United Healthcare for approval of three home

health aide (HHA) visit daily. The petitioner had previously been approved for three HHA visits daily.

4 On or about February 21, 2017, United Healthcare informed the petitioner by written notice that his request for home health aide visits had been denied. The denial notice stated the following:

Your doctor has asked for a home health aide for you. We asked your doctor for your medical records. We looked at your medical records. Based on your records this request cannot be approved at this time. Your health plan guidelines do not cover home health care to help with such services as feeding, grooming or dressing.

5. The respondent's witness, Dr. Fishman, stated there must be a skilled component in the patient's care needs in order for the health plan to approve HHA visits. In the petitioner's case, his needs were for assistance with hygiene and activities of daily living (ADLs).

6. The petitioner lives alone and has no caregivers. His medical conditions include

[REDACTED]

[REDACTED] He stated he has back pain and sometimes cannot move due to the pain. He stated his home health aide came to his home twice per day for about 1.5 hours each visit. He stated he has also paid out-of-pocket himself for additional assistance. The aide helps him with bathing, meal preparation, and housekeeping.

7. Home health services under the Medicaid State Plan in Florida are provided in accordance with the respondent AHCA's Home Health Visit Services Coverage Policy ("Home Health Visits Policy"), effective November, 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. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent since the petitioner was previously approved for HHA visits. 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.).

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 Home Health Visits Policy is incorporated by reference in Chapter 59G-4, Florida Administrative Code.

13. Section 409.973, Florida Statutes, sets forth the various services which must be offered by Medicaid MMA plans. “Home health agency services” and “nursing care” are among the required services.

14. The Home Health Visits Policy describes home health services as follows:

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), private duty nursing, and personal care services.

15. The Home Health Visits Policy describes intermittent home health aide visits as follows:

Medically necessary skilled nursing and home health aide services that are provided at intervals for the length of time necessary to complete the service.

16. The Home Health Visits Policy also states the Medicaid Program will provide up to three intermittent home health visits daily for non-pregnant recipients over age 21. Individuals under age 21 and pregnant individuals are entitled to up to four intermittent home health visits daily. The amount of visits is determined by medical necessity criteria.

17. Fla. Admin. Code R. 59G-1.010 defines medical necessity as follows:

(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 ...

18. Section 4.2.2 of the Home Health Visits Policy states the following:

Florida Medicaid reimburses for home health aide visits for recipients under the age of 21 years who have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs.

19. The United Healthcare plan provisions concerning home health care exclude coverage for “custodial care”, which is defined as “[n]on-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring, ambulating and companion services).”

20. The United Healthcare plan provisions also state the following:

This Coverage Determination Guideline provides assistance in interpreting United Healthcare benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersedes this Coverage Determination Guideline.

21. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the respondent has not met its burden of proof in demonstrating it was correct in denying the petitioner’s request for home health visits. The respondent’s position is that an individual over age 21 is not entitled to home health visits unless that individual has a skilled nursing need.

22. Although the undersigned acknowledges that Section 4.2.2 may create an ambiguity with regard to the scope of covered services, there is no reference in the Home Health Visits Policy which denies HHA visits to individuals over 21 if the individual only requires ADL support. The Policy defines Home Health Visits as being both skilled

nursing services as well as home health aide services. The applicable statute also requires MMA plans to offer both home health agency services as well as nursing care. As stated in the United Healthcare plan provisions, if there is a conflict between the plan provisions and state coverage requirements, the state requirements must prevail.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the petitioner is entitled to continuation of his previously approved home health visits.

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 22 day of May, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

17F-02106

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Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

Jun 15, 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-02137

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 [REDACTED]
UNIT: 88129

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 18, 2017 at 11:00 a.m.

APPEARANCES

For the petitioner: [REDACTED], authorized designated representative for the petitioner from [REDACTED] Healthcare

For the respondent: Stan Jones, ACCESS Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his 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 an on-line application on February 1, 2016 to apply for Adult-Related Medicaid benefits. There was no notice sent to the petitioner to inform him that he was denied for these benefits. At the outset of the hearing, the respondent explained that the system did not generate a notice of case action regarding the respondent's action to deny the February 1, 2016 application. On March 9, 2017, the petitioner requested a hearing to challenge the denial of his Adult-Related Medicaid benefits application. Since the petitioner was not properly notified of the denial, the undersigned has jurisdiction to hear the issue at matter, pursuant to Florida Administrative Code 65-2.043.

After the hearing, the petitioner submitted one exhibit, which was entered as Petitioner's Exhibit "1". The respondent submitted one exhibit, which was entered as Respondent's Exhibit "1". The record was held open until close of business on April 27, 2017 for submission of additional evidence from the respondent. On April 24, 2017, additional evidence was received and entered as Respondent's Exhibit "2". The record closed on April 27, 2017.

FINDINGS OF FACT

1. The petitioner's representative applied for Adult-Related Medicaid benefits on February 1, 2016. On the application, it was reported that the petitioner (52) is disabled. The petitioner is not age 65 or older and does not have any minor children. The petitioner requested retroactive Medicaid coverage for January 2016 on his application. He reported his sources of income were Public Retirement pension benefits for himself and his wife's earned income from [REDACTED].

2. The petitioner applied for disability with the Social Security Administration (SSA). The petitioner's representative explained SSA declared the petitioner to be disabled; however, his disability payments are pending. The petitioner filed a reconsideration with SSA regarding disability payments through the Social Security Disability Income. The SSA appeal remains pending.
3. 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 February 15, 2016.
4. The respondent explained on February 19, 2016, DDD denied the petitioner's disabling claim with a denial code of N31. The Department explained that the code N-31 is defined as "Non-Pay-Capacity for substantial gainful activity-customary past work, no visual impairment". However, it is unknown if DDD conducted an independent review. No documentation was presented nor a witness appeared regarding DDD's denial reason. The respondent denied the petitioner's application. No notice was issued to the petitioner regarding the denial of his February 1, 2016 Medicaid application or his request for retroactive coverage.
5. The petitioner's representative explained SSA determined the petitioner was disabled beginning September 1, 2015. The representative is requesting retroactive coverage for November 2015, December 2015 and January 2016.
6. The respondent's Running Record Comments state the following:



CL	DATE ENTERED	COMMENTS
--	04042017	

7. The respondent sought clarification regarding the above notations from the Medicaid File Coordinator, who indicated that the petitioner’s “SSI claim was allowed and needs a review in April 2019 to determine if eligibility for payment continues.”

8. The record was left open for the petitioner’s SSA decision notice. The petitioner presented a copy of a Notice of Decision for Supplemental Security Income (SSI) from SSA dated May 12, 2016. The petitioner was declared disabled by SSA; however; he was not entitled to SSI benefits due to income in the household. SSA established the petitioner’s disability began on September 1, 2015.

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. 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...

12. The Code of Federal Regulations at 20 C.F.R. § 416.994, How we will determine whether your disability continues or ends, disabled adults., states in part:

(a) General. There is a statutory requirement that, if you are entitled to disability benefits, your continued entitlement to such benefits must be reviewed periodically. Our rules for deciding whether your disability continues are set forth in paragraph (b) of this section. Additional rules apply if you were found disabled under a State plan, as set forth in paragraph (c) of this section...

(c) Persons who were found disabled under a State plan. If you became entitled to benefits because you were found to be disabled under a State plan, we will first evaluate your impairment(s) under the rules explained in paragraph (b) of this section. We will apply the same steps as described in paragraph (b) of this section to the last decision granting or affirming entitlement to benefits under the State plan. If we are not able to find that your disability continues on the basis of these rules, we will then evaluate your impairment(s) under the appropriate State plan. If we are not able to find that your disability continues under these State plan criteria, we will find that your disability ends. Disability will be found to end the month the evidence shows that you are no longer disabled under the criteria in paragraph (b) of this section (or appropriate State plan criteria), subject to the rules set out in paragraph (b)(6) of this section.

13. The Code of Federal 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....

(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....

(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, ...

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

14. According to SSA's Notice of Decision, the petitioner has been determined disabled effective September 1, 2015. In accordance with above controlling authorities, the undersigned concludes the petitioner met the disability requirement for eligibility under the SSI-Related Medicaid Program.

15. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner met his burden of proof in establishing that the respondent incorrectly denied his application for Adult-Related (SSI) Medicaid benefits for the retroactive coverage months (November 2015, December 2015 and January 2016), for the month of application (February 1, 2016) and ongoing. Therefore, the undersigned hereby remands this matter to the Department to obtain the necessary information and complete the eligibility determination process for the petitioner's SSI-Related Medicaid benefits. The respondent is ordered to determine the petitioner's SSI-Related Medicaid eligibility beginning November 1, 2015, the first month of the retroactive period, and ongoing months. Once an eligibility determination is made, the respondent is to issue a new notice to the petitioner 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 to take correction action as specified in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAR

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 15 day of June, 2017,

in Tallahassee, Florida.



Cassandra Perez
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

66STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

May 18, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02203

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 April 21, 2017, at 1:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent: Linda Latson, Registered Nurse Specialist - AHCA

STATEMENT OF ISSUE

At issue is the respondent United Healthcare'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 a witness for the petitioner was her husband [REDACTED]. Near the conclusion of the hearing, the petitioner's case manager from United Healthcare, [REDACTED], arrived at the petitioner's home and the petitioner placed her on the conference call; however, Ms. [REDACTED] had no relevant testimony to offer which had not already been discussed during 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 the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, Case System Screenshots, Medical Assessment Form, and Medical Records.

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-six (86) years of age and lives with her husband. She utilizes a walker to ambulate due to knee problems and also suffers from an unspecified muscular disease.

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 14 hours weekly of home health services (5 hours of personal care and 9 hours of homemaker services) through United Healthcare. She also receives incontinence supplies.

5. On or about December 19, 2016, the petitioner made a request to United Healthcare for home-delivered meal services. On December 22, 2016, United denied the request for home-delivered meals based on medical necessity criteria. The denial notice stated the following:

You have asked for home delivered meals. The health plan covers delivered meals when no one in the home can prepare meals. Your caregivers are able to prepare three meals daily. Delivered meals are in excess of your needs. Services in excess of your needs are not medically necessary. The health plan will not approve delivered meals.

6. The petitioner stated she cannot cook for herself. She stated her husband tried to cook one day and he left the stove on. She also stated her home health aide assists her with bathing and sometimes does the shopping.

7. The petitioner's husband stated he is 76 years old and has his own medical problems. He stated he does not know how to cook. He also stated he receives a home-delivered meal each day for himself from a program sponsored by the City of [REDACTED]. He also stated a neighbor sometimes helps him and his wife.

8. The respondent's witness, Dr. Kaprow, stated that the petitioner did not meet the criteria for home-delivered meals due to the assistance she is already receiving in the home. The petitioner does not live alone and she can be assisted by her husband. The home health aide can also assist with meal preparation. He also stated there are programs which can assist with food purchases if the petitioner has financial difficulty in that regard.

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. 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 she should receive home-delivered meals as part of her LTC Program services.

15. 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.

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 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.

19. 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."

20. 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."

21. 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.

22. 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 14 hours of home health services weekly to assist her with daily living activities. Homemaker services are part of these services, which include assistance with meal preparation. In addition, the petitioner’s husband should be able to provide some type of assistance to her.

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 18 day of May, 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
UNITED HEALTH CARE HEARINGS UNIT

Jun 19, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO.: 17F-02223

PETITIONER,

Vs.

AMERIGROUP REALSOLUTIONS
MANAGED CARE ORGANIZATION,
AND
AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 13 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 5, 2017 at 9:41 a.m.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner

For Respondent: Carlene Brock, L.P.N.
Quality Operations Nurse
Amerigroup RealSolutions

STATEMENT OF ISSUE

Petitioner is appealing the denial of a cotton blanket. Petitioner carries the burden of proving its position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner introduced Exhibit "1" to "2," inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

Dr. Marisabel Bravo D.O., Medical Director with Amerigroup RealSolutions ("Amerigroup") appeared as a witness for Respondent.

Respondent introduced Exhibits "1" to "4," inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

Stephanie Lang, R.N., Fair Hearing Liaison with the Agency for Health Care Administration appeared as an observer.

The record was left open until May 16, 2017 close of business for Respondents to provide a copy of the Florida Medicaid Durable Medical Equipment Handbook and the Florida Medicaid Fee Schedule. Respondents provided the information on May 8, 2017. The Florida Medicaid Durable Medical Equipment Handbook shall be admitted into evidence as Respondent's Exhibit "5," and the Florida Medicaid Fee Schedule shall be admitted into evidence as Respondent's Exhibit "6." Petitioner submitted a response on May 17, 2017, which shall be admitted into evidence as Petitioner's Exhibit "3."

At the request of Respondent, the Hearing Officer took administrative notice of the following:

- Rule 59G-4.070, *Florida Administrative Code*

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 55-year-old male a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC)-Managed Medical Assistance (MMA) plan. He receives services under the plan from Amerigroup.
2. Petitioner's Doctor indicated on his script that Petitioner suffers from dry skin. (See Respondent's Exhibit 2).
3. On or about February 9, 2017, Petitioner's physician submitted an authorization request to Amerigroup for approval of a cotton blanket. (See Respondent's Exhibit 2).
4. Petitioner's physician script indicated that the cotton bed blanket is needed because it is better tolerated on Petitioner's skin. (See Respondent's Exhibit 2).
5. On February 13, 2017, Amerigroup denied the pre-authorization request for a cotton blanket. The denial notice stated:

The requested service is not a covered benefit. The facts that we used to make our decision are: We cannot cover your blanket (E1399 – cotton bed blankets). This is not a covered benefit. This decision was made using the Florida Medicaid Provider Handbook. (See Respondent's Exhibit 3).
6. Petitioner stated he has urinary incontinence. Petitioner believes his skin is irritated by the wool blanket and it causes him to have hives. Petitioner believes the wool blanket is not good for his sensitive skin.
7. Petitioner believes that the cotton blanket is medically necessary and Amerigroup should pay for it.

8. Respondent's witness Dr. Bravo stated that the requested cotton blanket is not a covered benefit or item for adults under Florida Medicaid. The cotton blanket is not a medical item.

9. Respondents stated that a cotton blanket falls under personal comfort, convenience or general sanitation items, which is a non-covered item under the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook, effective September 2010. The cotton blanket is not on the Florida Medicaid Fee Schedule.

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 Section 120.80, Florida Statutes.

11. The Florida Medicaid Program is authorized by Florida Statutes Chapter 409 and Chapter 59G, *Florida Administrative Code*. The Florida Medicaid Program is administered by AHCA.

12. This proceeding is a de novo proceeding pursuant to Rule 65-2.056, *Florida Administrative Code*.

13. This is a Final Order, pursuant to Section 120.569 and 120.57, Florida Statutes.

14. The standard of proof in an administrative hearing is a preponderance of the evidence pursuant to Rule 65-2.060(1), *Florida Administrative Code*.

15. Section 409.906, Florida Statutes, addresses Optional Medicaid Services under the State Medicaid Plan:

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

16. The Florida Medicaid Provider General Handbook ("Provider Handbook"), July 2012 is promulgated into law by Rule 59G-5.020, *Florida Administrative Code*.

17. Page 1-27 of the Provider Handbook states, "Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients."

18. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), September 2010 is promulgated into law by Rule 59G-4.070, *Florida Administrative Code*.

19. Page 2-3 DME Handbook states:

Many durable medical equipment (DME) items and services are limited to recipients under 21 years of age.

To determine whether a service is available to all recipients or limited to recipients under 21 years of age, refer to the DME and Medical Supply Services Provider Fee Schedules and the service specific requirements described in this handbook.

20. Page 2-97 to 2-98 DME Handbook states:

Non-Covered Items

The following list of items and services are not reimbursed through the Medicaid DME and Medical Supply Services Program; however some of these items maybe reimbursed through other Medicaid programs, such as the Medicaid State Plan, Home and Community-Based Waiver Programs, or other state-operated programs:

Audiology services

Blood pressure monitoring devices
Car seats or car beds
Clinically unproven equipment
Computers and computer-related equipment
Dentures
Diapers and incontinence briefs of any kind for recipients 21 years and older
Disposable supplies customarily provided as part of a nursing or personal care service or a medical diagnostic or monitoring procedure
Emergency and non-emergency alert devices
Environmental control equipment (air conditioners, dehumidifiers, air filters or air purifiers)
Equipment or devices used primarily for transport
Equipment or devices which require home modification (ceiling lifts)
Equipment designed for use by a physician or trained medical personnel
Experimental or investigational equipment of any type
Facilitated communications (FC)
Furniture and other items which do not serve a medical purpose
Hearing and vision systems
Institutional type equipment
Items or devices used or intended to be used for cosmetic purposes
Non-sterile cotton tip applicators
Personal comfort, convenience or general sanitation items
Physical fitness equipment
Powered wheelchair component for standing
Precautionary-type equipment (e.g., power generators, backup oxygen equipment unless specifically determined as medically necessary to assure life support)
Printers, unless the printer is a built-in component of a dedicated AAC system
Printer paper or cables
Routine and first aid items
Services or items provided to recipients out-of-state
Supplies or equipment covered by Medicaid per diem rates
Televisions, telephones, VCR machines and devices designed to produce music or provide entertainment
Training equipment or adaptive self-help equipment or devices
Transit tie downs
Wheelchair electronics upgrades to control or have interface with other non-covered services and exclusions
Wheelchair lifts
Wheelchair ramps and home modifications
(Emphasis Added)

21. Page 2-98 DME Handbook states, "Exceptions for Non-Covered Services and Exclusion are only for eligible recipients under 21 years of age." Petitioner is 55 years old and does not fall under the exceptions for Non-Covered Services.

22. The cotton blanket requested by Petitioner is not listed as a covered benefit or service in either the DME Handbook or the Medicaid fee schedule.

23. Managed care plans, such as Amerigroup, are required to comply with the various Medicaid Handbooks and regulations.

24. After considering all the documentary evidence and witness testimony presented, the undersigned concludes Amerigroup correctly denied Petitioner's request for a cotton blanket. The cotton blanket is a non-covered item or benefit pursuant to Medicaid guidelines, the hearing officer cannot make a medical necessity determination because it is not a covered benefit even through Petitioner may benefit from its use.

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 19 day of June, 2017, in
Tallahassee, Florida.



Allison Smith-Dossou
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

May 02, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02232

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 14 [REDACTED]
UNIT: 55143

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 27, 2017 at 9:53 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

LaTonya Williams, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of February 10, 2017 terminating her Family-Related Medicaid effective February 28, 2017 due to her child turning 18. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on March 20, 2017, which was entered as Respondent's Exhibit 1. The petitioner submitted evidence on April 27, 2017, which was entered as Petitioner's Exhibit 1.

The record closed on April 27, 2017.

FINDINGS OF FACT

1. The petitioner's child turned 18 in February 2017.
2. The Department received a notification on February 9, 2017 that the petitioner's child was turning age 18.
3. The Department issued a Notice of Case Action on February 10, 2017 to inform the petitioner that her Medicaid would end February 28, 2017 due to her child turning age 18.
4. The petitioner reports non-receipt of the above Notice of Case Action. The petitioner receives her mail at her sister's. The petitioner states her sister always leaves her mail for her on the table.
5. The Department reported that there is no record of any mail returned to the Department by the postal service.
6. Due to the discrepancy, the undersigned must make a finding. The undersigned relied on the presumption that correspondence properly mailed and not returned with no rebuttal evidence received (*Brown v. Giffen Industries, Inc.*, Fla. 1973, 281 So.2d 897, 1973 Fla. SCt 997) to make the finding that the petitioner did receive the Notice at issue.
7. The Department explained as the petitioner has no other children in the home under age 18, the petitioner no longer qualifies under Family-Related Medicaid.
8. The petitioner advised she filed for Social Security Disability on February 28, 2017 and had an interview with the Social Security Administration on March 13,

2017. The petitioner stated she has multiple health problems, which she believes will qualify her as disabled.

9. The petitioner believed as Medicaid was paying for her treatments, the Department was aware of her health conditions.

10. The Department did not explore transitioning the petitioner to any other Medicaid as the petitioner did not qualify for any other Family-Related Medicaid due to no children under 18 in the home.

11. The Department did not recall the petitioner's claim of reporting her disabling conditions at the supervisory review.

12. The Department advised if the petitioner believes she is disabled she can apply for "disability" Medicaid.

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

(4) Ex Parte Process.

(a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) before terminating Medicaid coverage. Both family-related Medicaid and SSI-

related Medicaid eligibility are determined based on available information. If additional information is required to make an ex parte determination, it can be requested from the recipient, or, for SSI-related Medicaid eligibility, from the recipient or from the Social Security Administration.

(b) All individuals who lose Medicaid eligibility under one or more coverage groups will continue to receive Medicaid until the ex parte redetermination process is completed. If the department determines that the individual is not eligible for Medicaid, the individual will be sent a notice to this effect which includes appeal rights. The individual may appeal the decision and, if requested by the individual within 10 days of the decision being appealed, Medicaid benefits will be continued pending resolution of the appeal.

...

(7) Re-evaluating Medicaid Adverse Actions. The department shall re-evaluate any adverse Medicaid determination upon a showing of good cause by the individual that the previous determination was incorrect and that the individual did not request a hearing within the time prescribed in Chapter 65-2, Part IV, F.A.C. This provision applies only when benefits were terminated or denied erroneously or a share of cost or patient responsibility was determined erroneously.

(a) Good cause exists if evidence is presented which shows any of the following:

1. Mathematical Error – The department made a mechanical, computer or human error in its mathematical computations of resources, income, or spend down requirements for Medicaid eligibility.
2. Error on the Face of the Record – The department made an error in a Medicaid determination which caused an incorrect decision. For example, there is evidence showing that the individual's resources satisfied Florida's standard of eligibility but the application was denied on the basis of excess resources.
3. New and Material Evidence – The department's determination was correct when made but new and material evidence that the department did not previously consider establishes that a different decision should be made.

16. Florida Admin. Code R. 65A-1.705, Family-Related Medicaid General

Eligibility Criteria, states in relevant part:

(7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested. A fully deprived child is one who is not living with either birth parent due to reasons such as death, abandonment or incarceration. The following are illustrations of SFU determinations:

...

(d) If assistance is requested for the parent of a child in an intact family, the parent, the mutual child's other parent, the mutual child and all siblings of the mutual child who have no income must be included in the SFU. Any siblings who have income, or any other related fully deprived children, are optional members of the SFU. 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.

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. The above controlling authority (Florida Admin. Code R. 65A-1.702)

explains that when coverage under one Medicaid coverage group ends, the Department must determine the eligibility under any other Medicaid coverage group **before** terminating the individual's Medicaid.

19. The findings show the Department took action to close the petitioner's Medicaid based solely on the fact the petitioner's child turned 18. The undersigned concludes the Department was correct in the determination that the petitioner does not qualify for Family-Related Medicaid as she no longer has a child under 18 in the home.

20. The findings show the Department did not explore any coverage outside of Family-Related Medicaid. The findings also show the Department was not aware of the petitioner's health conditions that she believes are disabling prior to the determination to

close her Family-Related Medicaid. The undersigned concludes the Department failed to confirm the petitioner did not have a potential eligibility for SSI-Related Medicaid based on disability prior to terminating the petitioner's Medicaid. The undersigned further concludes, when the petitioner described her conditions and her belief they are disabling, the Department should have re-evaluated the adverse action to determine if the petitioner's Medicaid closure was appropriate based on the new and material evidence presented.

21. The undersigned concludes the Department is to open the petitioner's Medicaid effective March 1, 2017. The petitioner's Medicaid eligibility remains until the ex parte redetermination process is completed. If the department determines that the individual is not eligible for Medicaid, the individual will be sent a notice to this effect which includes appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The Department is to open the petitioner with Medicaid eligibility beginning March 1, 2017 with coverage continuing through the ex parte determination process.

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.)
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DONE and ORDERED this 02 day of May, 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

Jun 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-02239

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 [REDACTED]
UNIT: 88655

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 15, 2017 at 3:46 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED] pro se

For the Respondent: Miguelena Jovane,
Operations Management Consultant

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for full Medicaid benefits at recertification. At the hearing, the burden of proof was assigned to the petitioner by a preponderance of evidence. However, after further review, the

burden of proof was reassigned to the respondent as the petitioner's Medicaid was terminated by the respondent.

PRELIMINARY STATEMENT

The petitioner submitted no evidence. The respondent submitted a 38-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "7". The record was left open through May 19, 2017 for additional information including the petitioner's Medicaid eligibility history, the policy related to Medicaid eligibility and income limits and updated Medicaid budgets for the petitioner. On May 18, 2017, the respondent submitted an additional 11-page evidence packet including all requested information, which was marked and entered as Respondent's Exhibits "8" through "12". The record was closed the same day.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner and her husband were both receiving full Medicaid through February 28, 2017.
2. On January 26, 2017, the petitioner submitted an electronic web application requesting Food Assistance and Medicaid for her household (Respondent's Exhibit 1).
3. The petitioner's household consisted of the petitioner (YC), her husband (VC), and their adult son (EC) (20 years old), and their minor son (11 years old).
4. VC has been determined disabled by the Social Security Administration (SSA) and receives \$2,520.60 per month in Social Security Disability income (SSDI). He receives Medicare Part A and Part B. His Part B premium of \$112 is deducted from his SSDI monthly (Respondent's Exhibit 4).

5. YC works as an independent contractor. She has not had any income in months because she works off commission (Respondent's Exhibit 4).
6. YC and VC file taxes jointly, claiming both the children as dependents.
7. The total household income was calculated as \$2,520.60 per month.
8. The respondent asserts the total household income is over the Family Medicaid income limit for a household of four.
9. The respondent enrolled the petitioner and her husband in the Medically needy (MN) program with a Share of Cost (SOC).
10. The respondent determined YC's Standard Filing Unit (SFU) as four and VC's SFU as four based on their tax filing status.
11. VC's SOC was updated after the hearing and calculated as follows (Respondent's Exhibit 8):

\$2,520.60	total household income
- 585.00	medically needy income limit (MNIL) for an SFU of four
<hr/>	<hr/>
\$1,935.00	SOC
- 104.90	medical insurance premium
<hr/>	<hr/>
\$1,830.00	remaining SOC

12. On February 14, 2017, the respondent sent the petitioner a Notice of Case Action (NOCA) informing her full Medicaid for YC and VC would be terminated effective February 28, 2017 and they would be enrolled in MN with a SOC (Respondent's Exhibit 7).
13. The petitioner timely requested the hearing.
14. The petitioner feels they should still be entitled to the full Medicaid because they do not have income beyond the SSDI her husband receives and she does not understand why they are no longer eligible when there have been no household changes.

15. The respondent asserts the couple is over the income limit for full Medicaid and the couple has received a full year of Medicaid.

16. During the hearing, the petitioner clarified the tax filing status for both adults.

17. The respondent considered the new information and submitted an updated budget with the updated tax filing status.

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, Fla. Stat.

19. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

Full Medicaid benefits will be addressed first:

21. Fla. Admin. Code R. 65A-1.704 Family-Related Medicaid Eligibility Determination Process states in pertinent part: "(1) Public assistance staff determine eligibility for Family-related Medicaid at application, when a change in conditions of eligibility is reported, or, on not greater than a 12-month cycle."

22. In accordance with the above cited authorities, eligibility for Family-Related Medicaid must be determined in 12-month cycles. In this instant case, the petitioner's full Medicaid eligibility began March 1, 2016 and was terminated February 28, 2017.

23. Based on the evidence and testimony, the petitioner received a full 12 months of full Medicaid and the respondent was required to review the petitioner's eligibility.

24. Fla. Admin. Code R. 65A-1.705 Family-Related Medicaid General Eligibility Criteria.

...(2) Coverage groups must meet the deprivation criterion only to the extent that children and parents or caretaker relatives meet payment standard income criteria [Refer to subsection 65A-1.716(2), F.A.C.]...

(7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested...

(d) If assistance is requested for the parent of a child in an intact family, the parent, the mutual child's other parent, the mutual child and all siblings of the mutual child who have no income must be included in the SFU.

25. In accordance with the above cited authority, the respondent correctly determined the petitioner's SFU as a household size of four, including both parents and two mutual children.

26. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria states in pertinent part: "(1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages... Total gross income includes earned and non-earned income from all sources."

27. The above cited authority explains Family-Related Medicaid eligibility is based on income, earned or unearned, received within the household. In accordance with the above cited authority, the petitioner's SSDI income was included in the Medicaid budget calculations.

28. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains: "(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size..."

29. The Family-Related Medicaid income criteria is set forth in 42 C.F.R § 435.603 - Application of modified gross income (MAGI). 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...

(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...

(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.

30. Federal regulations at 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (d) 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.

31. The Department's Program Policy Manual (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).

32. The Policy Manual, Appendix A-7, effective April 2016 lists the Family-Related Medicaid income limits for a household of four for adults as \$364, the Standard Disregard at \$221, and the Medically Needy Income Limit (MNIL) at \$585.

33. The Policy Manual, Appendix A-7, effective April 2017 lists the Family-Related Medicaid income limits for a household of four for adults as \$364, the Standard Disregard at \$221, and the MNIL at \$585.

34. In accordance with the above cited authorities and policy manual, the undersigned calculated Medicaid eligibility for the petitioner and her husband but did not find them eligible for full Medicaid as the household's MAGI is more than the income limit of \$364 for a household of four. Step 1. VC's SSDI income of \$2,520.60 was calculated as the MAGI. Step 2. There are no deductions provided, as there was no tax return provided. Step 3. The total income of \$2,520.60 less the standard disregard of \$221 is \$2,299. Step 4. The total countable net income of \$2,299 was greater than the income standard for a household of four of \$364 for full Medicaid. Step 5. With no MAGI disregard, the countable balance remains at \$2,299. The petitioner's income was greater than the income limit for full Medicaid. The undersigned concludes both adults are ineligible for full Medicaid. The undersigned further concludes Medically Needy (MN) eligibility must be explored.

Enrollment in Medically Needy and Share of Cost amount will now be addressed:

35. 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.

36. 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."

37. Fla. Admin. Code R. 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.

38. The Policy Manual at 2230.0400 Standard Filing Unit (MFAM) states:

The SFU is determined for each individual by following one of three rules based on intended tax filing status for the upcoming tax year as reported by the applicant/recipient. Individuals cannot receive Medicaid benefits under more than one assistance group, but can have their income included in more than one assistance group.

Filer Rule: If the individual being tested for eligibility expects to file a tax return for the tax year in which eligibility is being determined and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

- 1. individual,**
- 2. individual's spouse, if any, even if the individual and the individual's spouse are living separately and filing a joint tax return, and**
- 3. all claimed tax dependents of the individual living inside or outside of the household. (*emphasis added*)**

Tax Dependent Rule: If the individual being tested for eligibility expects to be claimed as a tax dependent for the tax year in which eligibility is being determined, the SFU includes the:

1. individual,
2. individual's spouse, even if the individual and the individual's spouse are living separately and filing a joint return,
3. tax filer,
4. tax filer's spouse, if any, even if the tax filer and tax filer's spouse are living separately and filing a joint return, and
5. all claimed tax dependents of the tax filer living inside or outside of the household.

39. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource

Criteria states in the pertinent part:(2) The department considers income in excess of the medically needy income level available to pay for medical care and services...The department deducts allowable medical expenses...(a) Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges..."

40. In accordance with the above controlling authorities, the respondent determined the SFU for both adults as a household of four based on his tax filing status of filing taxes jointly and the two minor children being tax dependent on both adults.

41. In accordance with the above controlling authorities, the respondent determined the petitioner's countable household income to be \$2,520.60. The MNIL of \$585 was subtracted from the income to determine the SOC of \$1,935. The respondent subtracted \$104.90 as the medical insurance premium to arrive to determine the SOC of \$1,830.

42. In careful review of the budget calculations, the undersigned determined the respondent erred in the amount of the medical insurance premium used to calculate the

final SOC. SSA subtracts \$112 per month effective December 2016 for VC's SSDI.

The petitioner's SOC is determined to be \$1,823 (\$1,935 - \$112).

43. The undersigned reviewed eligibility under the SSI-related Medicaid coverage and found it was more advantageous for the petitioner's eligibility to be determined based on the Family Medicaid standards.

44. Based on the testimony, evidence, review of the respondent's budget, and budget corrections, the undersigned has concluded that the respondent's action to deny the petitioner and her husband full Medicaid and enroll them in the Medically Needy program was proper. However, the department erred in calculations of the SOC. The undersigned remands the appeal to the respondent. The respondent will update the petitioner's SOC based on the corrected amounts provided by the undersigned effective March 1, 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby partially denied and partially granted. The portion of the appeal related to the denial of full Medicaid is denied. The portion of the appeal related to the SOC is correct; however, the amount is overstated and therefore remanded to the respondent for corrective action as stated in the above conclusions.

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

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 Department has no funds to assist in this review.

DONE and ORDERED this 26 day of June, 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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Email: Appeal.Hearings@myflfamilies.com

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

Jun 15, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 17F-02256

PETITIONER,

vs.

MANAGED CARE ORGANIZATION,
AND
AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, this matter convened for hearing before Hearing Officer Patricia C. Antonucci on June 1, 2017 at approximately 10:11 a.m. All parties and witnesses appeared via teleconference. As Petitioner's representatives are Spanish-speakers, an interpreter was also present on the line, and was placed under oath to translate the entire proceeding.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's Mother

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

STATEMENT OF THE ISSUE

At issue is a decision made by Respondent, the Agency for Health Care Administration (AHCA or “the Agency”), through its contracted health plan, Staywell/WellCare (“Staywell”), to deny Petitioner’s request for out-of-network/out-of-state thoracic procedures.¹ Petitioner bears the burden of proving, by a preponderance of the evidence, that these denials are improper.

PRELIMINARY STATEMENT

Via an April 10, 2017 Notice of Hearing, all parties were informed that a telephonic hearing in this matter would convene on June 1, 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).

On May 25, 2017, Staywell contacted the undersigned hearing officer to request a continuance, noting that all of their physician reviewers/medical directors would be unavailable on June 1, 2017, due to mandatory training sessions. Staywell noted that Petitioner objected to this continuance, as she considered her medical status (and thus, disposition of her appeal) to be urgent. The undersigned informed Staywell that if no physician witnesses were able to appear, Staywell was to call in on June 1, 2017 at the

¹ Upon review of the record, the undersigned notes that Staywell provided testimony regarding thoracic surgery, stating that both of Petitioner’s service requests were for the same procedures, but had different dates of service/expiration. Review of the documentary evidence reflects that this -- and thus, the Summary of matter prepared by Staywell (entered as Respondent’s Exhibit 2) -- are incorrect. (This will be discussed and clarified in further detail, below.)

previously scheduled time, so that the parties could determine a mutually agreeable date/time on which to reset hearing; however, when the conference line was activated on June 1, 2017, Staywell had two witnesses present and was ready to present its case.

Petitioner was not present at the phone hearing, but was represented by her mother, [REDACTED]. Petitioner's father, [REDACTED], was also present on the conference line. Petitioner's parents had not received Respondent's proposed evidence packet, but they opted to proceed with hearing, as scheduled. Respondent agreed to send a second copy of the evidence to Petitioner's parents, for their records; however, Petitioner's parents did not request leave to receive and respond to this documentation, as they wished for expeditious disposition of the appeal.

Respondent, Staywell, was represented Stephanie Shupe, Regulatory Research Coordinator, who presented two additional Staywell witnesses: Mayer Eisenfeld, M.D., Corporate Medical Director, and Nicholas Abid, D.O., Physician Reviewer. Lisa Sanchez, Medical/Health Care Program Analyst with AHCA, appeared for observation and monitoring. Respondent's Exhibits 1 through 15, inclusive, were accepted into evidence. Administrative Notice was taken of all pertinent legal authority.

Following testimony to establish the issue(s) on appeal, the undersigned determined that Respondent was not in compliance with the requirement, as set forth in the April 10, 2017 Notice of Hearing, to confer with Petitioner within 10 days of receipt of same. Staywell maintained that they had contacted Petitioner on or about March 14, 2017, to confirm that this matter would proceed to hearing; however, neither post-Notice contact nor any discussion as to potential resolutions were initiated. Petitioner's mother

testified that she had tried to contact Staywell on numerous occasions, only to be passed between departments or have her unanswered calls remain unreturned.

Staywell contends that there were no options for resolving Petitioner's appeal, as the denial of her request was based strictly on a benefit limitation regarding out-of-network providers. During the course of the hearing, testimony established that there were, in fact, possible resolutions to Petitioner's concerns, which remained previously unexplored.

Staywell was reminded that substantial, meaningful correspondence with their members must occur before any matter convenes for hearing. They were further advised that this is of particular importance when the issue(s) on appeal may be considered urgent. Although the parties agreed to continue working towards resolution, Petitioner requested that the undersigned render a formal decision of her appeal. As such, this Final Order follows.

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 12.5-month-old female, born in May of 2016. At all times relevant to this appeal, Petitioner has been eligible for and receiving services through Medicaid.
2. On or about January 1, 2017, Petitioner became a member of Staywell, a managed care organization (MCO), contracted with AHCA to provide medically necessary goods and services to eligible Medicaid recipients.

3. The Petitioner is diagnosed with multiple [REDACTED], including a [REDACTED],” present at birth, along with [REDACTED]

4. At approximately one-month of age, Petitioner underwent cardiac surgery to repair her heart; however, this procedure proved ineffective. Petitioner’s physicians have been monitoring the progression of her condition, and her family has sought additional opinions as to treatment protocol.

5. Following consultation between the Petitioner’s cardiologist and physicians at Boston Children’s Hospital, the latter submitted to Staywell a request for specific services, including:

- Via request 121274638, filed February 6, 2017: A 5-day, inpatient admission (May 15-20, 2017) for surgical procedures including CPT codes 33405, 33411, 33412, 33413, 33414, 33425, 33426, 33427, 33530, 33851, 33853, 33870, 34502, 35211, and 35271. (Submitted by Pedro del Nido, M.D., Department of Cardiology, Boston Children’s Hospital.)
- Via request 121277167, filed February 7, 2017: Outpatient/ambulatory surgical procedures (proposed service dates May 11-June 9, 2017) for catheterization and related services, including CPT codes 93530, 93531, 93563, 93564, 93565, 93566, 93567, 93568, 37246, and 75605. (Submitted by Diego Porras, M.D., Department of Cardiology, Boston Children’s Hospital.)

6. Staywell did not present any evidence to demonstrate a thorough review of these individual requests, instead testifying that both requests were for the same “thoracic surgery” services.

7. Via Notices of Action dated February 13, 2017 and February 14, 2017, Staywell informed Petitioner of its decision to deny her requests for services, noting in pertinent parts:

(Both Notices)

Staywell Health Plan has reviewed your request for Thoracic Surgery... After our review, this service has been:

Denied... The facts that we used to make our decision are:

(February 13, 2017 Notice re: request 121274638)

On 02/06/2017 we received a request to authorize [REDACTED] surgery care for your child with an out of network provider, [REDACTED] Surgeon. We did not approve the request for authorization because out of network services are not a covered benefit when services are available within the plan. Contingent on formal plan approval, this service can be provided by the following in-network provider(s): 1)UF Shands - Ranked 24th best pedcardiology hospitals 352-733-0111 A [REDACTED]

[REDACTED] will be contacted within 48 hours Please contact your child's primary care doctor for a referral to in-network provider/services, and feel free to contact the WellCare Customer Service Department if you wish their assistance or encounter any difficulty. Criteria referenced: Member Benefits Document Staywell Member Handbook, Section: Services Covered by Staywell (emphasis added.)

(February 14, 2017 Notice re: request 121277167)

On 02/07/2017 we received a request to authorize [REDACTED] surgery evaluation/procedures for your child with an out of network provider, [REDACTED] Children's Hospital. We did not approve the request for authorization because out of network services are not a covered benefit when services are available

within the plan. Contingent on formal plan approval, this service can be provided by the following in-network provider(s): ... 3) [REDACTED]

[REDACTED] (emphasis added).

8. On February 21, 2017, Petitioner's cardiologist, [REDACTED], contacted Staywell to appeal these denials. Within her narrative, [REDACTED] notes, in part:

[Petitioner's prior surgery] was performed by a [REDACTED] surgeon with over 30 years of experience, more years of experience than any of the surgeons listed within network. In addition, the surgical opinion at this institution is that her next surgery should be the [REDACTED] versus [REDACTED]. The [REDACTED] carries a higher surgical mortality and obligates the need for further surgeries during her lifetime. [Her] odds for survival and good quality of life are significantly improved with the operative approach proposed by [REDACTED] than for any other treatment alternatives.

Based on the level of treatment required we believe that [Petitioner] would be best serviced at an institution with significant experience and expertise in the surgical management of pediatric and congenital heart disease. The [REDACTED] is one of the world leaders in pediatric cardiology and cardiac surgery and has pioneered treatments that have dramatically improved survival rates. It is out sense that treatment at this institution could provide the best chance of survival with a minimum of associated morbidity.

9. Review of Staywell's case notes reflects Staywell's review process, upon receiving Dr. [REDACTED] appeal. Per entries dated February 23, 2017:

[Staff with Dr. [REDACTED] office] stated the surgeon in Florida who did the first operation, Dr. [REDACTED] referred patient to Dr. [REDACTED] because she needs [REDACTED] versus [REDACTED]

...
Spoke with... medical assistant for Dr. [REDACTED] to inquire if they had given the case to other pediatric [REDACTED] surgeons in network for review to verify that this out of network doctor is the only surgeon who can perform this operation. She stated that case was put up for conference with [REDACTED] In these conferences, multiple cardiologists, surgeons, pediatrics review the case together and come up with the best

recommendation for their patient. Collectively, they all agreed Dr. [REDACTED] at [REDACTED] was the best [REDACTED] surgeon for this surgery. She is faxing the conference notes for review so there is documentation the conferred with other specialists.

10. No “conference notes” (aside from what is included in correspondence between [REDACTED]/Petitioner’s current treating physicians)

were proffered as evidence.

11. A Staywell case note dated February 28, 2017 states, “... Also informed her [Dr. [REDACTED]], per Dr. Samerson, that she [Petitioner] could have the surgery with an in network or out of network surgeon as long as it is in Florida.”

12. Via Notice dated February 28, 2017, Respondent informed Petitioner and her provider that a board-certified, licensed doctor reviewed Petitioner’s case and presented his/her findings to Staywell’s Appeal Review Committee on February 28, 2017. The committee decided to uphold its previous denial, “because there are in plan surgeons in Florida. There are also plan facilities in Florida. You can be seen by an in plan doctor.”

13. On March 14, 2017, Petitioner’s mother requested a fair hearing to challenge this determination.

14. At hearing, Petitioner’s mother explained that she was assured by the Petitioner’s first surgeon that the procedure he performed would fix Petitioner’s heart, such that she would not require any further surgeries. Upon learning that said procedure was not successful, the mother sought additional opinions as to treatment options. She is concerned that Petitioner’s health is at risk and that she may require imminent surgery. The mother does not feel that Staywell has provided sufficient assistance or coordination with getting Petitioner the care she needs.

15. Having already worked with one Florida surgeon, Petitioner's mother seeks to have Petitioner's next procedure performed by a specialized surgeon, who is an expert in the field. She is concerned that limiting Petitioner to in-network surgeons will jeopardize her health and/or require more procedures in the future, if the in-network doctors are unable to treat her according to the plan proposed by [REDACTED]

16. The referrals to and responses from [REDACTED] include a December 19, 2016 narrative from Dr. [REDACTED], following his review of Petitioner's files. Dr. [REDACTED] writes, in part:

From the clinic notes, it appears that she has been reasonably stable on [REDACTED].

We have reviewed the echocardiogram and catheterization studies and concur with the diagnosis... Although [Petitioner] has been clinically doing reasonably well, we are concerned about the progressive nature of her LV outflow tract obstruction and mixed disease that she has at the level of the aortic valve. I reviewed her case with our Interventional Cardiology Group and our recommendation is that [she] should undergo repeat cardiac catheterization within the next couple of months to characterize in more detail the level of obstruction of the LV outflow to confirm that the right-sided pressures are low and also re-measure her left ventricular end-diastolic pressure as we are concerned that the level of aortic valvar regurgitation is more than mild. If her gradient remains below 50, then it would seem very reasonable to continue medical management and close observation. Otherwise, if the gradient has continued to rise, we would proceed with surgical intervention.

As far as the options of Ross vs. repair of the valve, this would depend on the operative findings... (emphasis added).

17. Dr. [REDACTED] findings are consistent with those of Dr. [REDACTED]), who notes via a December 15, 2016 narrative:

Clinically, she has been doing reasonable well (she is growing and is on [REDACTED]), so the recommendation at her local heart center was for expectant management with a plan to eventually proceed with [REDACTED] at an older age. The parents are seeking a second opinion.

...

Overall, I think it would make sense to repeat a catheterization with the following objectives:

1. Characterize the LVOT obstruction better and see exactly what the peak to peak gradient is now, since on echo it seems to have increased.
2. Make sure the RVp and PA pressures are in fact normal, since that may change the urgency of any surgery
3. See what the Lap and mitral valve inflow gradient is, since this could also change timing of surgery.
4. Make sure the arch is unobstructed.
5. See what the LVEDp is and get a different kind of assessment of AR, since the echo suggests more AR than was reported.

If the gradient remains under 50, there is mild AR and mild AS with no arch obstruction and normal PA pressures, I think we can continue with medical management. Otherwise, we could plan surgery accordingly.

18. It is unclear why [REDACTED] filed their request for the surgical procedures (via 121277167 for dates of service 05/15/17-05/20/17) one day before/at the same approximate time as their request for catheterization tests (via 121274638 for dates of service 05/11/17-06/09/17), when both physicians from Boston recommended a treatment plan that included surgery only if catheterization results warranted same. Neither party provide testimony to clarify this issue, nor did Staywell confirm (as referenced in their case notes) that Petitioner would be able to use an out-of-network provider, so long as said provider is situated in Florida.

19. Per Staywell, their decision to deny the procedures by an out-of-network provider is supported by Staywell's Managed Medical Assistance Contract with AHCA (see Section VI(A)(1)(e): "The Managed Care Plan shall allow each enrollee to choose

among participating providers in accordance with 42 CFR 431.51”), and by Staywell’s own Member Handbook. Page 16 of this Handbook notes, in pertinent parts:

- You can get services from any provider in our network
- ...
- Sometimes we may not have a provider in our network who can give you needed care; if this happens, we’ll cover the care out-of-network (at no additional cost to you), but you will need to get approval first from us or your PCP. WellCare will ensure that the cost to the member is no greater than it would be if the services were provided within the WellCare network.

Page 23 confirms that both inpatient and outpatient hospital services are covered.²

20. While providing a brief update as to Petitioner’s health status, her mother noted that Dr. [REDACTED] was also conferring with Dr. [REDACTED]

[REDACTED] It is the mother’s understanding that [REDACTED] was reviewing Petitioner’s case to determine if he would see her as a patient. The mother testified that she is willing to bring the Petitioner to [REDACTED] for a consultation, but she has not received word that an appointment is pending. As [REDACTED] is one of the participating providers referenced by Staywell, Respondent agreed to facilitate correspondence so as to expedite an appointment.

21. The parties were encouraged to remain in communication, and Staywell consented to assigning a case manager, who would contact Petitioner by June 3, 2017. Staywell also agreed that they would assist Petitioner in obtaining an appointment with [REDACTED]. Dr. [REDACTED] testified that he would be willing to speak directly to Dr. [REDACTED] after Petitioner was seen, to get a full picture of Petitioner’s current status. Dr. [REDACTED] also advised that if Dr. [REDACTED] felt surgery was necessary and that *he* could perform

² Both Section IV of the ACHA contract and the entire Staywell Member Handbook were accepted into evidence and are thus part of the record of this appeal.

same, the procedures could be authorized immediately. If Dr. [REDACTED] indicated that Petitioner requires surgery, but that the necessary procedure could only be performed at [REDACTED], then Staywell would reconsider their denial of the out-of-network/out-of-state service.

22. Petitioner's mother was encouraged to work with Staywell and Dr. [REDACTED] to determine the best course of action for meeting Petitioner's needs. She was urged to notify Staywell immediately if Petitioner's condition worsens, and Staywell confirmed that, in keeping with the requirements of Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT), any need for immediate or emergency care might override their prior denials.

23. While Petitioner's mother was comfortable pursuing possible treatment with Dr. [REDACTED], she indicated that she did not wish to withdraw Petitioner's appeal. The mother requested that the undersigned issue a Final Order to rule on same.

CONCLUSIONS OF LAW

24. 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.

25. Legal authority governing the Florida Medicaid Program is found in Chapter 409, Fla. Stat., and in Chapter 59G, Fla. Admin. Code. Respondent, AHCA, administers the Medicaid Program.

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, in accordance with Fla. Admin. Code R. 65-2.056.

28. The burden of proof in the instant case is assigned to Petitioner, who is requesting out-of-network/out-of-state cardiac/thoracic services.

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

30. The Florida Statutes addresses mandatory Medicaid services under State Medicaid Plan at § 409.905, which states:

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.

...

(5) HOSPITAL INPATIENT SERVICES [see Petitioner's request #121274638] —The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

...

(6) HOSPITAL OUTPATIENT SERVICES [see Petitioner's request #121277167].— (a) The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that

payment for such care and services is limited to \$1,500 per state fiscal year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity....

(emphasis added).

31. Also 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.

32. Additional exemptions are noted at § 409.972, Fla. Stat.; however, no evidence was presented to demonstrate that Petitioner may opt-out of managed care for her health care needs.

33. Via Fla. Admin. Code R. 59G-4.002, AHCA has promulgated its Provider Reimbursement Scheduled and Billing Codes (“Fee Schedules”), which notate the rate at which CPT-coded medical procedures are reimbursed and whether such procedures require Prior Authorization (PA). Review of the “Practitioner Fee Schedule” reflects that Petitioner’s requested service codes (for thoracic surgery: 93530, 93531, 93563, 93564, 93565, 93566, 93567, 93568, 37246; for catheterization: 33405, 33411, 33412, 33413, 33414, 33425, 33426, 33427, 33530, 33851, 33853, 33870, 34502, 35211, and 35271) each represent a covered procedure that does *not* require PA. Similarly, the “Radiology Fee Schedule” reflects coverage without PA for requested CPT code 75605.³

³ The Medicaid Fee Schedules are available at:

https://ahca.myflorida.com/medicaid/review/fee_schedules.shtml (See “Practitioner Fee Schedule” and “Radiology Fee Schedule,” both accessible as pdf or xls files).

34. Notably, Staywell does not dispute that the requested services are/may very well be medically necessary (see Fla. Admin. Code R. 59G-1.010(166)). Staywell did not deny the procedures based upon a medical necessity review, but rather, because Petitioner did not offer proof that she would be unable to obtain the same services via in-network providers, within the state of Florida. It is not clear why Staywell also suggested that Petitioner seek out-of-network providers within the state; however, should Petitioner wish to explore this option, she may coordinate with Staywell.

35. Although not the basis for denial, medical necessity does factor into this determination, insofar as a demonstration that it is medically necessary for Petitioner to receive services from [REDACTED] would override Respondent's exclusion of the physicians at [REDACTED] as a non-participating providers.

36. As the petitioner is under the age of 21, a broader definition of medically necessary applies, to include both Fla. Admin. Code R. 59G-1.010(166) and the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Both have been considered in the development of this Order.

37. 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.

38. 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, underlined emphasis added).

39. In the instant case, the thoracic procedures are requested to treat and ameliorate the medical needs, which Petitioner’s heart conditions present. As such, in a general sense, the request is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because these procedures are recognized Medicaid services, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

40. 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 the requested Boston-based procedures to fulfill these criteria, Petitioner must demonstrate that the same procedures could not be provided in Florida, where they would constitute “equally effective and less-costly treatment.” (See *also* 42 C.F.R. § 431.51.) Thus, even when reviewing Petitioner’s requests based on medical necessity, Petitioner has not met her burden of proof and thus, has not shown that it is proper to override Staywell’s benefit limitation-based determination.

41. The undersigned shares the frustration experienced by Petitioner’s mother, following Staywell’s delay in engaging her in meaningful conversation regarding the Petitioner’s needs. It is unfortunate that Staywell failed to comply with the undersigned’s requirement to confer, as memorialized in the Notice of Hearing, and did not assign a case manager early on, who could assist Petitioner’s mother in obtaining services, in-state and in-network, under ██████████ care. This is particularly true with regard to the requested diagnostic, catheterization procedures, as it is not clear whether Petitioner was ever adamant that these (as distinct from the actual surgery) be performed at ██████████. The results of the catheterization tests are likely to drive Petitioner’s course of treatment, and would also assist in determining the urgency of any surgical needs.

42. To this end, Staywell is strongly encouraged to remain in close contact with both Petitioner’s mother and her treating physicians, while maintaining their agreement to facilitate appointments with ██████████. Staywell is reminded that this is likely a matter of

some urgency, and is therefore instructed to pursue authorization for medically necessary services with the attention and thorough analysis their member deserves.

43. Should Petitioner still wish to undergo surgery at [REDACTED] Hospital and/or should she require any other services (in or out of network), she may submit such requests to Staywell at any time. If Staywell denies said services, Petitioner will receive written notification of this adverse action and will retain the right to appeal that/those specific action(s).

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby 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-02256

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DONE and ORDERED this 15 day of June, 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

Jun 05, 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-02297

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 April 18, 2017 at 3:00 p.m.

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 whether the respondent Simply Healthcare's action to partially deny the petitioner's request for home health/personal care services (PCS) was correct. The

respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

At the conclusion of the hearing, the record was left open for the petitioner to submit any documentary evidence and for the respondent to supplement its evidence packet with a copy of the initial denial notice.

The petitioner submitted a handwritten letter from her behavior assistant, which was marked as Petitioner Exhibit 1. The petitioner also submitted a copy of her original appeal request, which was marked as Petitioner Exhibit 2.

Appearing as witnesses for the respondent were Diana Anda, Appeals Manager, and Dr. Jeannette Rios, Medical Director, from Simply Healthcare, which is the petitioner's managed care health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked Respondent composite Exhibit 1 – Authorization Request (including medical records and plan of care), Initial Denial Notice, Appeal Letter, Letter from PCP, Appeal Resolution Letter, and the Medicaid Personal Care Services Coverage Policy.

FINDINGS OF FACT

1. The petitioner is a four (4) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives Medicaid services through Simply Healthcare. Her medical conditions include [REDACTED].

2. The Agency for Health Care Administration (AHCA) is responsible for management of the managed medical assistance 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 Simply Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.
3. On or about January 10, 2017, the petitioner's home health services provider submitted an authorization request to Simply for approval of 6 hours daily of home health care services, 5 days per week (Monday to Friday). The petitioner had previously been approved for 6 hours of services daily, Monday to Friday.
4. On or about January 13, 2017, Simply sent the petitioner a Notice of Action denying the requested home health services as not being a covered benefit. The denial notice stated the following concerning the reason for the denial:

Your request for home health aide for babysitting purposes is denied. Babysitting services is not covered service under Medicaid or your health plan.

5. Thereafter, the petitioner initiated an internal grievance/appeal with Simply. On February 27, 2017, Simply sent the petitioner an appeal determination notice which stated the health plan changed its initial decision and decided to partially approve the request services. That notice stated the following:

Based upon our review, we have decided to partially approve this appeal request. According to the documentation received during appeal, there is need [sic] for the service of 6 hours daily of home health aide and therefore the request for 6 hours is denied. However, the services could be provided and have been approved for 2 hours daily based on Florida Medicaid Home Health visit services coverage policy.

6. The petitioner's mother stated she did not request babysitting services. She also stated the Medicaid Handbook allows for up to 24 hours of services daily.

7. The respondent's witness, Dr. Rios, stated the petitioner's plan of care required assistance with activities of daily living (ADLs), such as bathing, feeding, and toileting. She stated the Medicaid Handbook describes the times allotted for certain services – such as 30 minutes for bathing, 15 minutes for dressing, 15 minutes for brushing teeth, and 15 minutes for shampooing hair. The health plan's position is that 2 hours daily is medically necessary to assist with these activities, and the balance of the requested hours are considered to be not medically necessary. She also stated the health plan did not adhere to the appropriate Medicaid rules previously when it had approved 6 hours daily.

8. Personal Care Service (PCS) for individuals under 21 years of age is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent AHCA's Personal Care Services Coverage Policy (November, 2016).

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 previously been approved for 6 hours of services daily. 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, Fla. Stat. and Chapter 59G, Fla. Admin. Code. The Medicaid Program is administered by the respondent, AHCA.

14. The petitioner has requested personal care or home health aide services. As the petitioner is under 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.

15. 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.

16. 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.

17. The service the petitioner has requested (personal care or home health aide services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409, Fla. Stat., states, in part:

Any service under this section shall be provided only when medically necessary ...

(4) (a) In providing home health care services, the agency may require prior authorization of care based on diagnosis

(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.

¹ "You" in this manual context refers to the state Medicaid agency.

18. 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.

19. 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. The 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.

20. Based upon the information submitted by the petitioner's physician and/or home health provider, Simply Healthcare completed a prior authorization review to determine medical necessity for the requested personal care services.

21. In the petitioner's case, Simply Healthcare has determined that medical necessity has been established for only 2 hours of personal care services daily, rather than 6 hours daily.

22. 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 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.

23. 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.

24. The AHCA contract with managed care plans such as Simply Healthcare includes a provision for home health services, as follows:

(a) The Managed Care Plan shall provide Home Health Services. Home health services are medically necessary services, which can be effectively and efficiently provided in the place of residence of a recipient. Services include home health visits (nurse and home health aide), private duty nursing and personal care services for children, therapy services, medical supplies, and durable medical equipment.

(b) The Managed Care Plan shall comply with provisions of the Medicaid Home Health Services Coverage and Limitations Handbook. In any instance when compliance conflicts with the terms of this Contract, the Contract prevails. In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those in the Medicaid Home Health Services Coverage and Limitations Handbook.

25. The petitioner's request for service is also governed by AHCA's Personal Care Services Coverage Policy, which replaced the prior Home Health Services Coverage and Limitations Handbook. The Policy addresses Personal Care Services as follows:

Florida Medicaid personal care services provide medically necessary assistance, in the home or in the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to

enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.

26. The Policy also sets forth certain criteria for personal care services, as follows:

Florida Medicaid reimburses for up to 24 hours of personal care services per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLs when the recipient meets the following criteria:

- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and do not have a parent or legal guardian able to provide the required care
- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

27. The Policy also contains a parental responsibility provision, which is described as follows:

Florida Medicaid reimburses for personal care services 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.

28. The Policy also addresses which services Medicaid does not provide reimbursement for in regard to personal care services. This list includes:

- Assistance with homework
- Babysitting
- Care, grooming, or feeding of pets and animals
- Certification of the POC by a physician
- Companion sitting or leisure activities

- Escort services
- Housekeeping (except light housekeeping to make the environment safe), homemaker, and chore services
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence
- Yard work, gardening, or home maintenance work

29. The petitioner's physician ordered a service frequency greater than that approved by Simply Healthcare. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

30. As stated by the respondent's witness, the Appendix to the Personal Services Coverage Policy contains certain allotted time periods for specific personal care tasks, such as bathing, toileting, and dressing.

31. After considering the witness testimony and documentary evidence presented, the undersigned concludes that the respondent has not demonstrated it was correct in reducing or partially denying the petitioner's personal care services. Although the Medicaid Personal Care Services Coverage Policy lists the allotted time periods for specific activities such as bathing, dressing, toileting, etc., these time periods are described as "General Time Allowances". There is no provision in the Policy that sets these periods as any kind of maximum time limit, and the Policy allows for up to 24 hours per day of personal care services. In addition, there was no evidence presented that the petitioner's ADL needs can actually be met within the allotted time periods. Accordingly, her services should not be reduced at the present time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, and the petitioner shall continue receiving 6 hours daily of personal care services, Monday to Friday.

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

FINAL ORDER (Cont.)

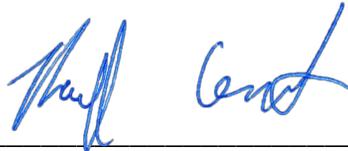
17F-02297

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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 05 day of June, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
SIMPLY HEARINGS UNIT

Jun 09, 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-02381

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 [REDACTED]
UNIT: AHCA

AND

STAYWELL HEALTH PLAN

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 10, 2017 at 3:18 p.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Katrina Young, regulatory research coordinator

STATEMENT OF ISSUE

Whether the petitioner is eligible to receive six resin composite fillings, 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. The Agency contracts with numerous health care maintenance organizations (HMOs) to provide medical services to Medicaid enrollees. Staywell Health Plan (Staywell) is the contracted HMO in the instant case. Staywell subcontracts with Liberty Dental to provide dental services to its enrollees.

By notice dated December 14, 2016, Staywell informed the petitioner that his request for six dental fillings was denied because “[t]he requested service is not a covered benefit.” The petitioner requested reconsideration. By notice dated January 17, 2017, Staywell informed the petitioner that the original denial decision has upheld.

The petitioner timely requested a hearing to challenge the denial decision.

There were no additional witnesses for the petitioner. The petitioner submitted documentary evidence which was admitted into the record as Petitioner’s Exhibit 1.

Present as a witness for the respondent from Liberty Dental: Dr. Richard Hague, dental director. Present as an observer from AHCA: Dianne Soderlind, registered nurse specialist. The respondent submitted documentary evidence which was admitted into the record as Respondent’s Composite 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 (age 45) is a Florida Medicaid recipient. The petitioner is enrolled with Staywell HMO. (Respondent’s Exhibit 1)

2. In December 2016, the petitioner's dental provider, [REDACTED], submitted a request to Staywell for six resin (white) composite fillings, under dental codes D2332, D2932 and D2933. (Respondent's Exhibit 1)

3. Liberty Dental, Staywell's dental vendor, denied the request as a non-covered benefit. (Respondent's Exhibit 1)

4. The petitioner timely requested a hearing to challenge the denial decision.

5. The petitioner is currently on a waitlist for a [REDACTED]. His treating physician wants to "eliminate all possibility of infection" and has recommended that the petitioner's six dental cavities be filled. (Petitioner testimony)

6. [REDACTED] coordinator with [REDACTED], wrote a letter addressing the petitioner's need for the requested dental services. The letter is dated December 9, 2016 and reads:

The letter is to confirm that [petitioner] is currently undergoing a [REDACTED] [REDACTED] evaluation here at [REDACTED].

Pertaining to his impending [REDACTED] surgery, it is medically necessary for [petitioner] to have the discussed dental work so that these teeth will not present any risk for his future procedure.

It would be recommended the [petitioner] has his dental procedures in advance of any planned [REDACTED] ...

7. The petitioner asserted that the dental cavities are not causing any pain or swelling; the cavities do not impact or impair his ability to eat. (Petitioner testimony)

8. Dental fillings are considered restorative services. Medicaid only covers restorative services for recipients age 20 and under, even if the services are recommended by a treating physician. (Testimony of Dr. Richard Hague)

CONCLUSIONS OF LAW

9. 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.

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

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 petitioner.

13. 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.).

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

15. Medicaid Dental Services Policy (May 2016) explains that Medicaid will only reimburse for dental services that are 1) medical necessary and 2) a covered benefit. Section 2.0 of the dental policy reads, “If a service is limited to recipients under the age of 21 years, it is specified in section 4.0.” Section 4.0 reads: “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.” Fillings are considered restorative services. Section 4.2.8 of the handbook addresses restorative services and reads: “Florida Medicaid reimburses for all-inclusive restorative services for recipients under age of 21...”

16. The respondent denied the petitioner’s request for six dental fillings as a non-covered benefit because the petitioner is 45 years old. Medicaid only covers restorative services if the recipient is under age 21.

17. The petitioner argued that an exception should be made due to his impending [REDACTED] and because his treating physician has determined that the service is medically necessary.

18. The definition of medical necessary is found in Fla. Admin. Code R.59G-1.010 and reads: “the fact that a provider has prescribed, recommended, or approved medical...services does not, in itself, make such...services medically necessary...or a covered service.”

19. Medicaid provides limited dental services for individuals over age 20; these services are limited to emergency services to alleviate pain and/or infection and denture preparation services. The petitioner acknowledged that his dental cavities are not painful, there is no swelling, and the petitioner has no issues eating food. The petitioner does not require emergency dental services. The requested service is “to eliminate all possibility of infection” that could impact the petitioner’s impending liver transplant.

20. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet his burden of proof in this matter. The petitioner did not prove by a preponderance of the evidence that the requested

dental service is a covered benefit. The respondent's decision in this matter was correct.

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 09 day of June, 2017,

in Tallahassee, Florida.



Leslie Green
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
Staywell Hearings Unit

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

FILED

May 22, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02433

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 [REDACTED]
UNIT: 88778

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 2, 2017 at 11:35 a.m.

APPEARANCES

For the Petitioner: The petitioner was not present and was represented by her son, [REDACTED]

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

ISSUE

At issue is the Department's action on March 13, 2017 to deny the petitioner's request for retroactive coverage for Institutional Care Program (ICP) Medicaid for the months of October 2016 through December 2016.

Also at issue is the Department's action to deny ICP Medicaid for the application month of January 2017.

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

PRELIMINARY STATEMENT

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

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. On January 27, 2017, the petitioner's son and Power of Attorney, applied for ICP Medicaid benefits on the petitioner's behalf. The petitioner is 102 years of age and is residing at the [REDACTED] nursing facility located in [REDACTED], Florida.

2. The petitioner's son provided evidence of the balances in the petitioner's checking account at [REDACTED]. The petitioner had the following balances in her checking account: \$8067 for the month of October 2016; \$9052 for the month of November 2016; \$5080 for the month of December 2016; \$6059 for the month of January 2017; and \$1587 for the month of February 2017.

3. The Department determined that the petitioner was not eligible for ICP Medicaid prior to the month of February 2017 due to the balances in her checking account exceeding the asset limit in the amount of \$2000 for an individual. The Department determined that the petitioner was eligible for ICP Medicaid beginning in the

month of February 2017, as the balance in her checking account was under the \$2000 threshold.

4. The petitioner's son does not dispute that the balance of the petitioner's checking account exceeded the threshold for the months at issue. The petitioner's son argues that he maintained a large balance in the petitioner's checking account in order to be prepared for any unexpected expenses that may have occurred in the care of his mother. The petitioner's son explained that he used his own monies totaling \$75000, rather than the petitioner's, to pay the facility for his mother's care. The petitioner's son explained that the balances in his mother's account consisted of an accumulation of the deposits of her Social Security income.

5. The petitioner's son now understands the Department's policy regarding the asset limit. The petitioner's son contends that if he had known about the rules and regulations regarding the asset limit for the ICP Medicaid program, he would have been using the petitioner's monies in her account, rather than his own, in order to spend down the balance. The petitioner's son explained that once he learned about the rules of the ICP Medicaid program, he used \$5000 of her money to pay the facility for the month of February 2017 in order to get her balance to be under the asset limit. The petitioner's son would like for the Department to make an adjustment in his mother's case for the months she was ineligible for ICP Medicaid.

6. The Department's records show that the petitioner's Social Security income is \$1136 and that the state of Florida pays her Medicare premium. The Department explained that the petitioner is not eligible for the higher asset limit for the program as

her income exceeds the Medicaid for the aged and disabled (MEDS-AD) income limit, which is \$885 for an individual. The Department explained that the petitioner was not eligible for ICP Medicaid for the months in question because her checking account balance exceeded the asset limit in the amount of \$2000. The Department explained that even with the \$2500 burial exclusion, the petitioner was not eligible for ICP Medicaid due to exceeding the asset limit for the months of October 2016 through January 2017.

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. 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...

10. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource

Eligibility Criteria, states: “

(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...”

(2) Exclusions...

(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.

11. 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.

12. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1640.0205 Asset Limits (MSSI, SFP) states in relevant part:

Total countable assets for an individual or a couple must not exceed the following limits:

1. For MEDS-AD and Medically Needy, the asset limit is \$5,000 for an individual and \$6,000 for a couple.

...

3. For ICP, PACE, all HCBS Waivers and Hospice, the asset limit is \$2,000 for an individual (\$3,000 for eligible couple) or \$5,000 if the individual's income is within the MEDS-AD limit (\$6,000 for eligible couple).

13. The Policy Manual, Appendix A-9, effective July 2016, lists the MEDS-AD income limit for an individual as \$872 (effective at the time of the denial of the requested retroactive months). The MEDS-AD income limit increased to \$882 effective April 2017, according to the Policy Manual, Appendix A-9.

14. The above authorities explain that an asset is cash, a liquid asset, real, or personal property owned by an individual that can be converted to cash. An example of a liquid asset is property that can be converted to cash within 20 days, such as a financial institution account.

15. The asset limit is \$2000 for individuals whose income is over the MEDS-AD income limit. The findings show that the petitioner owned an investment account with a financial institution and her income is over the MEDS-AD income limit. Therefore, the undersigned concludes that the Department was correct to include as a liquid asset, the petitioner's investment account with a financial institution. The undersigned concludes that the Department is to determine eligibility for the petitioner using the \$2000 asset limit.

16. The findings show that the petitioner had a checking account with a financial institution with a balance over the asset limit for the months at issue, which were not spent down to under the asset limit for an individual until February 2017. The petitioner's son requests for the Department to grant eligibility for the three retroactive months prior to the date of the application, to include the month of application, due to his not being knowledgeable of the rules and regulations regarding the asset limit for the ICP Medicaid program. The petitioner's son's arguments and situation is recognized;

however, the petitioner's checking account balance was over the asset limit for the months of October 2016 through January 2017. The undersigned was unable to locate any legal authority that would allow the Department to override its policy and approve the petitioner for ICP Medicaid when her assets exceeded the threshold for the months at issue. Therefore, the undersigned concludes the Department was correct to deem petitioner ineligible for ICP Medicaid for October 2016 through January 2017. Even with the \$2500 burial fund exclusion, petitioner would still exceed the \$2000 asset limit for ICP Medicaid during the time period at issue.

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-02433

PAGE -8

DONE and ORDERED this 22 day of May, 2017,
in Tallahassee, Florida.



Paula Ali

Hearing Officer

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1317 Winewood Boulevard

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

Jun 16, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 17F-02443

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 
UNIT: 88322

DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 4, 2017 at 2:19 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: , petitioner's sister.

For the Respondent: Mary Triplett, supervisor.

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for SSI-related Medicaid based on disability. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

██████████, senior care specialist with ██████████, appeared as a witness for the petitioner.

The petitioner submitted no exhibits. The respondent submitted a 24-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "11". The record was left open through May 19, 2017 for additional information including policy related to Hankerson adoption decisions, a copy of the disability report that was submitted, a copy of the Social Security Administration denial notice, and additional medical reports from ██████████ that were not submitted to the respondent prior to completion of the application. On May 5, 2017, the petitioner submitted a 40-page exhibit and a 29-page exhibit, which included information related to an April 16, 2017 hospitalization, a medical report from ██████████, medical records from ██████████, proof of Medicaid coverage in ██████████, which was marked and entered as Petitioner's Exhibit "1" through "9". On May 19, 2017, the record was closed. On May 24, 2017, the respondent submitted additional evidence including the policies requested, the disability report submitted, and information provided to the respondent from the petitioner including the Social Security Administration hearing appeal notice, after the record was closed. The information was marked and entered as Respondent's Exhibit "12" through "14". The record was closed the same day.

FINDINGS OF FACT

1. The Department of Children and Families (DCF, respondent) 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 for individuals applying for disability benefits under the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and approval of any benefits due.

2. In 2015, the petitioner applied for Social Security Disability with the Social Security Administration (SSA). The petitioner was suffering from a back injury and post-traumatic stress disorder (PTSD) at the time (Petitioner's Exhibit 7).

3. In September 2015, the petitioner was denied disability with the SSA. On November 5, 2015, an appeal was filed with SSA. No SSA denial notice was provided (Petitioner's Exhibit 8).

4. On December 4, 2015, the petitioner was assessed for Temporary Disability Assistance in [REDACTED], reporting a [REDACTED] diagnosis with an expected duration of 12 months or more. The petitioner has been suffering with symptoms for several years and began seeing [REDACTED], a psychiatrist, in June 2015 (Respondent's Exhibit 7).

5. Prior to the action under appeal, the petitioner was living in an assisted living facility in [REDACTED] receiving full Medicaid there. The petitioner moved to Florida with his sister in December 2016 (Petitioner's Exhibit 9).

6. On December 16, 2016, the petitioner was seen by [REDACTED] to establish care. The conditions addressed by the doctor were [REDACTED] [REDACTED] (Petitioner's Exhibit 2).

7. On January 27, 2017, the petitioner was seen again by [REDACTED] in relation to [REDACTED]. The medical report states the petitioner is unable to

work due to his cognition. The petitioner's sister has help the petitioner dress and bathe himself daily. It is noted his sister is looking for placement for him (Petitioner's Exhibit 2).

8. On February 3, 2017, the petitioner submitted an electronic web application requesting SSI-related Medicaid and DDD (Respondent's Exhibit 2).

9. The petitioner (54 years old) lives with his sister and has no household income. He is the only one applying for benefits. The petitioner does not meet the technical requirements under the Family-Related Medicaid program (Respondent's Exhibit 2).

10. On February 22, 2017, the respondent submitted the disability packet to the Division of Disability Determinations (DDD) unit in [REDACTED] citing early onset [REDACTED] (Respondent's Exhibit 3).

11. On March 2, 2017, DDD denied the petitioner's claim of disability, adopting the October 2015 SSA denial citing it as a Hankerson using code "N32: Non-pay- Capacity for substantial gainful activity, other work no visual impairment". The case notes indicate the primary diagnosis as back and secondary diagnosis as anxiety. DDD did not make an independent determination on the petitioner's medical condition, as it determined the petitioner's medical conditions to be the same/related allegations previously known to SSA (Respondent's Exhibit 3).

12. On March 3, 2017, the respondent sent a Notice of Case Action (NOCA) informing the petitioner the request for SSI-related Medicaid had been denied (Respondent's Exhibit 1):

13. The petitioner timely requested the appeal.

14. On April 16, 2017, the petitioner was admitted to [REDACTED]. He was assessed and given a diagnosis of [REDACTED] [REDACTED] (Petitioner's Exhibit 1).

15. The petitioner's sister contends the respondent did not send the correct information to the DDD office in [REDACTED]. She further states no disability interview had been conducted with her, or her brother, or the authorized representative from Senior Care Connector to provide the full scope of the medical conditions (Petitioner's Exhibit 3).

16. The respondent states the disability report was sent with the information provided via fax from the petitioner, including the allegations of [REDACTED] with a noted begin date of June 27, 2012 (Petitioner's Exhibit 3). The petitioner's SSA denial is still under appeal.

17. The petitioner further states an update on his current medical conditions and their severity was given to the attorney handling the appeal of the SSA disability denial and she feels it was not taken into consideration by DDD.

18. The respondent explained that it denied the petitioner's Medicaid application because SSA has determined that he is not disabled and DDD has adopted the same decision based on its policy. The respondent further explained that once DDD determines the petitioner is not disabled, the respondent must deny the application for Medicaid under the SSI-related Medicaid Program for people under the age of 65.

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, Fla. Stat.

20. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

22. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the respondent determines eligibility for: (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) Adult-Related (referred to SSI-Related Medicaid) for disabled adults and adults 65 or older.

23. 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. 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.

24. The Code of Federal Regulations at 42 C.F.R. § 435.000 sets forth the definition and determination of disability and states in relevant part: "Definition of disability (a) Definition. The agency must use the same definition of disability as used under SSI..."

25. 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 §435.912 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.

26. The ACCESS Program TRANSMITTAL NO.:I-03-05-0025, Disability Reminders,

dated May 23, 2003 states :

If the SSA disability denial was made over a year prior to the application for Medicaid with DCF, the state must conduct an independent disability determination unless the client's case is still under appeal with SSA based on the same condition. Again, it may be necessary to obtain a copy of the SSA denial letter in order for staff to determine whether or not the client has a condition that is different than that which is under appeal.

27. The above cited authorities explain the SSA determination is binding for the department and when SSA determination made over a year prior to the application for Medicaid, an independent disability determination must be made unless the client's case is under appeal with SSA based on the same conditions. In this instant case, the petitioner applied with SSA in 2015 and the denial is currently under appeal with SSA. The petitioner provided additional medical evidence to the attorney handling the SSA appeal after the original denial.

28. The medical report from [REDACTED], dated January 27, 2017, indicates the petitioner's diagnosis of [REDACTED]. The [REDACTED] diagnosis was previously known based on medical reports dated June 2015. The petitioner reported the [REDACTED] diagnosis with an onset date in June 2012 in the DDD report that she completed.

29. DDD's denial is based upon adoption of the denial SSA from 2015. The petitioner did not provide the SSA denial notice in order to determine which conditions SSA has considered in the application for disability.

30. Based on the evidence and testimony provided, the undersigned concludes the petitioner failed to meet the burden of proof that the conditions currently under review by SSA are not the same current allegations of disability. Changes in the severity of the severity of the petitioner's medical conditions have been reported to his attorney who in turn report to SSA. The undersigned found no evidence of new conditions and concludes the petitioner's current diagnosis is known to SSA and currently under appeal with SSA.

31. After careful review of the cited authorities, the respondent's action to deny the petitioner's request for SSI-related Medicaid was within rule of the program. The petitioner's application with SSA for disability is currently under appeal and the petitioner has provided all new or worsening conditions to the attorney handling the appeal.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the 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 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- 02443
PAGE -10

DONE and ORDERED this 16 day of June, 2017,
in Tallahassee, Florida.

Pamela B. Vance

Pamela B. Vance
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Email: Appeal.Hearings@myflfamilies.com

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

Jun 19, 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-02484

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: 88778

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on May 10, 2017 at 1:06 p.m.

APPEARANCES

For the Petitioner: [REDACTED], eligibility specialist, [REDACTED]

For the Respondent: Betty Lewis, economic self-sufficiency specialist II

STATEMENT OF ISSUE

At issue is the denial of the petitioner's SSI-Related Medicaid application. The burden of proof was assigned to the petitioner by a preponderance evidence.

PRELIMINARY STATEMENT

At the hearing, the respondent submitted two exhibits which were accepted into evidence and marked as Respondent's Composite Exhibits 1 and 2. The petitioner

submitted one exhibit which was accepted into evidence and marked as Petitioner's Composite Exhibit 1.

FINDINGS OF FACT

1. On February 15, 2017, the petitioner's representative submitted an application on behalf of the petitioner for SSI-Related Medicaid benefits. The petitioner was 90 years old at the time of her application. There was no income or assets reported on the application. As part of the application process, the respondent was required to explore and verify certain factors of eligibility which included technical requirements, income and assets. The respondent reviewed the application and requested verification of Immigration and Naturalization Service (INS) status, proof of loans, contributions and gifts used to pay expenses. The information was provided and the case file updated. The respondent was also required to trigger its Assets Verification System (AVS)/electronic Data Exchange system. (Respondent's Composite Exhibit 1).
2. On March 16, 2017, the respondent received a response from AVS indicating that the petitioner was a joint owner of a savings account at [REDACTED]. The account balances were \$10,626.45 for March 2017 and \$10,726.37 for February 2017 (Respondent's Exhibit 1).
3. The respondent determined that the petitioner's assets exceeded the maximum asset limit for an individual who is disabled by \$5,626. The maximum asset limit is \$5,000.
4. On March 17, 2017, the respondent mailed a Notice of Case Action to the petitioner informing her that her Medically Needy application was denied. The reason

for the denial was “ineligibility due to value of undisclosed assets” (Respondent’s Composite Exhibit 1).

5. On March 22, 2017, the petitioner requested a hearing to challenge the respondent’s action.
6. On March 29, 2017, the petitioner’s representative requested information pertaining to the denial.
7. On May 1, 2017, the respondent sent an email informing the petitioner’s representative of the asset overage/bank account and the supporting policy.
8. The petitioner’s representative asserted that the petitioner does not own the savings account at [REDACTED]. She argued that the savings account belongs to the petitioner’s son. The representative provided a letter from the petitioner’s son stating that he owns the savings account with the petitioner at [REDACTED]. Additionally, the letter stated that he opened the account and added the petitioner’s name at a later date in case he needed help managing the account (Respondent’s Exhibit 2 and Petitioner’s Composite Exhibit 1).
9. The representative also provided a letter from the petitioner’s daughter stating that her mother does not have any assets at any institution in her name (Petitioner’s Composite Exhibit 1)
10. The respondent did not accept the letters provided from the petitioner’s representative as verification of asset. There is no indication that the petitioner did not have access to the funds in the account or that the funds were unavailable to her.
11. At the hearing, the respondent asserted that the petitioner needs to provide proof from the bank as to who opened the account, the date it was opened and the owners on

the account. The respondent asserted that the petitioner's name is first on the account, which is an indication that she is the primary owner of the account (Respondent's Composite Exhibit 1).

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 Fla. Admin. Code R. 65-2.056.

14. 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."

15. Fla. Admin. Code R.65A- 1.205 Eligibility Determination Process, states in the pertinent part:

...(5) The Department can substantiate, verify or document information provided by the applicant/recipient as part of each determination of eligibility. For any program, when there is a question about the validity of the information provided, the Department will ask for additional documentation or verification as required. The term verification is used generically to represent this process.

(a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.

(b) Verification confirms the accuracy of information through a source(s) other than the individual. The Department can secure verification electronically, telephonically, in writing, or by personal contact.

(c) Documentation establishes the accuracy of information by obtaining and including in the case record an official document, official paper or a

photocopy of such document or paper or electronic source that supports the statement(s) made by the individual.

(6) The Department conducts data exchanges with other agencies and systems to obtain information on each applicant and recipient. It uses data exchanges to validate or identify social security numbers, verify the receipt of benefits from other sources, verify reported information, and obtain previously unreported information...

(b) The Department compares information found through the data exchanges with the information already on file. If the data exchange identifies new or different information than was previously available, the Department conducts a partial eligibility review to determine whether it must change benefit levels.

16. The Department's Policy Manual (The Policy Manual), at passage 1640.0205 addresses Asset Limits (MSSI, SFP) and states: "For MEDS-AD and Medically Needy, the asset limit is \$5,000 for an individual.

17. Federal regulations at 20 C.F.R. §416.1201 addresses, Resources and 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. 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.).

18. Fla. Admin. Code R. 65A-1.303, Assets, states in part:

(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.

19. Fla. Admin. Code R. 65A-1.716, Income and Resource Criteria, sets forth the Medically Needy monthly asset limit for an individual at \$5,000 for a single-individual household.

20. Fla. 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. 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.

21. The above cited authorities define assets, establishes rules set for determining availability of assets and where it is considered countable in determining eligibility. The

petitioner's representative disputes that the petitioner is the owner of the savings account or has access to it. She claims that the account belongs to the son.

22. The federal regulation 20 C.F.R. §416.1208 addresses, how funds held in financial institution accounts are counted and states in 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.

(c) *Jointly-held account—(1) Account holders include one or more SSI claimants or recipients. If there is only one SSI claimant or recipient account holder on a jointly held account, we presume that all of the funds in the account belong to that individual. If there is more than one claimant or recipient account holder, we presume that all the funds in the account belong to those individuals in equal shares* (emphasis added).

(2) *Account holders include one or more deemors.* If none of the account holders is a claimant or recipient, we presume that all of the funds in a jointly-held account belong to the deemor(s), in equal shares if there is more than one deemor. A deemor is a person whose income and resources are required to be considered when determining eligibility and computing the SSI benefit for an eligible individual (see §§416.1160 and 416.1202).

(3) *Right to rebut presumption of ownership.* If the claimant, recipient, or deemor objects or disagrees with an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, we give the individual the opportunity to rebut the presumption (emphasis added). Rebuttal is a procedure as described in paragraph (c)(4) of this section, which permits an individual to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to him or her. Successful rebuttal establishes that the individual does not own some or all of the funds. The effect of successful rebuttal may be retroactive as well as prospective.

Example: The recipient's first month of eligibility is January 1993. In May 1993 the recipient successfully establishes that none of the funds in a 5-year-old jointly-held account belong to her. We do not count any of the funds as resources for the months of January 1993 and continuing.

(4) *Procedure for rebuttal. To rebut an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, the individual*

must:

- (i) Submit his/her statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account,** why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;
- (ii) Submit account records showing deposits, withdrawals, and interest (if any) in the months for which ownership of funds is at issue; and
- (iii) Correct the account title to show that the individual is no longer a co-owner if the individual owns none of the funds; or, if the individual owns only a portion of the funds, separate the funds owned by the other account holder(s) from his/her own funds and correct the account title on the individual's own funds to show they are solely-owned by the individual (emphasis added).

23. The above authority addresses joint account holders and allows for the right to rebut presumption of ownership. The petitioner's son (the other account owner) provided a letter that he owns the Bank of America account and that the petitione ris on the account in case he needs help managing.

24. The Department's Public Assistance Policy Manual, Passage

1640.0302.04, Proof Needed to Rebut Ownership states as follows:

When an individual has unrestricted access to the funds in a joint account but does not consider himself an owner of part or all of the account funds, you must advise the individual that:

1. the funds are presumed to be his; and
2. he may rebut the presumption of ownership by presenting proof the funds belong to someone else.

To rebut the presumption of ownership, the individual must provide the following information:

First [*emphasis in original*], the individual must provide a written statement and corroborating evidence from the financial institution(s) and other sources to substantiate:

1. any claims about ownership of the funds or interest from the funds;
2. the reasons for establishing the joint account;
3. whose funds were deposited into the account;
4. who made withdrawals from the account; and
5. information on how withdrawals were spent.

Second [*emphasis in original*], the individual must provide a written statement from the joint owner(s) explaining their understanding of the

ownership of the account(s); that is, claims of ownership, why the account was set up, who deposited funds, withdrew funds and used the account. When an individual is a co-owner of an account with someone who is incompetent or a minor, the corroborating co-owner statement is not necessary. You must obtain a corroborating statement from a third party who has knowledge of the circumstances.

If there is no third party or the individual is unable to provide all bank verification, you must make a rebuttal determination based on the evidence submitted. Enter an explanation on CLRC why no written corroborating statement was obtained from the joint owner.

To successfully rebut ownership of a joint account, the evidence must clearly support that the individual is not a joint owner of the funds.

25. The above-cited authority defines the owner of an asset as “any individual who has the legal ability to dispose of an interest in an asset.” In the instant case, as the petitioner’s name appeared on the assets in question, the respondent presumed that the petitioner owned the assets, and therefore, considered the assets available to the petitioner.

26. In accordance with the above cited authority and policy manual, the respondent used an electronic Data Exchange system to verify the petitioner’s asset value in her savings account. The Data Exchange showed the savings account balances were \$10,626.45 for March 2017 and \$10,726.37 for February 2017. The respondent determined the petitioner’s assets were over the asset limit. However, the petitioner’s representative argued that the petitioner does not own the asset. The petitioner son, joint owner of the savings account provided a letter stating that he owns the savings account with the petitioner. There was no indication or proof provided that the funds in the savings account were unavailable to the petitioner.

27. The undersigned concludes that the funds in question were available to the petitioner at the time of the denial, and by the account having the petitioner’s name on

it, she has unlimited access to the funds in the account whether she chooses to use them or not. The petitioner's representative has not met her burden and has not successfully refuted petitioner's ownership or availability of the asset in question. As the value of the funds was over \$5,000, the undersigned concludes that the petitioner exceeded the resource limit and was ineligible for Medicaid benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the respondent's action is 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 19 day of June, 2017,

in Tallahassee, Florida.



Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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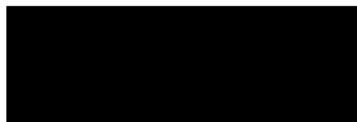
Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Jun 12, 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-02496

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 
UNIT: 88222

RESPONDENT.



FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:16 p.m. on April 14, 2017.

APPEARANCES

For the Petitioner:


petitioner's authorized representative (AR)

For the Respondent:

Susan Martin, ACCESS
Operations Management Consultant I

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Institutional Care Program (ICP) Medicaid, 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 did not submit exhibits. The respondent's representative submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on April 14, 2017.

FINDINGS OF FACT

1. On February 3, 2017, an ICP application was submitted for the petitioner (Respondent Exhibit 2).
2. On February 6, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA), requesting documents, including a bank statement, to determine eligibility. The documents were due by February 16, 2017 (Respondent Exhibit 3).
3. The only document not received from the petitioner was a bank statement.
4. On March 7, 2017, the Department mailed the petitioner a NOCA, notifying her February 3, 2017 application was denied, "Reason: We did not receive all the information requested to determine eligibility." (Respondent Exhibit 3, page 20)
5. The AR agreed that the bank statement was not provided. And explained that the reason it was not provided was because the bank account where the petitioner's Social Security check was being deposited does not belong to the petitioner.
6. The AR asserts that she and the petitioner went to the bank where the petitioner's check was being deposited at, to get a bank statement. And the employee at the bank recognized the petitioner, but was unable to provide her with the bank statement because the petitioner's name is not on the account.

7. The respondent's representative suggested the AR submit a letter from the bank where the petitioner's check is/was being deposited, stating that the petitioner is not on the account.
8. The AR asserts that the petitioner's Social Security check is now being deposited into a Direct Express account.
9. The respondent's representative also suggested the petitioner go on-line and create a password for her Direct Express account, which will allow her to print her account statement. And submit another ICP application.
10. The AR was appreciative of the respondent's representative suggestions and agreed to proceed with the suggestions.

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 *Florida Administrative Code* R. 65-2.056.
13. *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...

14. In accordance with the above authority, the respondent mailed the petitioner a NOCA on February 6, 2017, requesting the petitioner's bank statement (among other items).

15. The AR agreed that the bank statement where the petitioner's Social Security check is/was being deposited was not provided to the Department.

16. Also, in accordance with the above authority, the Department denied the petitioner ICP Medicaid on March 7, 2017, for not submitting the required document to determine eligibility.

17. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner's AR did not meet the burden of proof. The undersigned concludes the Department's action to deny the petitioner ICP 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 12 day of June, 2017,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
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
[REDACTED]

Jun 20, 2017

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

PETITIONER,

Vs.

APPEAL NO. 17F-02515

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 66032

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 10, 2017 at 1:30 p.m.

APPEARANCES

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

For the Respondent: Sylma Dekony, Economic Self Sufficiency Specialist II
Department of Children and Families

STATEMENT OF ISSUE

Petitioner appeals the amount of his Share of Cost (SOC) in the Medically Needy (MN) Program. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner appeared but elected to have [REDACTED] speak on his behalf.
Respondent did not object.

Petitioner and Respondent both submitted evidence, which was not entered on the record. After the hearing, the undersigned entered Petitioner and Respondent's evidence into the record. Petitioner submitted one exhibit at hearing, which was entered into evidence and marked as Petitioner's Exhibit "1." Respondent submitted an evidence packet at hearing consisting of ten exhibits, nine of which were entered into evidence and marked as Respondent's Exhibits "1" – "9." The undersigned did not enter Respondent's exhibit pages 2 – 4 into evidence as it consisted of notices created by the Office of Appeal Hearings and already included on the docket. The record closed on April 10, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal, Petitioner was receiving full Medicaid through Supplemental Security Income (SSI) (Respondent's Exhibit 5, page 17).
2. In February 2017, Petitioner's SSI Medicaid terminated as he was determined eligible for Social Security Disability Income (SSDI) through the Social Security Administration (SSA) (Petitioner and Respondent's Testimony).
3. On February 23, 2017, Petitioner submitted an on-line application to Respondent for SSI-Related Medicaid for himself (Respondent's Exhibit 3).
4. As part of the eligibility process, Respondent verified through the Department's State of Florida On-Line Query that Petitioner receives \$1,931.00 per month in SSDI (Respondent's Exhibit 5, page 18).
5. Respondent calculated Petitioner's total countable income as \$1,911.00, after a \$20.00 unearned income disregard was subtracted from his \$1,931.00 SSDI benefits (Respondent's exhibit 6).

6. The income limit for an aged/disabled individual to receive full Medicaid on the date of application was \$874.00 (Respondent's Exhibit 9, page 43). Petitioner's total countable income exceeded that limit. Accordingly, Respondent enrolled Petitioner in the MN Program.

7. To determine the SOC, Respondent determined the Medically Needy Income Level (MNIL) at the time of application and for a household size of one was \$180.00 (Respondent's Exhibit 9, page 43). This amount was subtracted from Petitioner's \$1,911.00 total countable income (Respondent's Exhibit 6).

Respondent calculated Petitioner's SOC as follows:

Total unearned income:	\$1,931.00
Unearned income disregard:	-\$ 20.00
Total countable income:	\$1,911.00
MNIL:	-\$ 180.00
SOC:	\$1,731.00

8. On March 7, 2017, Respondent mailed a Notice of Case Action (NOCA) to Petitioner at his current residence approving him for the MN Program and enrolling him with a \$1,731.00 SOC for February, 2017, and ongoing (Respondent's Exhibit 2).

9. Petitioner explained that due to recurring medical expenses for ongoing [REDACTED] treatment he cannot afford to meet the SOC and maintain his costs of living based on his current monthly income (Petitioner's testimony and Petitioner's Exhibit "1"). Petitioner requested a lower SOC.

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 of the Florida Statutes. This order is the final administrative decision of the Department of Children and Families under section 409.285 of the Florida Statutes.

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

12. Florida Administrative Code Rule 65A-1.710, SSI-Related Medicaid Coverage

Groups, states in part:

The Department covers all mandatory coverage groups and the following optional coverage groups:

...

(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. Florida Administrative Code Rule 65A-1.713 defines the income limits for SSI-

Related Medicaid programs:

(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:

...

(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," shall be considered available for payment of medical care and services...

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

15. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2640.0500, Share of Cost (MSSI), sets forth:

The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's assets and/or income exceeds the appropriate categorical asset/income limits. The eligibility specialist determines whether the assistance group's assets are within the Medically Needy asset limits and whether the assistance group members meet the technical factors. If the Medically Needy asset limit is met and the assistance group meets all technical factors, the eligibility specialist determines the amount of countable income and computes a budget using the MNIL which is the same for both family and SSI-Related Medicaid coverage groups (refer to Appendix A-7).

If income is equal to or less than the MNIL, there is no share of cost and the individual is eligible. Medicaid is authorized for individuals who are eligible without a share of cost. If income is greater than the MNIL, share of cost is determined for appropriate members. Appropriate members are enrolled but cannot be eligible until the share of cost is met.

16. The Code of Federal Regulations Title 20, section 416.1124, defines unearned income that is not counted in SSI-Related Medicaid programs and states in part "(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month..."

17. Florida Administrative Code Rule 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for one person at \$180.00.

18. In accordance with the above cited authorities, Respondent deducted \$20.00 unearned income disregard and \$180.00 MNIL from Petitioner's \$1,931.00 SSDI to arrive at a \$1,731.00 SOC for February, 2017, and ongoing.

19. In careful review of the cited authorities and evidence, the undersigned concludes Petitioner did not meet the burden of proof to indicate Respondent incorrectly calculated his SOC, or that the SOC should be less than that calculated under mandate

of law. The undersigned concludes that Respondent correctly calculated Petitioner's SOC as \$1,731.00.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED. 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 20 day of June, 2017,

in Tallahassee, Florida.



Erik Swenk, Esq.
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jun 19, 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-02579

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 [REDACTED]
UNIT: 88993

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 8th, 2017, at 11:33 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

For the Respondent: Ed Poutre, Senior Worker for the Department of Children and Families

STATEMENT OF ISSUE

The petitioner is appealing the termination of his SSI-Related Medicaid application. The respondent carries the burden of proving its position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The petitioner did not present any documents 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 May 8th, 2017, to allow the respondent time to provide additional information. The information was provided timely, and the documents were entered as Respondent's Exhibit 9. An Interim Order was issued on May 19th, 2017, that allowed the petitioner 10 days to respond to the additional evidence if he chose to do so. The petitioner responded telephonically to the Office of Appeal Hearings but did not speak directly to the hearing officer. The hearing officer concluded there was no need to reconvene. Therefore, the record was closed at the close of business May 30th, 2017.

By way of a Notice of Case Action (NOCA) dated December 28th, 2016, the respondent informed the petitioner that his Medicaid benefits would end January 31st, 2017 because he was not age 65 years or older, did not meet a disability requirement, and no household members were eligible for the program. On March 24th, 2017, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner submitted an online recertification for Food Assistance (FA) and SSI-Related Medicaid on December 19th, 2016. FA is not an issue for this appeal. (See Respondent's Exhibit 2). As part of the application process, the respondent is required to explore and verify all technical factors of eligibility.
2. The petitioner is a single-person household and was age 44 at the time of the application. There are no children under the age of 18 living in the petitioner's household.
3. The respondent previously authorized SSI-Related Medicaid for the petitioner beginning October 1st, 2014, with a review date of November 1st, 2015. (See

Respondent's Exhibit 4). However, a review of the SSI-Related Medicaid eligibility was not completed until the petitioner applied for a recertification on December 19th, 2016.

4. The petitioner applied for disability through the Social Security Administration (SSA) on January 6th, 2015. SSA denied the petitioner's application with the denial reason "N31" or "Non-pay – Capacity for substantial gainful activity – customary past work, no visual impairment." According to evidence provided by the respondent, the petitioner appealed the SSA denial on May 11th, 2015 and the appeal is coded with the letter "R." (See Respondent's Exhibit 6). The respondent asserted that the denial was currently under appeal. However, the petitioner asserted that the appeal had already been denied, and that he did not appeal the decision a second time.

5. The petitioner described his medical conditions as blood clots in his lungs and arms, advanced [REDACTED]. The petitioner asserts that he needs assistance with daily living and is periodically admitted to the hospital for treatment. The petitioner contends that his conditions have worsened since the SSA denial. The petitioner testified that he is unable to drive, unable to lift anything that weighs over two pounds, and cannot enter into stressful situations.

6. The respondent testified that it did not complete a disability determination with the petitioner when he applied on December 19th, 2016. An entry in the department's business notes (CLRC) reads as follows:

"Closed MM S med since PIP indicated on web appl [sic] that his disability will not last more than 30 days or 12 months or longer."

As part of the fair hearing review process, the respondent faxed a request for SSA Disability Status to the Department of Disability Determination (DDD) on April 25th, 2017. On April 27th, 2017, DDD updated CLRC with the following response:

“DDD response: not disabled: 05/29/2015.”

7. The petitioner disagrees with the respondent’s action of terminating his SSI-Related Medicaid. The petitioner continues to require medical treatment for his conditions and asserts that many of the conditions result in hospitalizations and high dose medications.

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 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

10. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process states in part:

(a) The Department must determine an applicant’s eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter...

(2) In accordance with 7 C.F.R. Section 273.14, 45 C.F.R. Section 206.10(a)(9)(iii), 42 C.F.R. Section 435.916, and Section 414.095, F.S., the Department must determine eligibility at periodic intervals.

(a) A complete eligibility review is the process of reviewing all factors related to continued eligibility of the assistance group.

11. As stated in the above-cited authority, the respondent must determine the petitioner's eligibility at the initial application and at periodic intervals. The petitioner was determined eligible for disability Medicaid and applied for a review at what would be considered a "periodic interval." However, instead of reviewing eligibility for continued disability Medicaid coverage the respondent closed the Medicaid based on information located on the application. According to the respondent's testimony, a review of the SOLQ system shows that the petitioner's Social Security application is under appeal. As shown in the Findings of Fact, the respondent provided proof of the appeal date, as listed on SOLQ. In addition to the appeal date is a code listed as "R." A review of the SOLQ guide shows that the code "R" in the category of "Appeal Code/Date" means, "Gearing – affirmation of prior decision." This indicates that the appeal is complete, and the original denial was affirmed. Therefore, there is not currently a SSA appeal in process. In conclusion, the hearing officer does not affirm the respondent's action to terminate the petitioner's disability Medicaid without first completing a disability review.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the appeal is granted to the extent described above. This decision is not a guarantee of eligibility. Rather, the respondent is ordered to take corrective action in the appeal as described above.

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.)

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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 Department has no funds to assist in this review.

DONE and ORDERED this 19 day of June , 2017,

in Tallahassee, Florida.



Kimberly Vargo
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

Jun 16, 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-02586

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 [REDACTED]
UNIT: 88651

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 26, 2017 at 1:08 p.m.

APPEARANCES

For the Petitioner: [REDACTED], mother

For the Respondent: Ronda Lanum, ACCESS supervisor

STATEMENT OF ISSUE

At issue is whether the petitioner meets the eligibility requirements for participation in the SSI-Related Medicaid Program. The petitioner holds the burden of proof at the level of preponderance of the evidence.

PRELIMINARY STATEMENT

Florida Department of Children and Families (Department or DCF or respondent) determines eligibility for participation in the Medicaid Program.

By notice dated March 9, 2017, the Department informed the petitioner that his application for SSI-Related Medicaid was denied. The notice reads in relevant part, “[y]ou...do not meet the disability requirement.”

On March 24, 2017, the petitioner timely requested a hearing to challenge the Department’s decision.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence during the proceeding.

There were no additional witnesses for the Department. The Department submitted documentary evidence which was admitted in the records as submitted Respondent’s Composite Exhibit 1.

The petitioner requested the record be held open for submission of proposed orders. The Department did not object to the record being held open, but did not wish to submit a proposed order. The record was held open until close of business on June 6, 2017. The petitioner timely filed a proposed order which was considered during the development of this decision.

The hearing record was closed on June 6, 2017.

FINDINGS OF FACT

1. The petitioner (age 34) applied for SSI-Related Medicaid on February 6, 2017. The petitioner is a single. He lives in the family home with his mother and father. (DDD). (Respondent’s Composite Exhibit 1)

2. The petitioner asserted that he is disabled due [REDACTED] (which occurred in September 2016) [REDACTED], and [REDACTED]). (Testimony of petitioner's mother)

3. Prior to applying for Medicaid with the Department, the petitioner applied for disability benefits with the Social Security Administration (SSA). The application was filed on September 28, 2016. SSA denied the application on January 13, 2017. SSA concluded that the petitioner was not disabled because the duration of his incapacitation was not expected to exceed 12 continuous months. The petitioner filed an appeal with SSA on February 6, 2017. The appeal was still pending at the time of the hearing. (Respondent's Composite Exhibit 1)

4. On March 9, 2017, the Department denied the petitioner's Medicaid application due to not meeting the disability requirement. Department witness, Ronda Lanum, explained that the Department is required to adopt SSA disability decisions made within the last 12 months, unless there is a new disabling condition not reviewed by SSA. (Testimony of Ronda Lanum)

5. The petitioner's mother confirmed that all disabling conditions were reported to SSA. The petitioner has no new disabling conditions. However, she disagreed with SSA's conclusion that the petitioner's incapacitation will not exceed 12 continuous months. She asserted the petitioner's impairments are severe and will last indefinitely unless he receives proper medical care. The petitioner is verbal and ambulates without an assistive. However, he has short term memory issues which prevent him for completing even simple tasks without verbal reminders. Due to his impairments, he can

no longer engage in his former job, installing and repairing commercial air conditioning systems. He can no longer drive a car.

6. The petitioner did not have third party insurance coverage at the time of the [REDACTED] in September 2016. He did not qualify for workmen's compensation benefits because his impairment was not a result of his work. (Testimony of petitioner's mother)

7. The petitioner has incurred over \$700,000 in medical bills. Without a source of income, he has no means to pay. His parents are supporting him, but they have limited income and cannot afford the cost of the petitioner's care. (Testimony of Petitioner's mother)

8. After the [REDACTED], the petitioner was approved for limited health services through the local Department of Health (DOH). DOH does not cover rehabilitative and neuropsychological services the petitioner believes are necessary for him to recover and return to work. (Testimony of Petitioner's mother)

9. The petitioner's mother argued that "the system has failed him and adopted poor decisions." She asked that "Medicaid be granted so he can get medical support and rehabilitative help with Vocational Rehab for re-employment skills and opportunity to work in a job that is physically appropriate for him." (Testimony and Proposed Final Order of Petitioner's mother)

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-1.705(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...

13. The petitioner does not have a minor child under age 18 living in the household. In accordance with the above cited legal authority, he does not meet the technical requirement to be eligible for Family-Related Medicaid benefits.

14. Fla. Admin. Code R. 65A-1.711 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. For an individual less than 65 years of age to receive Medicaid benefits, he or she must meet the disability 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.

15. Federal Regulation at 42 C.F.R. § 435.541 provides standards for state disability determinations 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 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.

...

(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—

16. In March 2017, the Department denied the petitioner's application for SSI-Related Medicaid. The Department adopted SSA's January 2017 decision which concluded that the petitioner was not disabled because his impairments were not expected to last 12 continuous months.

17. The petitioner had no new disabling conditions which were not reported to SSA. The petitioner's appeal with SSA was still pending as of the date of the hearing. Because SSA's decision was made within the last 12 months and the petitioner had no new disabling condition, the controlling authorities preclude the Department from making an independent disability determination in the instant case. The Department must adopt SSA's decision.

18. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet his burden of proof in this matter. The petitioner did not prove by a preponderance of the evidence that he meets the disability requirement necessary for participation in the SSI-Related Medicaid Program.

DECISION

The petitioner's appeal is denied. The respondent's decision 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

FINAL ORDER (Cont.)

17F-02586

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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 Department has no funds to assist in this review.

DONE and ORDERED this 16 day of June, 2017,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jun 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. 17F-02645

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 May 22nd, 2017, at 8:23 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

For the Respondent: Roneige Alnord, Economic Self-Sufficiency Specialist II for the Department of Children and Families

STATEMENT OF ISSUE

The petitioner is appealing the termination of her SSI-Related Medicaid benefits. The respondent carries the burden of proving its position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

At the hearing, the petitioner did not present any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 7 were admitted into evidence.

The record was held open until the close of business May 30th, 2017, to allow either the petitioner or the respondent time to provide the petitioner's evidence. The petitioner provided the evidence timely. The documents were entered as Petitioner's Composite 1, and the record was closed.

By way of a Notice of Case Action (NOCA) dated March 1st, 2017, the respondent informed the petitioner that Medicaid benefits would close effective March 31st, 2017 because the youngest child is 18. On March 24th, 2017, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner submitted an online application to recertify for Food Assistance (FA) on February 24th, 2017. (See Respondent's Exhibit 3). The petitioner's Family Medicaid benefits were reviewed at the same time even though the certification was not due to end until April 30th, 2017. FA is not an issue for this appeal.
2. The petitioner's household includes herself, 49 years of age, and her daughter, 18 years of age.
3. The respondent previously authorized Family Medicaid for the petitioner beginning May 1st, 2017, with a review date of April 30th, 2017. According to the respondent, the petitioner's daughter turned 18 in November 2016 which caused the petitioner to lose eligibility. However, the Medicaid eligibility wasn't reviewed until the FA application was submitted on February 24th, 2017. During the review, the respondent determined that the petitioner was no longer eligible for Medicaid.

4. The respondent did not complete a disability determination with the petitioner.

On the application dated February 24th, 2017, the petitioner listed, "No" when asked if she was disabled. The respondent asserted that during a verbal review of the Medicaid, the petitioner was asked if she was disabled, and she again said, "No."

5. The petitioner testified that she had applied for Social Security benefits through the Social Security Administration (SSA) "years ago" but was denied. The petitioner did not consider herself disabled.

6. The petitioner is a single mother of a disabled 18-year-old child and provided multiple dates for her child's upcoming medical appointments. The petitioner asserts that due to her daughter's medical conditions, she cannot maintain employment and must remain in good health. The petitioner noted that in the past she has suffered from [REDACTED] and [REDACTED] and currently has [REDACTED]. All other medical conditions mentioned relate to the petitioner's daughter.

7. The respondent advised to the respondent reconsider applying for benefits through SSA. The respondent further asserted that to maintain Medicaid eligibility, the petitioner must meet disability criteria or have a child under the age of 18 in the home.

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 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

10. Fla. Admin. Code R. 65A-1.705 Family-Related Medicaid General Eligibility

Criteria states in relative part:

(1) Technical eligibility criteria of living in the home of a specified relative, age, residence, citizenship and deprivation apply to coverage groups as follows.

(d) If assistance is requested for the parent of a child in an intact family, the parent, the mutual child's other parent, the mutual child and all siblings of the mutual child who have no income must be included in the SFU...**For the parent to be eligible, there must be at least one child under age 18 [emphasis added]...**

11. As mentioned in the above-cited authority, in order for a parent to be eligible for Medicaid, there must be at least one child under the age of 18 in the household. As stated in the Findings of Fact, the petitioner's daughter turned 18 in November 2016. Furthermore, the petitioner does not consider herself disabled. Therefore, a disability determination was not considered.

12. The hearing officer recognizes the petitioner's claim that her daughter has numerous medical appointments which makes it difficult to maintain employment and secure health insurance. However, there is no provision in the regulations that allows a parent to have continued Medicaid coverage after the youngest child turns 18 based solely on the child's health status. Accordingly, the hearing officer concludes that the respondent's action to terminate the petitioner's Medicaid was correct.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. 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 13 day of June, 2017,

in Tallahassee, Florida.



Kimberly Vargo
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jun 26, 2017

Office of Appeal Hearings
Dept. of Children and FamiliesSTATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-02650

PETITIONER,

Vs.

CASE NO [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 88274RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 9, 2017 at approximately 1:28 p.m. CDT.

APPEARANCESFor the Petitioner: [REDACTED], *pro se*

For the Respondent: Ed Poutre, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of April 21, 2017. The respondent tracked medical bills received as a reported change approving Medically Needy (MN) Medicaid effective October 18, 2016. The petitioner asserts that the bill tracking should have resulted in an effective date of October 13, 2017. 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 remained open pending the receipt of further documentation from the respondent. This information was received May 19, 2017. It was admitted into evidence and marked as Respondent's Composite Exhibit "10". The record was closed May 19, 2017.

At the hearing, the undersigned assigned the burden of proof to the respondent, but upon further consideration determines the affirmative argument is that of the petitioner.

FINDINGS OF FACT

1. The petitioner received a notice of case action (NOCA) dated January 9, 2017 informing her that her SOC had not been met because the bills she submitted totaled \$441.02 and her SOC was \$1,486. She was also informed that bills from [REDACTED] could not be tracked because they lacked actual dates of service with the costs for each date of service and the total bill amount. The NOCA also informed her that statements, estimates, quotes, insurance claim forms and receipts were not acceptable (Respondent's Exhibit 10).
2. The petitioner received a notice of case action (NOCA) dated January 20, 2017 informing her that her MN SOC was met and she was Medicaid eligible from October 19 through October 31, 2016 (Respondent's Exhibit 3).
3. Another NOCA, one dated February 2, 2017, was sent to the petitioner informing her that her SOC was met effective October 19, 2016 (Respondent's Exhibit 10).

4. On February 20, 2017, the petitioner reported a change to the respondent. The change consisted of medical bills provided for tracking to meet her share of cost (SOC) (Respondent's Exhibit 2).
5. The petitioner received a NOCA dated February 21, 2017, informing her that the respondent needed copies of her medical bills for October 2016 (Respondent's Exhibit 10).
6. The petitioner received a NOCA dated April 6, 2017 informing her that her April 5, 2017 Medicaid application was approved and that she was eligible for October 2016 (Respondent's Exhibit 10).
7. The petitioner received a NOCA dated April 21, 2017 informing her that her SOC had been met effective October 18, 2016 (Respondent's Exhibit 3).
8. The Florida Medicaid Management Information System (FLMMIS), the system used by the Agency for Health Care Administration (AHCA) to manage Medicaid eligibility files and payments, shows the petitioner is Medicaid eligible in the MN program from October 18 through October 31, 2016.
9. The petitioner received notification of eligibility for the month of October and then later received a more restrictive notification stating that she would only be Medicaid eligible first from October 19, 2016 and later corrected to October 18, 2016.
10. The respondent testified that the October 19, 2016 effective date was an error corrected by the respondent once documentation with the correct date was received. The respondent stated that bills submitted do not meet the SOC for the petitioner prior to October 18, 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.

15. 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. Federal Regulations at 20 CFR § 416.1121 Types of unearned income states:

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.

...

18. The above authority explains that unearned income, such as Social Security income, is included as income in determining eligibility for the Medicaid programs. The findings show that the petitioner is receiving Social Security income. Therefore, the undersigned concludes that the Department was correct to include the petitioner's Social Security income in its calculations.

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

(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. Fla. Admin. Code R. 65A-1.710 SSI-Related Medicaid Coverage Groups states

in part:

(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. 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:

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

(2) (c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:

1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and

personal care services in the home prescribed by a recognized member of the medical community.

22. The Department's Program Policy Manual, CFOP 165-22, passage

2640.0507.02 Tracking Medical Expenses (MSSI) explains bill tracking and the meeting of SOC. It states:

Allowable medical expenses must be tracked on a monthly basis for each individual/family with a different assistance group and share of cost.

Allowable medical expenses whether paid or unpaid must be tracked in chronological order by date incurred (date of service to the individual).

Inpatient hospital medical expenses are to be tracked on a day-by-day basis. An itemized bill should be requested from the hospital. If the

hospital cannot or will not provide an itemized bill, it is appropriate to divide the bill by the number of days of the hospital stay. The eligibility

specialist would then track on a daily basis until the individual has met the individual's share of cost. At that point, only the non-Medicaid

compensable services, if any, could be carried forward to meet a future month's share of cost. Allowable medical expenses being tracked for a

specific day should be tracked using paid bills first. On the day on which an individual meets their share of cost, expenses are considered in the

following order:

1. Medicare or other recognized health insurance cost;

2. bills of individuals who cannot be entitled to Medicaid, are considered next; and

3. paid bills are a final consideration.

Other bills should be tracked to the advantage of the individual.

23. The Medicaid income limits are set forth in the Fla. Admin. Code at R. 65A-1.716 :

(1) The monthly federal poverty level figures based on the size of the filing unit...

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows...

Size...1 Level \$180...

24. Federal Regulations at 20 CFR § § 416.1124 Unearned income we do not count states:

(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.

25. The petitioner's share of cost was calculated by including her countable gross monthly income less the standard disregard and Medically Needy Income Level (MNIL) for an individual. The gross monthly household unearned income of \$1,791, less the \$20 standard disregard and MNIL of \$180, equals a share of cost of \$1,591. The hearing officer found no exception to this calculation. From the \$1591 amount of an \$111 medical insurance premium was deducted lowering the share of cost to \$1,480. The undersigned concludes that the respondent's action to enroll the petitioner into the Medically Needy Program and to determine the amount of the monthly share of cost as \$1,480 was a correct action.

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 June, 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

Jun 15, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 17F-02658

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 13 
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on June 1, 2017, at 10:30 a.m.

APPEARANCES

For the petitioner: , pro se

For the Respondent: Sloan Karver, M.D.
Long-Term Care Medical Director
United Healthcare

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly reduced the petitioner's Personal Care Services from 31 hours per week to 13 hours per week and her Homemaker Services from 12 hours per week to five hours per week?

PRELIMINARY STATEMENT

Christian Laos, Senior Compliance Analyst with United Healthcare, appeared as a witness on behalf of the respondent, United Healthcare. Sheila Broderick, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration (“AHCA” or “Agency”), was present solely for the purpose of observation.

The respondent introduced Exhibits “1” through “13” at the hearing, which were accepted into evidence and marked accordingly. The hearing officer left the hearing record in this matter open until the close of business on the day of the hearing for the respondent to submit a copy of the United Healthcare Community Plan Health and Home Connection Enrollee Handbook. Once the Handbook was received, the hearing officer accepted it into evidence and marked it as respondent’s Exhibit “14”. The hearing record was then closed.

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 63-year-old female.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. The petitioner is an enrolled member of the United Healthcare Community Plan. United Healthcare 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 United Healthcare was April 1, 2015.

5. The petitioner is a participant of the Long-Term Care Program.

6. The petitioner was previously approved to receive the following services through United Healthcare: 31 hours per week of Personal Care Services; and 12 hours per week of Homemaker Services.

7. The United Healthcare Community Plan Health and Home Connection Enrollee Handbook ("member handbook") defines Personal Care Services as: "Assistance with eating, bathing, dressing, and personal hygiene."

8. The United Healthcare member handbook defines Homemaker Services as: "General household activities such as meal preparation and routine household tasks provided by a trained homemaker."

9. As the result of an assessment completed by the petitioner's case manager at United Healthcare, the respondent determined the petitioner's needs could be met with a total of 18 hours per week of services.

10. United Healthcare sent the petitioner a Notice of Action dated February 2, 2017 advising her that her Personal Care Services were being reduced from 31 hours per week to 13 hours per week. 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)

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

11. The February 2, 2017 Notice of Action goes on to state:

The facts that we used to make our decision are: You asked to continue 43 hours of care at home. Your care plan is based on your needs. You can be provided with 18 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.

12. In a second Notice of Action, dated February 1, 2017, United Healthcare also informed the petitioner that it was reducing her Homemaker Services from 12 hours per week to five hours per week. 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)

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury and not be in excess of the patient's needs.

13. The February 1, 2017 Notice of Action goes on to state:

The facts that we used to make our decision are: 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. The request is denied.

14. After learning of the proposed reduction of services, the petitioner requested an administrative hearing. This proceeding ensued.

15. The petitioner's medical history is remarkable for the following conditions:

[REDACTED]

[REDACTED]

16. The petitioner lives in the family home with her 22-year-old daughter and one-year-old granddaughter.

17. The petitioner's daughter works and goes to school.

18. The petitioner is alone for most of the time that her aide is not with her.
19. The petitioner has been bedridden for the past 10 years. She is confined to her bed.
20. The petitioner is on multiple medications – she takes as many as 19 pills at night and five pills in the morning.
21. The petitioner described her mental state as foggy and explained that she sleeps a lot.
22. The petitioner is unable to ambulate to the bathroom. She uses a bedpan which her aide empties.
23. The petitioner requires assistance with all of her daily living functions.
24. The petitioner's aide assists the petitioner with the following: he provides breakfast, lunch, and dinner to the petitioner; prepares some of the petitioner's meals; bathes the petitioner; washes the petitioner's hair when needed; changes the petitioner's bed linens; cleans the petitioner's bedroom and bathroom; does light housework in other parts of the petitioner's home; does the petitioner's laundry; reminds the petitioner to take her medications and test her blood sugar; and assists the petitioner with toileting activities.
25. The petitioner's aide is normally with her from 8:30 a.m. until 12:30 p.m. or 1:00 p.m. and again from 6:00 p.m. until 8:00 p.m. or 8:30 p.m., seven days per week.
26. The petitioner explained there was a fire in her neighborhood recently and expressed concerns about her safety when she is home alone.
27. The petitioner testified that she cannot do anything for herself and that the reduced number of hours are insufficient to provide her with the assistance she requires in order to ensure her health and safety.

28. The Medical Director appearing as a witness for the respondent testified that the decision to reduce the petitioner's services resulted from the evaluation of information contained in a recent assessment completed by the petitioner's case manager. However, the Medical Director did not provide any specific reasons substantiating the reduction of services in the presentation of her direct case.

CONCLUSIONS OF LAW

29. 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 Chapter 120.80, Fla. Stat.

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

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

32. In the present case, the respondent is purporting to reduce the petitioner's existing services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof is assigned to the respondent.

33. 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.).

34. 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.

35. 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...

36. Under § 1915(c) of the Social Security Act (42 USC § 1396n(c)), a state may obtain a Medicaid waiver that allows the state to include in the state's Medicaid program the cost of home or community-based services (other than room and board) provided to individuals who otherwise would require care in a hospital, nursing facility, or intermediate care facility.

37. Home or community-based services include personal care services, habilitation services, and other services that are "cost effective and necessary to avoid institutionalization." See 42 CFR § 440.180.

38. Section 409.978, Florida Statutes, 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. Fla. Stat. § 409.981(1), authorizes AHCA to solicit bids from and utilize provider service networks to achieve this goal. In the instant case, the provider network/HMO is United Healthcare.

39. The definition of medically necessary is found in the 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.

40. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Chapter 59G-4. In accordance with the above Statute, the Handbook states 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.

41. 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.”

42. Section 400.462(24) defines personal care as follows:

“Personal care” means assistance to a patient in the activities of daily living, such as dressing, bathing, eating, or personal hygiene, and assistance in physical transfer, ambulation, and in administering medications as permitted by rule.

43. The United Healthcare Community Plan Health and Home Connection

Enrollee Handbook (‘member handbook’) defines Personal Care Services as:

“Assistance with eating, bathing, dressing, and personal hygiene.”

44. Section 400.462(16), Fla. Stat. defines a homemaker as follows:

“Homemaker” means a person who performs household chores that include housekeeping, meal planning and preparation, shopping assistance, and routine household activities for an elderly, handicapped, or convalescent individual. A homemaker may not provide hands-on personal care to a client.

45. The United Healthcare member handbook defines Homemaker Services

as: “General household activities such as meal preparation and routine household tasks provided by a trained homemaker.”

46. United Healthcare’s services are not more restrictive than those of the Agency for Health Care Administration.

47. The petitioner participates in the Long-Term Care Program. The Long-Term Care Program is designed to provide recipients with the services they need in order to continue living independently in the community. It is a nursing home diversion program.

48. In the present case, the respondent’s Medical Director testified the decision to reduce the petitioner’s Personal Care Services and Homemaker Services resulted from an evaluation of the information contained in a recent assessment completed by the petitioner’s case manager. However, the witness did not provide any specific testimony

explaining why the services are no longer medically necessary. Conversely, the petitioner provided concrete examples of why the services are medically necessary to ensure her health and safety.

49. After careful consideration, the hearing officer concludes the respondent has not met its burden of proof to demonstrate that the Personal Care Services and Homemaker Services it is proposing to reduce are no longer medically necessary and that its decision to reduce those services is correct.

DECISION

The 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 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 15 day of June, 2017,

in Tallahassee, Florida.



Peter J. Tsamis
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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FINAL ORDER (Cont.)

17F-02658

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Copies Furnished To:

██████████, Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

Jun 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-02728

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 88266

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 17, 2017 at approximately 1:20 p.m. CDT

APPEARANCES

For the Petitioner: [REDACTED], *pro se*

For the Respondent: Ed Poutre, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of March 21, 2017 denying her application for disability-related Medicaid. 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 petitioner submitted a packet of information that was admitted into evidence and marked as Petitioner's Exhibit "1".

FINDINGS OF FACT

1. The petitioner is a 44 year old female without dependents in a household of one (Respondent's Exhibit 2).
2. On April 23, 2016, the petitioner applied for Supplemental Security Income (SSI) from the Social Security Administration (SSA) (Respondent's Exhibit 7).
3. This application was denied by SSA on July 8, 2016 with denial code N36. The respondent testified that the N36 code means "Non-pay – Insufficient or no medical data furnished" (Respondent's Exhibit 7)
4. The petitioner appealed this SSA denial on December 19, 2016 (Respondent's Exhibit 7).
5. On January 25, 2017, the petitioner submitted an application to the respondent requesting Food Assistance, Cash Assistance, SSI-Related Medicaid and DDD, Division of Disability Determination Assistance. This hearing concerns only the SSI-Related Medicaid and the DDD determination (Respondent's Exhibit 2).
6. On January 26, 2017, the petitioner completed the medical interview requirement for the requested disability determination (Respondent's Exhibit 9).
7. Because of the untimely receipt of documentation, the DDD packet was sent for review on March 8, 2017 (Respondent's Exhibit 1).
8. On March 20, 2017, the respondent received the DDD decision denying the Medicaid application. The decision cited the SSA denial and denial code N36. In the

remarks on the Disability Determination form is written "Hankerson 10/16. Same/related allegations, hearing pending" (Respondent's Exhibit 5).

9. The respondent testified that the Medicaid application was denied based on DDD's decision to adopt the SSA's denial.

10. There was no representative from DDD to testify as to their procedures or the reasoning behind their decision.

11. The petitioner testified to her poor health and mentioned many diagnoses, including [REDACTED] that was discovered during an MRI at [REDACTED] in December 2016; [REDACTED]

[REDACTED] which were diagnosed in August and September 2016 (Petitioner's Exhibit 1).

12. The petitioner testified that the SSA decision is under appeal and that she has secured representation. She states that she understands because of backlog, it may be a year or more before there is an actual SSA appeal hearing. The petitioner is unsure as to whether or not her attorney has submitted evidence of her new potentially disabling conditions to the SSA. If he has, he has not reported any response by the SSA related to them.

13. The petitioner testified that the illnesses diagnosed after her April 2016 SSI application were not considered by the SSA when denying her disability determination request.

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.

15. 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. 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.

[Emphasis added.]

18. The findings show that the petitioner applied for disability benefits with the SSA and was denied as she was found not disabled. The denial date was July 8, 2016. The respondent's January 25, 2017 application is within one year of the SSA denial.

19. The findings also show that the petitioner has impairments that were not considered as part of her SSA application as they were not diagnosed at the time of the

SSA application including [REDACTED] and [REDACTED] diagnosed in December 2016 and [REDACTED] diagnosed in July and August 2016. The undersigned concludes that these are potentially disabling conditions “different from, or in addition to, that considered by SSA in making its determination.”

20. The findings also show that the SSA decision adopted was N36, insufficient evidence. Without sufficient information, the SSA decision would not be based on a disability determination (Five-Step). As the SSA did not make a medical determination of disability, the undersigned concludes that the DDD should have been asked to make one.

21. In careful review of the cited authorities, evidence and testimony, the undersigned concludes the petitioner has met her burden of proof that the respondent incorrectly denied her request for an independent disability determination.

22. Therefore, the undersigned remands the case to the respondent for further development. In accordance with the controlling legal authorities, the respondent is hereby ordered to complete an independent disability review on the petitioner for the time period of December 2016 on-going. The respondent is to issue a Notice of Case Action when the review is completed and said notice shall include appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is REMANDED to the Department for an independent disability determination for the months of December 2016 on-going. Once the new review is completed, the respondent is to issue written notice including appeal rights to the petitioner.

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 June, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jun 28, 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-02732

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: 88701

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 8, 2017 at 1:38 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Barbara Dean, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the Department's action on April 3, 2017, denying his application for SSI-Related Medicaid benefits as he did not meet the disability requirement. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented a packet of documents which was entered into evidence as marked as Respondent's Exhibits 1 through 6.

The petitioner did not present any documents at the hearing. The record was held open until May 18, 2017, for the petitioner to provide evidence on his medical condition and the denial letter from Social Security Administration (SSA). The petitioner provided two exhibits which were entered into evidence and marked as Petitioner's Exhibits 1 and 2. The record was closed on May 18, 2017.

Present as witness for the petitioner was [REDACTED], petitioner's mother.

FINDINGS OF FACT

1. The petitioner filed a disability application with the Social Security Administration (SSA). SSA denied the petitioner's disability application on August 25, 2015. On December 31, 2015, the petitioner appealed the SSA denial. That appeal is currently pending.
2. On March 17, 2017, the petitioner submitted an application for SSI-Related Medicaid benefits to the respondent. He has no minor children. At the time of the application, the petitioner was 38 years old. His date of birth is [REDACTED]. As he is not yet 65 years of age and has no minor children in her household, the petitioner must meet the disability-related criteria in order to be considered for Medicaid. On the above-mentioned application, the petitioner answered, "Yes" that he was disabled.
3. On March 27, 2017, a disability determination packet was sent to the Division of Disability Determinations (DDD), to complete a determination of disability.

4. DDD did not conduct an independent review but instead, denied the petitioner's disability application by adopting the SSA denial decision of August 25, 2015.

5. On March 31, 2017, DDD denied the petitioner's disability application.

6. On April 3, 2017, the respondent sent a Notice of Case Action informing the petitioner that his Medicaid application was denied. The reason for the denial was that he did not meet the disability requirement.

7. On April 3, 2017, the petitioner requested a hearing to challenge the respondent's decision.

8. On April 5, 2017, the respondent received a Disability Determination and Transmittal form from DDD, which stated in the remarks section "Hankerson 11/15 same related allegations, hearing pending. The reason for the denial was "Non-pay— Capacity for substantial gainful activity – other work, no visual impairment". This was indicated by reason code N32 on the transmittal.

9. At the hearing, the petitioner alleged new disabling conditions since the initial denial of his SSA disability application. He stated his new conditions are d [REDACTED]

10. The petitioner provided medical records of the alleged new disabling conditions. He provided a medical document of an evaluation done on August 10, 2016 indicating that he was diagnosed with [REDACTED]. The evaluation was done between March 3, 2017 and March 8, 2017, at the [REDACTED] Medical Center. On March 29, 2017, he was seen by [REDACTED] for a foot evaluation with complaints of severe contracture, severe [REDACTED] and pain in both

feet. He provided additional medical evaluations for April 4, April 5, 2017, May 3, 2017, and May 5, 2017.

11. The petitioner provided a letter from SSA which denied Social Security benefits. The reason for that denial was that he does not have enough work credits to qualify for benefits.

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 Fla. Admin. Code R. 65-2.056.

14. Florida 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 to receive Medicaid who is less than 65 years of age, 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 or any other substantial gainful work that exists in the national economy...

15. The Code of 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 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 [emphasis added]
 - (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; (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 above authorities explained 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 meet the duration requirement of the Act, **and** he or she has not filed a disability claim with the SSA regarding the alleged medical conditions. The petitioner does not fit these criteria as he has a pending appeal with the SSA. The petitioner reported that he has new conditions of [REDACTED]

[REDACTED] which were not considered by SSA; however, he did not provide the disability report from SSA to show the conditions reviewed by SSA. His medical evidence indicates that he had diabetes for years prior to the SSA denial; therefore, it is not a new condition. The medical records/reports dated April 4, 2017, May 3, 2017, May 10, 2017 occurred after DDD denied the petitioner's disability application. Any new conditions occurring after the Department's denial will need a new application for SSI-Related Medicaid if not already reviewed by SSA or being considered in petitioner's SSA appeal.

17. The ACCESS Program TRANSMITTAL NO. I-03-05-0025, Disability Reminders, dated May 23, 2003 states:

If the SSA disability denial was made over a year prior to the application for Medicaid with DCF, the state must conduct an independent disability determination unless the client's case is still under appeal with SSA based on the same condition. Again, it may be necessary to obtain a copy of the SSA denial letter in order for staff to determine whether or not the client has a condition that is different than that which is under appeal.

18. The above cited authorities explain the SSA determination is binding for the Department and when SSA determination made over a year prior to an application for Medicaid, an independent disability determination must be made unless the client's

case is under appeal with SSA based on the same conditions. In this instant case, the petitioner's SSA denial is currently under appeal with SSA.

19. The petitioner has not met his burden to show he has new disabling conditions that were not considered by SSA. The above authority states if there is no new disabling condition the state agency does not make a disability determination.

20. After considering the evidence, testimony and the appropriate authorities, the undersigned concludes the petitioner must complete the appeal process with SSA. The Department correctly adopted the SSA disability decision to deny the petitioner SSI-Related Medicaid rather than make an independent decision on petitioner's disability request.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the respondent's decision is 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.)
17F-02732
PAGE -8

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

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

May 09, 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-02780

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: 88222

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:35 a.m. on May 5, 2017.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the respondent's (Department) action to deny the petitioner Medicaid Qualified Medicare Beneficiary (QMB) benefits for December 2016, January 2017 and February 2017. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing originally convened on April 28, 2017. The parties agreed to reconvene on May 5, 2017, for the Department to submit verification that the petitioner's QMB for December 2016, January 2017 and February 2017 was approved.

The petitioner did not submit exhibits. The respondent's representative submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on May 5, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal the petitioner received QMB (Respondent Exhibit 4).
2. In October 2016, the Department received an electronic notification of \$8,738.05 undisclosed assets for the petitioner. The Department notified the petitioner that her QMB would end in December 2016 unless she provided verification that the asset was not hers.
3. On March 6, 2017, the petitioner submitted a paper application for Food Assistance and Medicaid benefits (Respondent Exhibit 1). QMB Medicaid is the only issue.
4. On March 8, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA) denying the petitioner's March 6, 2017 Medicaid application, due to "No household members are eligible for this program." (Respondent Exhibit 2). The petitioner was over the asset limit for QMB, due to the \$8,738.05.
5. On March 14, 2017, the petitioner submitted verification that the \$8,738.05 did not belong to her.
6. On March 16, 2017, the Department mailed the petitioner a NOCA, notifying QMB was approved for March 2017, April 2017 and ongoing (Respondent Exhibit 2, page 20).

7. On March 24, 2017, the respondent's representative completed a pre-hearing conference with the petitioner and approved QMB for December 2016, January 2017 and February 2017 (Respondent Exhibit 3).
8. The petitioner asserts that the Social Security Administration (SSA) has only reimbursed her for one of the three months that they deducted the Medicare premium from her checks. And insists that the Department must contact the SSA and have them reimburse the remaining two months of Medicare premium.
9. The respondent's representative explained that it is up to the petitioner to contact the SSA and provide evidence that the Department has approved QMB for December 2016, January 2017 and February 2017.
10. The Hearing Officer explained that she does not have jurisdiction over the SSA.

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 *Florida Administrative Code* R. 65-2.056.
13. *Florida Administration Code* R. 65-2.042, Applicant/Recipient Fair Hearings in part states:

The Department of Children and Family Services, hereinafter referred to as Department or Agency, is required to provide notice and an opportunity of a hearing to any applicant or recipient when the Department's action, intended action or failure to act would adversely affect the individual's or family's eligibility for an amount or type of Financial Assistance, Medical

Assistance, Social Services, or Food Stamp Program Benefits, or where action on a claim for such assistance or services is unreasonably delayed...

14. *Florida Administration Code R 65-2.044*, Right to Request a Hearing in part states:

Any applicant/recipient dissatisfied with the Department's action or failure to act has a right to request a Hearing. He/she may do so when it is believed that:

- (1) Opportunity to make application has been denied.
- (2) The application has been rejected.
- (3) The application has not been acted upon within a reasonable length of time.
- (4) The benefits have been modified or discontinued.
- (5) Reconsideration of the assistance/service benefits is refused or delayed.
- (6) Opportunity has not been given to make a choice of service.
- (7) Any other DCF action (or inaction) is incorrect.

15. The above authorities explain a Fair Hearing may be requested on actions taken by the DCF. The SSA is not part of DCF. Consequently, the Office of Appeal Hearings does not have jurisdiction over the SSA not reimbursing the petitioner her Medicare premium.

16. The evidence submitted establishes that the Department approved the petitioner QMB for December 2016, January 2017 and February 2017. Resulting in no other issues for the undersigned to address. Therefore, the appeal is HEREBY dismissed as moot.

DECISION

Based upon the forgoing Findings of Fact and Conclusions of Law, the appeal is denied and dismissed as moot.

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 09 day of May, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
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Jun 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. 17F-02815

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 [REDACTED]
UNIT: 88510

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned began a telephonic administrative hearing in the above-referenced matter on April 27th, 2017. Due to a continuance requested by the respondent, the hearing was rescheduled and completed on May 31st, 2017 at 3:00 p.m.

APPEARANCES

On April 27, 2017:

For the Petitioner: [REDACTED], Medical Representative, [REDACTED]

For the Respondent: Patricia Rodriguez, Supervisor for the ESS Program.

On May 31, 2017:

For the Petitioner: [REDACTED], pro se.

For the Respondent: Patricia Rodriguez, Supervisor for the ESS program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's denial of his Medicaid application dated December 28th, 2016, based on an existing Child Support Enforcement (CSE) sanction against the petitioner. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for April 27th, 2017, however, the respondent requested a continuance to bring in their witness from Child Support Enforcement, which was granted, and the hearing was rescheduled as described above.

The petitioner did not appear at the hearing on April 27th, 2017 and the medical representative did not have proper authorization from the petitioner. The petitioner was present at the rescheduled hearing on May 31st, 2017.

Appearing as a witness for the petitioner was Ms. [REDACTED] from the [REDACTED]
[REDACTED]

Appearing as a witness for the respondent was Ms. Julie Williamson-Chambers, Revenue Administrator from the Child Support Enforcement (CSE), Department of Revenue.

At the hearing, the petitioner requested additional time to submit medical records, and the record was held open for that purpose until close of business on June 2nd, 2017, at which time the record was closed. The petitioner's document was marked and entered into evidence as Petitioner's Composite Exhibit 1.

At the hearing, the respondent submitted one composite exhibit which was marked into evidence as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. The petitioner applied for Medicaid and Food Assistance (FA) on December 28th, 2016. By way of Notice of Case Action (NOCA) dated January 30th, 2017, the respondent informed the petitioner that it had denied the petitioner's Medicaid application due to not receiving all information requested to determine eligibility.

2. Upon receiving said notice, the petitioner contacted the respondent and was informed that he has an existing child support sanction placed against him, which prevented him from becoming eligible for Medicaid.

3. The petitioner submitted another application for Medicaid on January 31st, 2017, and the respondent authorized Medicaid for the petitioner effective February 1st, 2017 due to the petitioner complying with child support effective February 1st, 2017.

4. The petitioner stated that he has outstanding medical bills for December 2016 and January 2017, and need to have Medicaid approved for those months. He contends that had he known about the child support sanction when he applied on December 28th, 2016, he would have complied. The petitioner stated that he was willing to cooperate, but was unable to do so due to his medical condition at the time of application.

5. The petitioner's witness stated that the petitioner is not contesting the child support sanction in place, but contends that he had cooperated, but was unable to fulfill all aspects of that cooperation. The witness also stated that she is aware of the cooperation requirements, and advised the petitioner to complete the requirements for cooperation.

6. The respondent stated that the petitioner had the child support sanction effective September 2015, and the petitioner was informed of the same by the respondent by way of notice of case action issued on September 9th, 2015.

7. The respondent stated that it received the petitioner's initial application on December 28th, 2016. The respondent issued a notice to the petitioner on January 3rd, 2017 requesting to have a phone interview by January 6th, 2017 in order to determine eligibility. On this notice, the respondent also requested to provide verification of any income the petitioner receives.

8. The respondent stated that the petitioner did not keep his appointment, so, on January 9th, 2017, the respondent issued another notice to the petitioner informing him that he had not called or came in by the deadline date to complete the interview. The respondent also informed the petitioner that it is his responsibility to reschedule a time to complete the interview, failing which his benefits may be denied. 9. The respondent stated that had the petitioner kept his interview appointment, he would have been reminded of existing child support sanction since September 2015.

9. The respondent stated that in order to be eligible for Medicaid, a parent or caretaker relative has to cooperate with child support enforcement, and failure to do so will result in a sanction. Once a child support sanction is imposed, it cannot be removed unless instructed by Child Support Enforcement.

10. The respondent's witness from CSE testified that the petitioner was notified of his non-cooperation back in July 2015. The petitioner contacted CSE's customer service center in April 2016 and inquired about how to start services again. He was then advised by CSE staff to

contact the Department of Children and Families to send service request to CSE, so that CSE can initiate services again. However, CSE never heard from the petitioner again until February 1st, 2017, at which time he cooperated with CSE, and services were reinstated.

11. The respondent's witness testified that the petitioner's sanction cannot be lifted prior to his compliance date of February 1st, 2017 because the petitioner did not cooperate prior to that time. The required paper work was mailed to the petitioner's confirmed address, however, he did not complete and return the paper work to go forward with his case. The witness stated that there is no good cause for medical reasons, which would give the petitioner an exception to the rule.

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 Fla. Admin. Code R. 65-2.056.

14. 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).

15. 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.

16. 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...

15. 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...

17. 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.

18. 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.

19. The petitioner was informed by CSE of his non-cooperation back in July 2015, and was mailed the necessary paper work to complete with the opportunity to cooperate with CSE. However, the petitioner did not cooperate and a child support sanction was placed on him effective September 2015. The petitioner did cooperate with CSE, but only on February 1st, 2017, and the sanction was subsequently lifted effective that date. The prior months beginning from September 2015 and ending in January 2017, are sanctioned months for the petitioner, which would make him ineligible for Medicaid.

20. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's action to deny the 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 13 day of June, 2017,

in Tallahassee, Florida.



Sajan George
Hearing Officer
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Jun 30, 2017

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 17F-02864

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 
UNIT: 88345

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 22, 2017 at 10:39 a.m.

APPEARANCES

For the Petitioner:  designated representative

For the Respondent: Ed Poutre, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of denying retroactive Medicaid coverage for February 1, 2016 through May 31, 2016. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence prior to the hearing which was entered as Respondent's Exhibit 1. The petitioner submitted evidence prior to the hearing which was entered as Petitioner's Exhibit 1.

The record closed on May 22, 2017.

FINDINGS OF FACT

1. The petitioner was a 43-year-old male at the time of his original applications for SSI-Related Medicaid. He had not been determined disabled. The petitioner is deceased as of August 27, 2016.
2. The Department and petitioner concur the petitioner filed applications for SSI-Related Medicaid on April 27, 2016, May 11, 2016, and August 11, 2016 which were each denied.
3. Social Security Administration denied the petitioner's application for Social Security Disability on February 18, 2016 under the code N35. The N35 code means "Non-pay, impairment severe at time of adjudication, but not expected to last 12 months."
4. The petitioner stated that staff from his office had interviewed the petitioner and were aware of the application for Social Security disability, but were unaware the denial was so recent and thus they did not file an appeal of the denial.
5. The petitioner filed an application on September 4, 2016 for SSI-Related Medicaid. The application reflects the petitioner having medical bills in July 2015, December 2015, February 2016, April 2016, May 2016, July 2016 and ongoing. The petitioner listed no minor children in the home.

6. The Department issued a Disability Determination and Transmittal to the Division of Disability Determinations (DDD) office on October 3, 2016. The Department indicated on the transmittal the earliest month retroactive coverage requested was December 2015.

7. DDD issued a favorable determination of disability to begin on June 1, 2016. The summary decision stated "43-year-old male deceased due to

[REDACTED] . [REDACTED]
[REDACTED] CLMT ALLOWED. A62 - Listing 4.02."

8. The petitioner's representative reported the petitioner had a diagnosis of [REDACTED] caused him to be hospitalized multiple times from February 2016 through May 2016. It is the representative's belief that this diagnosis also led to his [REDACTED] [REDACTED] and death in August 2016. The representative explained he has submitted complete medical records to the Department in the past.

9. The Department concurred that the old applications which were denied could be used to cover retroactive months if necessary IF there was a changed disability determination.

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. 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.

13. The definition of MEDS-AD Demonstration Waiver 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.

14. 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).

15. 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.)

16. 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)

17. The undersigned explored potential eligibility for Medicaid for the petitioner under the SSI-Related Medicaid program. The petitioner was 43 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.

18. The findings show the petitioner was denied for Social Security disability in February 2016. The findings show the petitioner did not appeal this decision. The

findings show the petitioner is deceased as of August 27, 2016. The undersigned concludes the petitioner's death is a new or worsened condition criteria within the 12 months of the most recent SSA determination denying disability.

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

(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).

...

(7) Re-evaluating Medicaid Adverse Actions. The department shall re-evaluate any adverse Medicaid determination upon a showing of good cause by the individual that the previous determination was incorrect and that the individual did not request a hearing within the time prescribed in Chapter 65-2, Part IV, F.A.C. This provision applies only when benefits were terminated or denied erroneously or a share of cost or patient responsibility was determined erroneously.

(a) Good cause exists if evidence is presented which shows any of the following:

1. Mathematical Error – The department made a mechanical, computer or human error in its mathematical computations of resources, income, or spend down requirements for Medicaid eligibility.
2. Error on the Face of the Record – The department made an error in a Medicaid determination which caused an incorrect decision. For example, there is evidence showing that the individual's resources satisfied Florida's standard of eligibility but the application was denied on the basis of excess resources.
3. New and Material Evidence – The department's determination was correct when made but new and material evidence that the department did not previously consider establishes that a different decision should be made.

...

(c) A re-evaluation must be requested before the expiration of 12 months from the effective date of the notice of adverse action.

20. The above controlling authority allows the three months immediately preceding the month of application to be considered as the retroactive period. The findings show the petitioner the petitioner filed an application on May 11, 2016. The

undersigned concludes the retroactive period for this application is February 2016 through April 2016. The findings show the petitioner filed an application August 11, 2016. The undersigned concludes the retroactive period for this application is May 2016 through July 2016.

21. The above controlling authority explains that when an adverse action is taken in a Medicaid case, the Department can re-evaluate it if the request for re-evaluation is within 12 months of the effective date of the notice of adverse action and good cause exists. One of the reasons cited in the authority that qualifies as good cause is new and material evidence. The undersigned concludes the Department's determination on applications filed during the February 2016 through August 2016 were accurate at the time of decision as they were based off the SSA denial decision from February 2016.

22. The findings show the petitioner was denied by SSA with a reason code N35 "Non-pay, impairment severe at time of adjudication, but not expected to last 12 months." The undersigned concludes the petitioner's death in August 2016 is new and material evidence that should be considered and may result in a different conclusion for these retroactive months which are attached to the previously denied applications.

23. Based on the evidence and testimony presented as well as the above cited rules and regulations, the undersigned concludes the Department must proceed with a determination of disability for the months of February 2016 through May 2016 for the purpose of determining eligibility for retroactive Medicaid coverage for the aforementioned period.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the Department for determination of disability and eligibility for February 2016 through May 2016. Upon determination, the Department is to issue a Notice of Case Action to 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 30 day of June, 2017,

in Tallahassee, Florida.



Melissa Roedel
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Jun 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-02936

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 [REDACTED]
UNIT: 09DDD

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 16th, 2017 at 3:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED], prose.

For the Respondent: Sylma Dekony, Economic Self-Sufficiency Specialist II for the ESS Program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action on March 27th, 2017, to deny the petitioner's application for Medicaid. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was [REDACTED], the petitioner's step-mother.

At the hearing, the petitioner submitted one composite exhibit which was marked into evidence as Petitioner's Composite Exhibit 1.

At the hearing, the respondent submitted documents, which were admitted into evidence as Respondent's Exhibits 1 through 5.

By way of Notice of Case Action (NOCA) dated March 27th, 2017, the respondent informed the petitioner that it had denied his Medicaid application due to failing to complete an interview to determine eligibility for the program (Respondent's Exhibit 1). On April 6th, 2017, the petitioner filed an appeal to challenge this action.

FINDINGS OF FACT

1. On February 22nd, 2017, the petitioner applied for Food Assistance (FA) and SSI-Related Medicaid, including retroactive Medicaid for the months of November and December 2016, and January 2017.

2. The respondent stated that a disability questionnaire along with a notice of case action to call for an interview was mailed to the petitioner on February 24th, 2017. The notice advised the petitioner to call in for a phone interview at [REDACTED], on or before March 6th, 2017, between the hours of 8:00 AM and 3:00 PM. (Respondent's Exhibit 1)

3. The petitioner stated that he was interviewed at a local office on March 2nd, 2017. Documents related to his disability, and the completed disability packet were returned to the respondent on March 2nd, 2017. (Respondent's Exhibit 4)

4. The petitioner submitted his telephone bill which shows the call log, stressing the telephone number [REDACTED], to which calls were made on several days. It shows calls were made on March 2nd, at 1:23 PM; on March 3rd, at 11:04 AM, 12:00 PM, 12:02 PM, 12:14 PM, 12:25 PM, and 4:16 PM; on March 6th, at 11:48 AM and 11:50 AM. (Petitioner's Composite Exhibit 1.) A final attempt on March 7th, 2017, proved successful.

5. The petitioner contacted the respondent on March 31st, 2017 and asked to reuse his application dated February 22nd, 2017. However, since this date was after the denial of the application, the respondent stated it was not able to reuse the original application that was submitted in February 2017. The respondent explained that it could not apply its 60-day rule policy on applications that are denied due to a missed interview. Therefore, the petitioner must reapply.

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. 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).

9. 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.

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** (emphasis added) 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.** (emphasis added) 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...

11. The findings show the petitioner is a 37-year-old male with no minor children in the home. The undersigned concludes the Department correctly began to review the petitioner's case for potential eligibility under the SSI-Related Medicaid Program rules.

12. 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).

13. 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.

14. 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)**.

15. 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.

16. 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].

17. 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.

18. In this case, the findings show that the petitioner tried to reach the respondent multiple times on several days to complete the disability interview. According to the respondent's own "Running Record Comments" dated March 2nd, 2017, the petitioner reported to Lakeland storefront to complete a face-to-face authentication. Respondent's running record comments dated March 7th, 2017 shows that the petitioner completed a face-to-face interview on that date. There is no indication of any effort from the respondent at any point to complete the disability interview with the petitioner, either on March 2nd, 2017, or on March 7th, 2017.

19. Based on the above findings of facts and conclusions of law, the undersigned cannot conclude that the petitioner demonstrated a refusal to cooperate with the application process. On the contrary, the undersigned concludes that, the petitioner tried his level best to have the interview completed by calling the telephone number provided by the respondent.

Furthermore, the petitioner submitted his disability report which would have then allowed the respondent to waive the disability interview requirement for the petitioner.

20. Therefore, the Department is remanded to complete a determination of eligibility with the Division of Disability Determination (DDD) back to the date of application of February 22nd, 2017, and any retroactive months if applicable. The petitioner may need to cooperate in this process. Once a determination has been completed, the respondent is to issue notice informing the petitioner of the outcome, and the notice will include appeal rights to be exercised should the petitioner disagree with the outcome.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the respondent for the determination of disability by DDD, and then for the determination of Medicaid eligibility by the respondent.

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 June, 2017,
in Tallahassee, Florida.

FINAL ORDER (Cont.)

17F-02936

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

Jun 13, 2017

Office of Appeal Hearings
Dept. of Children and FamiliesSTATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-02945

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 88007RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 30th, 2017, at 11:35 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

For the Respondent: Jennie Rivera, Economic Self-Sufficiency Specialist II for the Department of Children and Families

STATEMENT OF ISSUE

The petitioner is appealing the denial of his SSI-Related Medicaid application. The petitioner carries the burden of proving his position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was his mother, [REDACTED].

The petitioner did not present any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 7 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated April 7th, 2017, the respondent informed the petitioner that his application for Medicaid was denied because he did not meet the disability requirement. On April 10th, 2017, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner applied to add Medicaid to his open Food Assistance (FA) case on March 21st, 2017. (See Respondent's Exhibit 2). FA is not an issue for this appeal.
2. The petitioner is a single-person household and was age 26 at the time of the application. There are no children under the age of 18 living in the petitioner's household.
3. The petitioner applied for disability through the Social Security Administration (SSA) on July 18th, 2016. SSA denied the petitioner's application on November 9th, 2016 with the denial reasons N32 or Capacity for substantial gainful activity – other work, no visual impairment. (See Respondent's Exhibit 4). The petitioner did not appeal the SSA denial.
4. The petitioner described his medical conditions as [REDACTED]
[REDACTED] The petitioner asserts that all conditions were reported to SSA on the July 18th, 2016, application. According to the petitioner, the conditions are expected to last throughout his lifetime. However, none of the conditions have worsened since the SSA denial.
5. The March 21st, 2017 Medicaid application listed the petitioner as being disabled. It also listed earned income for the petitioner from Earthscapes Unlimited. The (See

Respondent's Exhibit 2). During the hearing, the petitioner asserted that the income listed must have been in error because he had not been employed since February 2017.

6. The respondent forwarded the petitioner's disability documents to the Department of Disability Determination (DDD) for review on March 30th, 2017. DDD denied the petitioner's Disability Medicaid on April 6th, 2017, due to adopting the previous SSA denial decision.

7. The respondent advised the petitioner to seek further assistance from SSA and determine if he was within the timeframe to file an appeal.

8. Ms. [REDACTED], witness for the petitioner, asserted that the petitioner was unable to maintain a job for any considerable length of time due to the symptoms related to [REDACTED]. Currently, the petitioner is seeking part-time employment. Ms. [REDACTED] further testified that she and the petitioner would revisit with SSA to determine if an appeal could be filed or if he should reapply.

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 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

11. The Code of Federal Regulations at 42 C.F.R. Section 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... (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 Section 435.911 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility... (b) Effect of SSA determinations. **(1)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA...** *[Emphasis added]* (c) Determination 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 disability condition different from, or in addition to, that considered by SSA in making its determination...

12. The above federal regulation indicates that the Department may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in Section 435.911 on the same issues presented in the Medicaid application. The regulation also states that the Department must make a determination of disability if the individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination or alleges more than 12 months after the most recent SSA determination. The Department is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

13. The hearing officer must consider whether or not the respondent took the correct action on the petitioner's Medicaid application. As established in the Findings of Fact, the petitioner conditions are described as, [REDACTED]

[REDACTED] According to the petitioner, these conditions were reported to SSA at the

time of the July 18th, 2016 application. The petitioner acknowledged no new or worsening conditions. The findings show that the petitioner did not appeal the SSA denial. Therefore, the hearing officer concludes that the respondent's action to deny the petitioner's SSI-Related Medicaid application was correct. The petitioner must exercise appeal rights through the SSA in the event that he disagrees with that decision.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. 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 13 day of June, 2017,

in Tallahassee, Florida.



Kimberly Vargo
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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FINAL ORDER (Cont.)

17F-02945

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

Jun 28, 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-03000

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 [REDACTED]
UNIT: 66255

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 24, 2017 at 1:45 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Paula Henao, Operations Management Consultant I

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's application for SSI-related Medicaid. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

██████████, Medicaid Coordinator for ██████████ and Solutions, and ██████████, Clinical Director and president of ██████████ and Solutions, both appeared as witness for the petitioner.

██████████ interpreter identification number ██████████ with Language Line Solutions, provided interpreter services for the hearing.

The petitioner submitted a 28-page evidence packet, which was marked and entered as Petitioner's Composite Exhibit "1". The respondent submitted a 124-page evidence packet, which was marked and entered as Respondent's Exhibit "1" through "7". The record was left open through May 26, 2017 for additional information including policy related to disability determination and policy related to the Hankerson Disability adoption policy. On May 26, 2017, policy related to the technical requirements for SSI-Related Medicaid was submitted, marked and entered as Respondent's Exhibit "8". The record was closed the same day.

FINDINGS OF FACT

1. The Department of Children and Families (DCF, respondent) 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 for individuals applying for disability benefits under the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and approval of any benefits due.
2. Prior to the action under appeal, the petitioner (21 years old) was been diagnosed with ██████████ with an onset date of July 2, 2013. (Respondent's Exhibit 6).

3. On July 24, 2016, the petitioner applied for disability with the Social Security Administration (SSA) (Respondent's Exhibit 5).
4. On September 28, 2016, the petitioner's application was denied by SSA. No appeal was filed for the denial decision (Respondent's Exhibit 5).
5. On January 5, 2017, the petitioner was seen at [REDACTED] Hospital. Severe [REDACTED] and [REDACTED] with severe inflammation and [REDACTED]. The petitioner was receiving [REDACTED] once every eight weeks to treat the [REDACTED]. She suffers daily stomach pains, drops in her immune system, and [REDACTED] as side effects to the treatments (Petitioner's Exhibit 1).
6. On March 6, 2017, the petitioner submitted a web application requesting SSI-Related Medicaid through a disability determination (Respondent's Exhibit 1).
7. The petitioner has no minor children and is not pregnant. She does not meet the technical criteria for Family-related Medicaid (Respondent's Exhibit 8).
8. The petitioner is currently working part-time.
9. On April 3, 2017, the respondent submitted the petitioner's disability report to DDD citing [REDACTED] as her disabling condition (Respondent's Exhibit 6).
10. On April 5, 2017 the petitioner's application was denied by DDD, citing Hankerson, using code "N30: no significant impairment and no functional limitations", primary diagnosis [REDACTED] (Respondent's Exhibit 6).

11. On April 5, 2017, the respondent sent a Notice of Case Action (NOCA) informing her the application for Medicaid had been denied because no one in the household met the requirements for the program (Respondent's Exhibit 3):

12. The petitioner timely requested the hearing.

13. The petitioner does not want to appeal the SSA denial or pursue any further eligibility with SSA because she only wants medical coverage, not payments.

14. One of the technical requirements for DDD is to pursue other benefits, including SSA benefits.

15. The respondent explained that it denied the petitioner's Medicaid application because SSA has determined that she is not disabled and DDD has adopted the same decision based on its policy. The respondent further explained that once DDD determines the petitioner is not disabled, the respondent must deny the application for Medicaid under the SSI-Related Medicaid Program for people under the age of 65.

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, Fla. Stat.

17. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

19. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the respondent determines eligibility for: (1) Family-Related Medicaid for

parents and children, and pregnant women, and (2) Adult-Related (referred to SSI-Related Medicaid) for disabled adults and adults 65 or older.

20. 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. 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.

21. The Code of Federal Regulations at 42 C.F.R. § 435.000 sets forth the definition and determination of disability and states in relevant part: “Definition of disability (a) Definition. The agency must use the same definition of disability as used under SSI...”

22. 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 §435.912 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.

23. 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.

24. The above cited authorities explain the SSA determination made within 12 months of the Medicaid application is binding for the respondent unless the applicant reports a disabling condition not previously reviewed by SSA. In this instant case, SSA has determined the petitioner's conditions were not severe enough to prevent her from engaging in substantially gainful activities.
25. The petitioner does not wish to appeal the decision made by the SSA and reports no new or worsening of medical conditions that the SSA was not aware of at the time of denial.
26. In accordance with the above authorities, the respondent denied the petitioner's Medicaid, as it must adopt the SSA denial decision.

27. The undersigned has 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 and she is not pregnant. 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 or the applicant must be pregnant. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits.

28. Based on the evidence and cited authorities, the undersigned concludes the respondent's action to deny the petitioner's application for Medicaid Program benefits was within 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 hereby denied and the respondent's actions 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.)
17F- 03000
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DONE and ORDERED this 28 day of June, 2017,
in Tallahassee, Florida.

Pamela B. Vance

Pamela B. Vance
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jun 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-03085 & 17F-03120

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 88266

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 24, 2017 at approximately 8:31 a.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED] associate and
authorized representative

For the Respondent: Roneige Alnord, economic self-sufficiency specialist II
Teresa Bowman, revenue administrator II,
Department of Revenue, Child Support

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 5, 2017 denying retro Medicaid for the month of December 2016. 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 "10".

FINDINGS OF FACT

1. On August 10, 2016, the respondent sent a notice of case action (NOCA) informing the petitioner that her application dated July 7, 2016 was denied effective August and September 2016 due to failure to cooperate with child support enforcement (CSE) (Respondent's Exhibit 4).
2. A sanction was placed on the case due to CSE non-cooperation effective September 1, 2016 through December 31, 2016 (Respondent's Exhibit 7).
3. Petitioner's witness TB testified that on December 28, 2016, the respondent's authorized representative, TC, appeared at the CSE offices and spoke with Charlotte. While at the offices, the system was updated with information sufficient to meet CSE cooperation requirements. TC was allegedly informed by Charlotte that the sanction would be lifted effective December 2016.
4. On January 5, 2017, the petitioner submitted an application to the respondent requesting ongoing Medicaid benefits for herself and her minor children, and retro Medicaid benefits for December 2016 (Respondent's Exhibit 3).
5. On January 9, 2017, the respondent received a data exchange from CSE requesting that the sanction be lifted effective January 4, 2017.
6. On January 10, 2017, the respondent sent a (NOCA) informing the petitioner that Medicaid had been approved effective January 2017 ongoing. The NOCA contained no

information about the request for the December 2016 retro coverage (Respondent's Exhibit 4).

7. On January 13, 2017, the respondent sent a NOCA informing the petitioner that she was eligible for continued Medicaid coverage (Respondent's Exhibit 4).

8. The petitioner's witness (TB), an employee at CSE, testified that TC did appear at the CSE offices and the CSE case was updated that day, and that TC was informed that the lifting of the sanction may take as many as 14 days. TB also testified that the effective date of the sanction lift should have been December 2016 and not January 2017. She explained that the remove date on the data exchange sent to the respondent from CSE was in error, that the January 4, 2017 lift sanction date was incorrect. She reiterated that the correct lift date is December 28, 2016, which would make the effective date for the beginning of reopened Medicaid benefits December 1, 2016.

9. The respondent testified, citing the Department's policy manual, passage 1430.1771, reading into the record: "The effective date for adding the sanctioned individual is retroactive to the first day of the month of compliance" (Petitioner'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 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-1.705(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...

14. According to the above authority, to be eligible for Family-Related Medicaid benefits, the petitioner must have a minor child under age 18 living in the household with her. Since the petitioner has a minor child under age 18 living in the household, she meets one of the technical requirements to be eligible for Family-Related Medicaid benefits.

15. Section 409.2572, Florida Statutes, Cooperation, states in part:

(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...

(2) Noncooperation, or failure to cooperate in good faith...

(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...

16. Federal Regulations at 42 C.F.R. § 435.610 define the assignment of rights to benefits and 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, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902 (1)(1)(A) of the Act (poverty level pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and...

17. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Passage 1430.1711, Ending Sanction (MFAM), it states in pertinent part, "The effective date of adding the sanctioned individual is retroactive to the first day of the month of compliance."

18. Pursuant to the above authorities, in order for the petitioner to receive Medicaid benefits for herself, she must cooperate with CSE in establishing support except when she claims good cause exists or is pregnant. The findings show that she cooperated with CSE on December 28, 2016 and this cooperation resulted in CSE requesting that her sanction be lifted. Findings show that the correct effective date for the lifting of the sanction is December 1, 2016.

19. After carefully reviewing the evidence, testimony and controlling legal authorities, the undersigned concludes that the denial of Medicaid for the month of December 2016 due to a CSE sanction was incorrect. Therefore, the respondent's action to deny Medicaid effective December 2016 is reversed. The appeal is remanded to the

respondent to determine Medicaid eligibility for the month of December 2016, as that is the month the CSE sanction was cured. Once the Department has taken such corrective action, a notice shall be issued, which includes appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the Department to take the corrective action cited above.

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 June, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jun 28, 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-03121

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 88695

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 24, 2017 at approximately 2:29 p.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED], daughter
[REDACTED] son
[REDACTED], designated representative

For the Respondent: Ed Poutre, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of March 13, 2017 denying Medicaid Nursing Home services (Institutional Care Program Medicaid) for being over the asset limit. 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 record was left open for the respondent to submit its evidence packet. This packet of information was received June 5, 2017. The packet was admitted into evidence and marked as Respondent's Exhibits "1" through "13". The record was left open until June 14, allowing the petitioner's designated representative the opportunity to respond to the packet. No response from petitioner's representative was received concerning the respondent's evidence package. The record was closed June 15, 2017.

A Motion to Reset Hearing was received June 2, 2017 from respondent's counsel. Petitioner's Objection to Motion to Reset Hearing was received June 5, 2017. The undersigned has decided not to reset the hearing. Even though a "cc" was not established in the Appeal Hearings Case Management System, when it was known that an attorney was representing the petitioner, the respondent was informed of the hearing date with over four weeks advanced notice; therefore, the respondent's staff had ample time to inform respondent's counsel if they had decided to do so. The Motion to Reset Hearing is denied.

FINDINGS OF FACT

1. On October 6, 2016, the petitioner entered into a Personal Needs Contract (PSC) with DLV and DLE (Respondent's Exhibit 9).
2. Also on October 6, 2016, DLV, as grantor, established an Escrow Trust in the petitioner's name for the specific purpose of meeting the payment terms set forth in the PSC (Respondent's Exhibit 10).

3. The transfers to the trust were all made prior to the November 29, 2016 application for nursing home Medicaid submitted for the petitioner. The Escrow Trust was funded on 10/26/16 with \$55,328.98 of the petitioner's money (\$21,034.04 Suntrust CD, 22,892.62 NY Life annuity and \$11,402.32 GE Capital Corp bon). An additional \$70,876.43 deposit was made on November 15, 2016, this was the petitioner's Transamerica Life Insurance Company annuity (Petitioner's Exhibit 6).

4. On November 29, 2016, the petitioner submitted an application for Institutional Care Program (ICP) Medicaid (Respondent's Exhibit 3).

5. On December 30, 2016, the respondent sent a notice of case action (NOCA) informing the petitioner that the November 29, 2016 application was denied for the months of November through February 2017 because "the value of your assets is too high for this program" (Respondent's Exhibit 3).

6. On multiple occasions in January, February and March of 2017, petitioner's counsel and designated representative contacted the respondent by phone to discuss the denial of ICP Medicaid (Respondent's Exhibit 13).

7. On March 13, 2017, the respondent sent a NOCA (Respondent's Exhibit 2) informing the petitioner of the following:

It has been determined that the Personal Service Contract is considered to be Vera's assets by our legal department. Therefore Vera is over the asset limit to qualify for nursing home services without setting up a special pooled trust. You may wish to seek legal advice to set up the "needed trust" for being over the asset limit. Thanks"

8. On March 30, 2017, DV and DLE, withdrew \$58,235 each from the Trust causing the petitioner's assets to fall below the asset limit, as the balance of the Trust was \$100.71 (Petitioner's Exhibits 4 and 6).

9. On March 31, 2017, the petitioner submitted an application to the respondent requesting nursing home Medicaid coverage. The "Comments After E-Signature" states, "Applicant's prior application is on appeal. Applicant has PSC with her two children. Applicant's assets have now been directly transferred to the children pursuant to the PSC. Assets available to Applicant are less than \$2,000. Prior application erroneously included two burial contracts owned by Applicant's deceased spouse ..."
(Respondent's Exhibit 1).

10. On May 2, 2017, the respondent sent a NOCA (Respondents Exhibit 4) informing the petitioner that the application/review dated March 31, 2017 is denied for the months of March through June 2017 because "the value of your assets is too high for this program."

11. In the hearing request submitted for this hearing, the petitioner states as one of the reasons for the hearing, "The Personal Services Contract complied in all regards with the requirements of MSSSI 1640.0614.04 and is therefore by definition a non-countable asset. The cited basis for denial is therefore spurious" (Respondent's Exhibit 6).

12. Per the designated representative's testimony, the personal services contract entered into by the petitioner of October 6, 2016 with DLV and DLE was written with Section 1640.0614.04 of the policy manual in mind: reasonable hours, 20 hours per week now that the petitioner is in a nursing home; a rate of pay based on local rates for various service providers; using the policy manual life expectancy from the table at Appendix A-14; for the lifetime of the petitioner. He also asserts that the PSC meets the

policy manual requirements and that neither the contract itself nor the assets transferred pursuant to the contract are available to the petitioner (Petitioner's Exhibits 2 and 7).

13. The designated representative testified that the amount of the assets transferred to pay for the PSC, approximately \$135,000.00, were clearly less than the value of the contract (Petitioner's Exhibit 7).

14. The petitioner concludes that perhaps the respondent meant to deny benefits on the basis that the assets transferred were available to the petitioner because they were transferred into the escrow trust rather than directly to the caregivers. The petitioner states that this position is directly refuted by the term of both the PSC and of the escrow trust (Petitioner's Exhibits 3 and 7).

15. The terms of the trust indicate that the escrow trust is irrevocable; the grantor nor any other person has the right to alter, amend, modify or revoke this trust; the petitioner has no interest in the income or principal of the trust; the petitioner has no revisionary interest; no right to alter amend or revoke; and, no right to become a trustee or change the trustee of this trust (Petitioner's Exhibits 3 and 7).

16. The terms of the trust indicate that the trustee has no right or discretion to use the income or principal for any purpose other than to pay the persons who provide the personal services to the petitioner required under the terms of the PSC. The assets of the trust may not be used to supplant, replace or reimburse any benefits the petitioner may receive or be eligible to receive from any federal, state or local government (Petitioner's Exhibits 3 and 7).

17. The designated representative asserts that the petitioner does not have authority to revoke or direct use of the trust; therefore, it is not and should not be considered her asset (Petitioner's Exhibit 7).

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.

19. 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 Fla. Admin. Code R. 65-2.056.

21. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1640.0405 When Asset Value Affects Eligibility (MSSI, SFP) states:

"Individuals who are eligible on any day of the month are eligible for the whole month."

22. Fla. Admin Code R. 65A-1.712 and 65A-1.716 addresses SSI-Related Medicaid asset criteria and in part state:

(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...

(5) SSI-Related Program Standards.

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

1. \$2000 per individual.

23. The above authorities set \$2,000 as the resource (asset) limit for an individual to be eligible for ICP (Institutional Care Program) Medicaid.

24. The petitioner's counsel's position is that the PSC meets the requirements of 1640.0614.04, and funding the trust in October 2016 allowably caused the petitioner's asset to fall below the asset limit. He further argued that the petitioner's assets were otherwise below the asset limit effective March 30, 2017 when the principal of the Trust was withdrawn by the caregivers.

25. The Policy Manual passages 1640.0308, 1640.0576.07, 1640-0312.01, 1640-0312.02 and 1640.0614.04 state:

1640.0308 General Availability (MSSI, SFP)

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 on the factor of assets.

Assets are considered available to an individual when the individual has unrestricted access to the funds.

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 the individual's support and maintenance, even though the individual may not choose to do so.

Assets not available due to legal restrictions or factors beyond an individual's control are not considered in determining total available assets. The only exception to this rule occurs when the legal restrictions were caused or requested by the individual.

1640.0312.01 Availability of Trusts (MSSI, SFP)

The availability of funds held in a trust depends on the conditions (wording) of the trust and whether the individual is the trustee or beneficiary of the trust.

1640.0312.02 Trust Availability to Trustee (MSSI, SFP)

The trust is not an asset to the trustee if the trustee cannot use any of the funds in the trust for his own benefit.

The trust is an asset to the trustee if the individual is the trustee and has the legal ability to revoke the trust and use the money for his own benefit, regardless of whose funds were originally deposited in the trust.

The trust is an asset to the individual if the individual or the individual's spouse created the trust and has the right to dissolve it and use the funds for his own benefit.

1640.0576.07 Trusts Established On or After 10/1/93 (MSSI, SFP)

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.

1640.0614.04 Compensation in Support or Services (MSSI)

Compensation in the form of support and/or maintenance or services is based on:

1. the FMV,

2. the support or services at the time of asset transfer, and

3. the frequency/duration of the support or service.

In order for compensation to be considered, a statement and any related documentation must be obtained from the person(s) to whom the property was transferred to establish the FMV of the support and/or maintenance provided if:

1. the intent is for a specified period, the actual length of time the support or service is provided is used;

2. services are to be performed on an "as needed" basis, or for an interim period, the statement must include the individual's expectation as to the frequency of the services and the basis for that expectation; and

3. the support or services are to be provided for the life of the individual, using the life expectancy tables in Appendix A-14.

To establish the value of support and maintenance for the individual's life, use the following formula:

Multiply the yearly fair market value (FMV) of the support and/or maintenance times the life expectancy factor corresponding to the individual's age (as of the last birthday) at the time the asset was transferred.

Contact with an outside source in the same locality will usually be necessary to determine value. The case record must:

1. state how the value was determined; and

2. include a copy of the agreement or a statement from the person receiving the transferred asset showing the type, frequency, and duration of the support or services.

26. Fla. Admin. Code R. 65A-1.702 Special Provisions, in part states:

(15) Trusts.

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

(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.** [Emphasis added.]...

27. The Escrow Trust was funded on 10/26/16 with \$55,328.98 of the petitioner's money (\$21,034.04 SunTrust CD, 22,892.62 NY Life annuity and \$11,402.32 GE

Capital Corp bon). An additional \$70,876.43 deposit was made on 11/15/16, this was the petitioner's Transamerica Life Insurance Company annuity. Since the petitioner's assets were used to establish the trust and the trust was established by her daughter/POA, the petitioner is considered to have established the trust and to be the grantor of the trust, even though the trust lists her daughter as the Grantor.

28. Fla. Admin. Code R. 65A-1.702, Special Provisions, addresses Trusts:

(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. [Emphasis added.]

29. In accordance with the above authority, even though the Escrow Trust is irrevocable and states, "the assets of the trust may not be used to supplant, replace or reimburse any benefits the petitioner may receive or be eligible to receive from any

federal, state or local government,” the above regulation is clear that any language in the trust that limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation...in Medicaid, shall be disregarded.

30. Additionally, the Social Security Program Operations Manual System (POMS) SI

1730.048 Medicaid Trust 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.] Payments from the trust or income on the trust for the benefit of the individual are income. Payments for any other purpose are considered a transfer of assets by the individual. Any portion of the trust or income on the trust from which no payment could be made under any circumstances to the individual is considered to be transferred assets on the date the trust was/is established. If, however, the access by the individual was “blocked” later, the date of the transferred assets will be the date that access was “blocked” (foreclosed)...

Exception from this rule is possible under one of several specific statutory provisions and also may occur when an individual establishes, pursuant to procedures developed by the State, that application of the provision on Medicaid trusts would work an undue hardship on the individual as determined on the basis of criteria established by CMS.

31. Further, 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, 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...

32. The petitioner's counsel argued that the funds in the Trust are to be used solely to pay the caregivers identified in the PSC.

33. 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.]

34. Petitioner's counsel argued the assets in the Trust have legal restrictions and are unavailable.

35. In accordance with the above authorities the petitioner's Trust is countable, as the limitations placed in the Trust on the disbursement of funds are disregarded.

36. 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."

37. The Policy Manual passage 1640-0613, Processing Transfer Cases (MSSI)

states in part:

Evaluate all transfers of assets or income that occur within the look-back period to determine the following if the:

1. transfer is legally binding; and
2. individual has any remaining ownership in the asset; and
3. individual received fair compensation.

...

A period of ineligibility is not imposed if the individual successfully demonstrates the following:

1. the asset was transferred solely for reasons other than to become Medicaid eligible; or
2. the individual intended to dispose of the assets either at fair market value or in exchange for other valuable compensation; or
3. **the transfers are considered allowable per policies in 1640.0609.04 and .05, 1640.0610, 1640.0611 and 1640.0612;** or
4. all transferred assets were returned to the individual (see 1640.0620); or
5. imposing the period of ineligibility would place an undue hardship on the individual. [Emphasis added.]

38. The evidence submitted establishes that prior to the creation of the PSC and the Trust, the petitioner had resources to pay for nursing home care.

39. The evidence submitted also establishes that as the petitioner's assets were used to fund the Trust the principal and interest of the Trust are available to the petitioner to pay for her nursing home care as the restrictions to how the principal and interest of the Trust may be disbursed are to be disregarded in the eligibility determination process.

40. The evidence submitted also established that the petitioner's countable assets were below the limit effective March 30, 2017, upon removal of funds from the Trust. As the petitioner's assets are within the eligibility limit as of March 30, 2017, the petitioner is potentially Medicaid eligible beginning the month of March 2017.

41. In careful review of the authorities, evidence and testimonies, the undersigned concludes that the petitioner did not meet its burden of proof. The undersigned concludes that the respondent's action to deny the petitioner ICP benefits for November 2016 through February 2017 is proper; however, the denial of the March 31, 2017 is not as the value of the Trust on March 31, 2017 was \$100.71. The case is remanded to the respondent to determine ongoing eligibility beginning March 2017. Upon determination of eligibility for March 2017 ongoing, the respondent will issue a notice of case action that includes hearing rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The respondent's action to deny Medicaid for November 2016 through February 2017 is affirmed. The respondent is ordered to make an eligibility determination effective March 2017 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 28 day of June, 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
[REDACTED], Esq.
Stephanie Camfield, Esq.

Jun 29, 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-03572

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 face-to-face administrative hearing in the above-referenced matter on June 22nd, 2017, at 12:58 p.m. in the Fort Myers Service Center.

APPEARANCES

For the Petitioner: [REDACTED] pro se.

For the Respondent: Ed Poutre, Senior Worker for the Department of Children and Families

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her SSI-Related Medicaid application. The petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was her daughter-in-law, [REDACTED]
[REDACTED].

Petitioner's exhibit 1 was admitted into evidence.

Respondent's exhibits 1 through 7 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated April 28th, 2017, the respondent informed the petitioner that her application for Medicaid dated March 24th, 2017, was denied because she did not meet the disability requirement. On May 3rd, 2017, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner submitted an online application for FA, SSI-Related Medicaid, and Temporary Cash Assistance (TCA) on December 29th, 2016. (See Respondent's Exhibit 1). FA and TCA are not issues for this appeal. According to the respondent, a second application for SSI-Related Medicaid was submitted on March 24th, 2017. However, the application was not provided as evidence.
2. The petitioner is a single-person household and was age 49 at the time of the application, and there are no children under the age of 18 living in the petitioner's household. The petitioner contends that she has been unable to work since January 2011.
3. The petitioner asserts that she applied for disability through the Social Security Administration (SSA) on January 15th, 2011, while living in Arkansas. According to the petitioner, the application was denied and subsequently appealed three to four times. The respondent provided, as part of its evidence, screen prints of SSA State On-Line Query (SOLQ) system. The most updated information from SOLQ indicates an application date of January 12th, 2012, and a denial date of April 13th, 2012. The corresponding denial code listed with the April 13th, 2012, denial is N32. According to

the SOLQ Guide, code N32 means, “Non-pay – Capacity for substantial gainful activity – other work, no visual impairment.” The SOLQ screen prints also indicate that an appeal was requested on July 22nd, 2013. The appeal is listed with an appeal code of “A,” which according to the SOLQ guide means, “Reconsideration – Appeal request filed.” (See Respondent’s Exhibit 4).

4. The petitioner described her medical conditions as [REDACTED]. The petitioner asserts that all conditions were reported to SSA on the January 15th, 2011, application. According to the petitioner, the conditions are expected to last throughout her lifetime, and the conditions continue to worsen. The petitioner also indicated that she takes approximately 20 prescription medications and injections daily. The petitioner provided, as evidence, an award letter from SSA dated June 6th, 2017. According to the award letter, the conditions reviewed were [REDACTED]. In addition to the conditions, the award letter verified that the SSA application date was January 12th, 2012, with a disability onset date of January 15th, 2011. (See Petitioner’s Exhibit 1).

5. The December 29th, 2016 SSI-Related Medicaid application lists the petitioner as being disabled. (See Respondent’s Exhibit 2). The respondent forwarded the petitioner’s disability documents to the Department of Disability Determination (DDD) for review on January 11th, 2017. (See Respondent’s Exhibit 6). DDD denied the petitioner’s Disability Medicaid on March 1st, 2017, with a code N32 as previously detailed above. (See Respondent’s Exhibit 5).

6. The respondent forwarded the petitioner's disability documents to DDD a second time on April 21st, 2017, as a result of the March 24th, 2017, SSI-Related Medicaid application. (See Respondent's Exhibit 6). DDD denied the petitioner's Disability Medicaid and issued an Interoffice Memorandum citing, "A determination was made in the last 90 days. The claimant should apply for a hearing." (See Respondent's Exhibit 5).

7. A DDD witness was not present to provide testimony, and a DDD case analysis was not provided as evidence.

8. The petitioner asserts that she should be eligible for Medicaid because she is unable to work due to the severity of her medical conditions and because she was approved for Social Security benefits. The petitioner contends that she moved to Florida from Arkansas in July 2016 and is having difficulty getting the SSA information transferred to Florida. The petitioner expects to receive payment from SSA within the next 60 days but believes that the demographic information may delay the payments.

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 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

11. The Code of Federal Regulations at 42 C.F.R. Section 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... (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 Section 435.911 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility... (b) Effect of SSA determinations. **(1)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA...** *[Emphasis added]* (c) Determination 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 disability condition different from, or in addition to, that considered by SSA in making its determination...

12. The above federal regulation indicates that the Department may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in Section 435.911 on the same issues presented in the Medicaid application. The regulation also states that the Department must make a determination of disability if the individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination or alleges more than 12 months after the most recent SSA determination. The Department is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

13. The hearing officer must consider whether or not the respondent took the correct action on the petitioner's Medicaid application. The petitioner applied for SSI-Related

Medicaid two times while there was a pending appeal with SSA, and both SSI-Related Medicaid applications were denied by DDD. As stated in the above-cited authority, "An SSA disability determination is binding on an agency until the determination is changed by SSA." Although, there was no witness testimony or case analysis from DDD, the regulation is clear that the agency is bound by an SSA decision. Therefore, at the time of both applications, the respondent was correct to deny the SSI-Related Medicaid since the Social Security benefits were still under appeal. However, according to the letter the petitioner provided as evidence, she was granted a fully favorable SSA decision as of June 6th, 2017. The letter also includes a protected disability onset date of January 15th, 2011. Under *de novo*, the fully favorable SSA decision may have changed the outcome of the SSI-Related Medicaid application dated March 24th, 2017, **if all other technical criteria were met.**

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the appeal is granted to the extent described above. This decision is not a guarantee of eligibility. Rather, the respondent is ordered to take corrective action as described above.

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-03572
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DONE and ORDERED this 29 day of June, 2017,
in Tallahassee, Florida.



Kimberly Vargo
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

May 02, 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. 17N-00005

PETITIONER,

Vs.

ADMINISTRATOR

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, a hearing in the above-referenced matter convened on April 19, 2017 at 11:35 a.m. at the [REDACTED], Florida.

APPEARANCES

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

For the Respondent: Fanley Romelus, Facility Administrator.

ISSUE

At issue is the facility's intent to discharge petitioner due to non-payment of a bill for services; a Nursing Home Transfer and Discharge Notice was issued on January 11, 2017 with an effective date of February 11, 2017.

The facility has the burden of proof to establish by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of

Federal Regulations at 42 C.F.R. § 483.15 and Section 400.0255, Florida Statutes (2009).

PRELIMINARY STATEMENT

By notice dated January 11, 2017, the respondent informed the petitioner that the facility was seeking to discharge/transfer him due to nonpayment. On January 11, 2017, the petitioner timely requested a hearing to challenge the discharge/transfer.

The hearing was originally scheduled to convene on February 28, 2017 at 11:30 a.m.

On February 8, 2017, the petitioner contacted the undersigned to request for the hearing to be cancelled as he was undergoing a medical procedure.

The petitioner's request was granted and the hearing was rescheduled to April 19, 2017 at 11:30 a.m.

Appearing as an observer for the petitioner was his friend, [REDACTED]

Appearing as a witness for the respondent was Janet Hickey, Social Services Director.

Evidence was received and entered as the Respondent's Exhibits 1 through 3.

A letter dated February 6, 2017 from the Agency for Health Care Administration (AHCA) was sent to the undersigned, stating that the representative did not find the facility in violation of any laws or rules. This was entered as Hearing Officer Exhibit 1.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. The petitioner has been residing in the facility since October 2016.

2. The respondent contends that on November 1, 2016, the petitioner was notified of the balance owed to the facility. The facility contends that attempts were made to collect payments from the petitioner.

3. The respondent contends that it hand-delivers the monthly statements to the petitioner to inform of the balance due to the facility. The facility explained that the patient responsibility is \$991 and that its records now indicate that the balance owed is in the amount of \$5694.

4. The petitioner does not dispute that he owes a balance to the facility. The petitioner acknowledges that the facility informed him beginning in November 2016 that he has a balance due to the facility. The petitioner explained that he does not have the funds to pay the facility because he needs to be reimbursed monies from his debit card that was stolen from him at another facility. The petitioner further explained that someone stole \$3000 out of his account when his debit card was stolen.

5. The petitioner also contends that another resident was stealing his clothing whenever he put his clothes in a hamper for washing. The petitioner alleges that he purchased approximately \$3000 worth of clothing to replace the items that were stolen from him by another resident. The petitioner argues that he needs to be reimbursed for the clothing he replaced in order to be able to pay the facility.

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 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

7. 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—

...

(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;

8. Based on the evidence presented, the nursing facility has established that the petitioner has failed, after reasonable and appropriate notice to pay for a stay at the facility. This is one of the six reasons provided in 42 C.F.R. § 483.15 for which a nursing facility may involuntarily discharge a resident.

9. 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.

10. 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

This appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge, as describe 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.

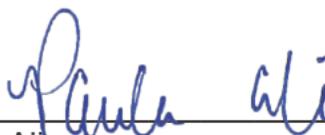
FINAL ORDER (Cont.)

17N-00005

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DONE and ORDERED this 02 day of May, 2017,

in Tallahassee, Florida.



Paula Ali

Hearing Officer

Building 5, Room 255

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Copies Furnished To: [REDACTED], Petitioner

[REDACTED], Respondent

Mr. Robert Dickson

Agency for Health Care Administration

FILED

May 04, 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. 17N-00017

PETITIONER,

Vs.

ADMINISTRATOR

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 13, 2017 at 9:43 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Heidi Shirley, Executive Director, [REDACTED]

STATEMENT OF ISSUE

Petitioner is appealing Respondent's notice of intent to discharge him from the facility issued on February 10, 2017. The respondent carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

This matter was originally scheduled for hearing on March 13, 2017. However, the petitioner was in the hospital on March 13, 2017 and unable to attend the hearing. The petitioner's sister, representative, contacted the undersigned on March 16, 2017

requesting the hearing be rescheduled and that she be allowed to appear telephonically as she is presently out of state. The hearing was rescheduled for April 13, 2017. The request of the petitioner's representative to appear telephonically was granted.

The petitioner was admitted to the hospital again prior to the hearing on April 13, 2017. On April 12, 2017, the petitioner requested he be allowed to participate telephonically so that the hearing process could proceed. The undersigned contacted the facility on April 12, 2017 to advise all parties would appear telephonically and provide the information to call into the hearing.

██████████ sister of the petitioner appeared as a witness for the petitioner. ██████████, ombudsman, appeared at the hospital to assist the petitioner with the hearing process.

Dr. William Effinger, Medical Director at ██████████ and attending physician for the petitioner at ██████████ appeared as a witness for the respondent.

██████████, petitioner's case worker with Humana was present. Kristi Conley represented the Agency for HealthCare Administration.

The Nursing Home Transfer and Discharge Notice was entered as Administrative Exhibit 1. AHCA submitted a letter with their survey results. The letter was entered as Administrative Exhibit 2. The respondent submitted evidence post hearing. This evidence was entered as Respondent Exhibit 1. The petitioner's sister submitted documentation on his behalf post hearing. This evidence was entered as Petitioner's Exhibit 1.

FINDINGS OF FACT

1. The petitioner was admitted to the facility on June 10, 2015.

2. The respondent's facility is considered a skilled nursing facility.
3. The petitioner is a paraplegic with multiple health conditions. The petitioner's conditions include bed sores on his posterior. These wounds became extensive around October 2016.
4. The respondent reported the petitioner refuses care and treatment at times. He also refuses care from certain staff members.
5. Dr. Effinger reported he has been the medical director and the petitioner's attending physician for approximately four months. He also follows the petitioner's care when he is in the hospital.
6. Dr. Effinger opined that due to the extensive nature of the petitioner's wounds, he will be best served in a long-term acute care facility that is equipped to provide the additional care he presently requires. He further stated the respondent's facility is not equipped with the support or resources to adequately care for the petitioner.
7. Dr. Effinger further opined that the petitioner's health continues to decline when at the respondent's facility where they are unable to properly care for his wounds.
8. The petitioner understands his health conditions. He understood when the doctor presented he is not getting better.
9. The petitioner's family expressed concern over the lack of care and concern shown to the petitioner and his health problems.
10. The petitioner desires to stay at this facility due to his family residing in [REDACTED]. He believes, if he is there and goes to wound care three days a week, he might get better.

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 said authority, this order is the final administrative decision of the Department of Children and Families.

12. 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.

13. Based on the evidence presented, the nursing facility has established 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.

14. The findings show the respondent is a skilled nursing facility. The findings also show the opinion that the petitioner requires care in a long-term acute care facility. The undersigned concludes the petitioner's needs are in excess of what the respondent provides to residents. The undersigned further concludes the respondent met the burden of proof in establishing they cannot meet the petitioner's needs.

15. The undersigned considered the petitioner's concerns that his family resides in the [REDACTED] area and desires to remain local to them to maintain his family connections. The undersigned concludes the health care needs of the petitioner cannot be met in the respondent's facility and therefore the discharge is appropriate.

16. 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.

17. 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 appeal is denied. The facility may proceed with discharge of the petitioner.

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 04 day of May, 2017,

in Tallahassee, Florida.



Melissa Roedel
Hearing Officer
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FINAL ORDER (Cont.)

17N-00017

PAGE - 7

Copies Furnished To: [REDACTED], Petitioner

[REDACTED], Respondent

Ms. Donna Heiberg, Agency for Health Care Administration

[REDACTED]

Jun 16, 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. 17N-00019

PETITIONER,

Vs.
ADMINISTRATOR

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on May 16, 2017, 9:46 a.m., at [REDACTED], Florida.

APPEARANCES

For the Petitioner: [REDACTED], sister and Power of Attorney (POA)

For the Respondent: Nicole Jordan, director.

ISSUE

At issue is whether the respondent's intent to discharge the petitioner from the facility because the safety of the other individuals in the facility is endangered is correct. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found at 42 C.F.R. § 483.15.

PRELIMINARY STATEMENT

At the hearing, the respondent presented six exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 6. The petitioner presented three exhibits which were entered into evidence and marked as Petitioner's Exhibits 1 through 3. A letter dated March 27, 2017, from the Agency for Health Care Administration (AHCA) was sent to the undersigned. It stated that a representative from AHCA completed an unannounced visit at [REDACTED] March 13, 2017 and found no violations. This was entered into evidence and marked as Hearing Officer's Exhibit 1.

The record was held open until May 26, 2017, for the petitioner to review the respondent's evidence and provide additional exhibits if needed. The petitioner provided one additional exhibit, which was entered into evidence and marked as Petitioner's Composite Exhibit 4. The record was closed on May 26, 2017.

Present as witnesses for the petitioner were [REDACTED], certified ombudsman/regional assistant and [REDACTED] ombudsman. The petitioner was also present.

Present as witnesses for the respondent were Becky Zambrana, director of social services, Margret Johnson, director of quality assurance and Maureen Browning, director of clinical services.

FINDINGS OF FACT

1. The petitioner (age 58) was admitted to the respondent's nursing facility on April 5, 2013.
2. In April 2016, the petitioner had a romantic/sexual relationship with a female resident. The relationship did not last very long, the female resident broke up with him

and transferred to another facility. The Nursing Facility provided psychological treatment/counseling for him to cope with the break up. The petitioner became attracted to other female residents and staff. His attraction developed to urges wanting to kiss female residents whom were not mentally competent.

3. On November 14, 2016, the respondent counseled the petitioner. He was warned that he was not to have contact with a certain mentally incompetent resident (Respondent's Exhibit 3).

4. On November 23, 2017, the petitioner was found attempting to make contact with the resident. He informed staff that he was going to the resident because he wanted to kiss her and did not know why (Respondent's Exhibit 3).

5. On February 3, 2017, a Nursing Home Transfer and Discharge notice was issued to the petitioner. The reason listed on the discharge notice was "the safety of other individuals in this facility is endangered." There was a brief explanation to support the action, "Resident's social wellbeing would benefit from being in an assisted living facility with all men." The Nursing Home Transfer and Discharge Notice was signed by Dr. Irman Malick.

6. The respondent feared that the petitioner may wonder into a certain female resident's room to fulfil his desires. The certain female resident is mentally incapable of giving consent.

7. On February 3, 2017, the petitioner's representative requested a hearing to challenge the respondent's intent to discharge the petitioner.

8. The petitioner wishes to remain in the facility as he has been at the facility for three years and his father is also in the facility. The petitioner's representative asserted

that the petitioner's sexual urges may be because of medications which can be evaluated and adjusted (Petitioner's Exhibit 3).

9. The petitioner's representative asserts that her brother should not be transferred to an Assisted Living Facility, he should remain in a facility that provides skilled nursing care based on the evaluation from [REDACTED]. Additionally, he needs help dressing (Petitioner's Exhibit 3).

CONCLUSION OF LAW

10. The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by Federal Regulations appearing at 42 C.F.R. § 431.200. 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.

11. A nursing facility must inform the residents of their rights. That information must be done both orally and in writing. 42 C.F.R. § 483.10 states:

(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

12. The Code of Federal Regulation at 42 C.F.R. § 483.15, limits the reasons a nursing facility may discharge a Medicaid or Medicare patient.

(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;...

(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider...

13. In this case, the petitioner was given a notice on February 3, 2017, indicating that he would be discharged from the facility stating the safety of others was endangered.

The above-cited authorities set forth the conditions which must exist for a nursing home to involuntarily discharge a resident.

14. Section 400.0255, Florida Statutes, Resident transfer or discharge; requirements and procedures; hearings, states in relevant 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...

(7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian

or representative, except, in the following circumstance, the facility shall give notice as soon as practicable before the transfer or discharge:

(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or

(b) The resident's health or safety or other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

15. The respondent's reason for discharge is the safety of other individuals within the facility. This is one of the reasons given in the above federal and state law to permit discharge from a facility.

16. The respondent's sole reason for the discharge was the petitioner's intent to make physical/sexual contact with other residents who are mentally incapable of such decision making. This was happening after he was warned not to make contact with a certain mentally incapable individual. The facility asserts that it has a responsibility to keep all residents safe. The facility's representative explained that it is unable to keep the petitioner confined to his room as he is allowed to move freely throughout the facility. The respondent fears that the petitioner will wonder into the female resident's room to satisfy his urges; therefore, it is best for him to be in an all-male facility.

17. After careful review of the entire record as well as the controlling authorities, the undersigned concludes the nursing facility has correctly established that the safety of individuals in the facility would be endangered. This is included as one of the reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

18 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 complaint line at (888) 419-3456.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law the appeal is denied and the facility may proceed with its proposed discharge in accordance with the Agency for Health Care Administration's rules and regulations.

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 16 day of June, 2017,
in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
[REDACTED], Respondent
Ms. Arlene Mayo-Davis
Agency for Health Care Administration
[REDACTED]

FILED

Jun 19, 2017

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 17N-00031

PETITIONER,

Vs.

Administrator

[REDACTED]
[REDACTED]
[REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, an administrative hearing in the above-reference matter convened before the undersigned at 8:55 a.m. on May 4, 2017, at [REDACTED]

[REDACTED]

APPEARANCES

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

For the Respondent: Charlene Bedor, Interim Administrator

STATEMENT OF ISSUE

At issue is whether the respondent's intent to transfer/discharge the petitioner from [REDACTED] (Facility) due to her needs cannot be met, is proper. The respondent carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

Appearing as witnesses from the Facility were, Urmilla Singh, Social Service Director, Donna Miller, RN Risk Manager and Michael Hubschmitt, RN Director of

Nursing. The petitioner did not submit exhibits. The respondent submitted five exhibits, entered as Respondent Exhibit "1" through "5". The record was closed on May 4, 2017.

FINDINGS OF FACT

1. The petitioner was admitted to the Facility on February 5, 2016, from the hospital.

Prior to being in the hospital, the petitioner was a resident of another Facility in [REDACTED] Florida. The [REDACTED] Facility refused to readmit the petitioner after her hospital visit, reason unknown.

2. The petitioner has been involved in the following eight altercations with other residents and Facility staff members. The October 4, 2016, altercation was initiated by another resident with the petitioner. It is unclear who started the November 1, 2016 altercation.

May 11, 2016 the petitioner struck another resident in the mouth, alleging the resident "took her daughters purse".

July 27, 2016 the petitioner struck and "dug her fingernails into a nurse's forearm, resulting in four skin tears."

July 28, 2016 the petitioner slapped a C.N.A. and another resident.

October 4, 2016.- a resident scratched the petitioner on the chest. The petitioner hit the resident in the mouth.

November 1, 2016 a resident and the petitioner grabbed each other's wrists, hands and fingers and began twisting.

January 2, 2017 the petitioner grabbed another resident and scratched her arm.

March 10, 2017 the petitioner struck a resident with a call light cord.

March 19, 2017 the petitioner struck her sleeping roommate in the chest.

3. The above altercations are documented in the Nurses Notes (Respondent Exhibit 3) and Care Plans (Respondent Exhibit 5).

4. The petitioner was placed on one-to-one monitoring on March 10, 2017. And on March 13, 2017, the one-to-one monitoring was removed. The petitioner was placed

back on one-to-one monitoring on March 19, 2017, and has continued the one-to-one monitoring.

5. The petitioner's daughter asserts that her mother is not the only resident in the Facility with behavior issues. She alleges seeing other residents hit and spit on each other, in addition to hitting C.N.A.s and nurses.

6. Due to the petitioner's behavioral and "wondering" (goes into other resident's rooms) issues, she is in a "memory care secure unit", with other 46 residents. The petitioner has been in the memory care secure unit since she entered the Facility.

7. In March 2016, the petitioner was removed from the memory care secure unit for a short time and was returned to the unit due to her behavioral and wondering issues.

8. The petitioner's current medications include [REDACTED] (mood stabilizer) and [REDACTED] (treats [REDACTED]).

9. The petitioner is also considered an "Elopement Risk" as she is "actively exit seeking... is verbalizing the desire to leave" (Respondent Exhibit 5, pages 44 through 46).

10. The petitioner's daughter disagrees that the petitioner is an Elopement Risk. She alleges that the petitioner has never attempted to leave the memory care secure unit.

11. Ms. Miller stated the Facility is unable to meet the petitioner's needs, because they are unable to continue the one-to-one monitoring requirement.

12. The petitioner's daughter moved from [REDACTED] to be closer to her mother at the current Facility. And disagrees with the Facility's transfer location ([REDACTED]), because it is six hours away.

13. The Facility has reached out to other Facilities in an attempt to find a Facility closer to the petitioner's daughter, to no avail. The only Facility willing to accept the petitioner is [REDACTED], Florida.

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 400.0255(15), Florida Statutes. In accordance with that section this order is the final administrative decision of the Department of Children and Families.

15. Federal Regulations 42 C.F.R. § 483.15, Admission, transfer, and discharge rights in part states:

- (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;** (emphasis added)
 - (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...
 - (F) The facility ceases to operate...
- (2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider...
- (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)...

- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section...
- (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must
 - (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
 - (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
 - (iii) Include in the notice the items described in paragraph (b)(5) of this section.
- (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged...
- (7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

16. The Facility's reason for requesting the petitioner's transfer/discharge is "Your needs cannot be met in the facility." Which is one of the reasons permitted for discharge from a Facility, in accordance with the above Federal Regulation.

17. The evidence submitted establishes that the petitioner has initiated at least six physical attacks on other residents and Facility staff members.

18. 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 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 evidence and the cited authorities, the undersigned concludes the respondent met its burden of proof. The undersigned concludes the Facility's intent to transfer/discharge petitioner, 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 transfer/discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the transfer/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 19 day of June, 2017,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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Ms. Kriste Mennella,
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