

FILED

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

Nov 14, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04039

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 [REDACTED]
UNIT: AHCA,

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 30, 2016 at 11:00 a.m. in [REDACTED] Florida.

APPEARANCES

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

For the Respondent: Lisa Sanchez, Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether the respondent's action to partially deny the petitioner's request for personal care service (PCS) hours for the certification period April 9, 2016 through October 5, 2016, was correct. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted an email letter from his step-father as evidence for the hearing, which was marked Petitioner Exhibit 1. The petitioner's Waiver Support Coordinator also submitted medical records, which were marked Petitioner Exhibit 2.

Appearing as witnesses for the petitioner were [REDACTED] Manager from [REDACTED] (the petitioner's home health services provider) and [REDACTED], his Waiver Support Coordinator.

Appearing as a witness for the respondent was Dr. Darlene Calhoun, 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: Statement of Matters, Clinical Notes, Denial Notices, and Supporting Documentation.

All parties and witnesses appeared in person for the hearing, except Dr. Calhoun, who appeared telephonically.

FINDINGS OF FACT

1. The petitioner's home health agency, [REDACTED] Services (hereafter referred to as "Provider"), requested the following PCS hours for the certification period at issue: 8 hours daily, 7 days per week.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for home health services. The petitioner's provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner's

medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions personnel had no direct contact with the petitioner, his family, or his physicians, other than a home health assessment which was completed in March, 2016. All exchange of information was through eQHealth Solutions' internet based system. The decision made by each physician at eQHealth was solely based on the information submitted by the provider and the caregiver.

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

- 12 years of age and resides with his mother
- [REDACTED]
- Ambulatory
- Incontinent
- Consumes a regular diet
- Takes several prescription medications

5. The petitioner's mother is employed as a teacher and also performs tutoring services some days after school in the late afternoon. The petitioner's step-father serves in the military and is generally not at home. Therefore, his mother is considered his sole caregiver.

6. The petitioner attends school from approximately 7:30 a.m. to 1:30 p.m., Monday to Friday.

7. The petitioner's mother suffered a mental health crisis described as a nervous breakdown in January, 2016 and was hospitalized for 4 days pursuant to the Florida Baker Act.

8. In addition to the petitioner's medical conditions described above, the petitioner's mother stated he was diagnosed with [REDACTED] syndrome in August, 2016 and he lost the skin on his hands. The petitioner's Waiver Support Coordinator also stated he suffers from [REDACTED] syndrome.

9. The petitioner was previously approved for 4 hours of PCS daily from Monday to Friday and 2 hours daily on the weekends. He requested 8 hours daily of PCS for the current certification period and this request was administratively approved by the respondent. Therefore, he is presently receiving 8 hours daily of services, which are utilized as follows – Monday to Friday from 6:00 a.m. to 8:00 a.m. and then 6 hours after school; Saturday and Sunday for 8 continuous hours, beginning anywhere from 7:00 a.m. to noon.

10. With regard to the issue of administrative approval, Dr. Calhoun from eQ Health Solutions did not know why administrative approval for the increased hours was granted in this case. Ms. Sanchez from AHCA stated the administrative approval was granted in error.

11. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the home health aide/personal care aide. The duties include, in part:

- Provide assistance with personal care and ADLs (activities of daily living) such as bathing and grooming, oral hygiene, and toileting
- Ensure total health and safety

12. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and partially denied the requested PCS hours. This physician-reviewer wrote, in part:

There have been no significant changes in the patient's condition or caregiver's status. The continuation of 4 hours of personal care services Monday to Friday and 2 hours of personal care services on Saturday and Sunday is adequate to assist with activities of daily living. The request for any additional personal care service is excessive. Caregivers are expected to care for patients to the fullest extent possible. Monitoring and supervision are not covered benefits.

A notice of this determination was sent to all parties on May 8, 2016.

13. The above notice stated should the parent, provider, or the petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was requested, and eQ Health Solutions sent a notice of reconsideration determination to all parties on May 23, 2016 which upheld the initial decision to partially deny the requested hours.

14. The petitioner thereafter requested a fair hearing and this proceeding followed. As stated above, the respondent administratively approved the requested hours (8 hours daily) pending the outcome of the fair hearing process.

15. The petitioner's witnesses stated he needs total assistance with his activities of daily living (ADLs). He must be monitored for aspiration while eating. He also suffers from ██████ (eating non-food items) and is allergic to nuts. They believe an ordinary babysitter cannot provide these services to the petitioner.

16. The respondent's witness, Dr. Calhoun, stated that the role of a personal care aide is to provide assistance with ADLS and supervision is not a covered service. She

also stated a personal care aide cannot administer medication to a patient. She believes the hours previously approved are sufficient based on the mother's work schedule.

17. Personal Care Service (PCS) for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Home Health Services Coverage and Limitations Handbook (October 2014).

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 Fla. Stat. § 120.80.

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

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 since the petitioner is requesting an increase in the hours of service. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

22. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent.

23. The petitioner has requested personal care 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.

24. 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.

25. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you¹ must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants

¹ "You" in this manual context refers to the state Medicaid agency.

regardless of whether the service or item is otherwise included in your Medicaid plan.

26. The service the petitioner has requested (personal care 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.

27. 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.

28. 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.

29. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested personal care services.

30. In the petitioner's case, the respondent has determined that some personal care services are medically necessary, but has approved 4 hours daily, Monday to Friday, and 2 hours daily on the weekends, rather than the 8 hours daily requested by the petitioner's provider.

31. 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.

32. 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.

33. The petitioner's request for service is governed by the respondent's Home Health Services Coverage and Limitations Handbook (October 2014). The Handbook, on page 1-2, addresses Personal Care Services as follows:

Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability. Medicaid reimburses for these services provided to eligible recipients under the age of 21 years.

ADLs include:

- Eating (oral feedings and fluid intake);
- Bathing;
- Dressing;
- Toileting;
- Transferring; and
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).

IADLs (when necessary for the recipient to function independently) include:

- Personal hygiene;
- Light housework;
- Laundry;
- Meal preparation;
- Transportation;
- Grocery shopping;
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments);
- Medication management; and
- Money management.

34. Page 2-24 of the Handbook addresses who can receive personal care services, as follows:

Medicaid reimburses personal care services for recipients under the age of 21 who meet all of the following criteria:

- Have a medical condition or disability that substantially limits their ability to perform their ADLs or IADLs.
- Have a physician's order for personal care services.

- Require more individual and continuous care than can be provided through a home health aide visit.
- Do not have a parent or legal guardian capable of safely providing these services.

35. Page 2-25 of the Handbook imposes a parental responsibility requirement with respect to personal care services, which is described as follows:

Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider 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. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

Medicaid can reimburse personal care services rendered to a recipient whose parent or legal guardian is not able to provide such care. Supporting documentation must accompany the prior authorization request in order to substantiate a parent or legal guardian's inability to participate in the care of the recipient.

36. Page 2-11 of the Handbook also addresses which services Medicaid does not provide reimbursement for under the home health services program. This list includes:

- Housekeeping (except light housekeeping), homemaker, and chore services, including any shopping except grocery shopping when provided as an IADL
- Meals-on-wheels
- Mental health and psychiatric services
- Normal newborn and postpartum services, except in the event of complications
- Respite care
- Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications
- Baby-sitting
- Services to a recipient residing in a community residential facility when those services duplicate services the facility or institution is required to provide
- Social services
- Transportation services (except when necessary to protect the health and safety of the recipient and no other transportation service is available or when provided as an IADL)

- Escort services
- Care, grooming, or feeding of pets and animals
- Yard work, gardening, or home maintenance work
- Day care or after school care
- Assistance with homework
- Companion sitting or leisure activities

37. The petitioner's physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

38. The respondent's witness, Dr. Calhoun, stated the previously approved hours are sufficient to provide assistance with ADLs and supervision is not a covered service.

39. The petitioner's mother and other witnesses believe he needs the requested 8 hours daily due to his mother's inability to completely provide care for him and due to his medical conditions and needs.

40. Although the undersigned acknowledges that the Handbook provisions cited above outline a parental responsibility requirement and supervision is not a covered service, the evidence presented establishes the petitioner's mother, who is his sole caregiver, is unable to provide complete care for him at this time to her medical conditions. Whether this was a factor in the respondent administratively approving the requested 8 hours daily is uncertain since the respondent's position is that the administrative approval of the hours was an error.

41. The undersigned concludes that the petitioner has demonstrated that the respondent should have approved the request for 8 hours daily of personal care services for the certification period at issue. However, the petitioner's family should be

aware of the parental responsibility provisions cited above and if the petitioner's mother's condition improves, it may be appropriate for the respondent to reduce the personal care service hours in the future.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, and the petitioner shall receive 8 hours daily of personal care services.

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 14 day of November , 2016,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429

FINAL ORDER (Cont.)

16F-04039

PAGE - 15

Fax: 850-487-0662

Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

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

FILED

Nov 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04175

PETITIONER,

Vs.

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

And

UNITED HEALTHCARE,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 27, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Brown, Petitioner's mother

For the Respondent, AHCA: No one appeared

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's request for Speech Therapy (ST) service hours was correct. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for the petitioner were [REDACTED], Director; [REDACTED], Speech Therapist, and [REDACTED], Principal, from [REDACTED], the petitioner's speech therapy provider. The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Susan Frischman, Senior Compliance Analyst, and Dr. Eina Fishman, Medical Director, from United Healthcare, which is the petitioner's managed care health plan. United Healthcare was included as an additional respondent in this proceeding since it is the petitioner's health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked Respondent composite Exhibit 1 – Statement of Matters, Appeal System Screenshots, Denial Notices, and Speech Therapy Plan of Care/Evaluation.

FINDINGS OF FACT

1. The petitioner is a fifteen (15) year old Medicaid recipient. He receives Medicaid services through United Healthcare.
2. On or about December 30, 2015, the petitioner's ST service provider, [REDACTED] (hereafter referred to as "the provider"), requested the approval of 3 hours weekly of speech therapy services from United Healthcare.
3. The petitioner had been receiving speech therapy services at [REDACTED] for several years. The services ended in September, 2015.

4. A Plan of Care dated September 27, 2015 was also submitted by the provider.

The document was signed by a physician and outlined the type of assistance to be provided by the ST provider. The long-term goals include the following:

- Improving expressive language skills
- Improving pragmatic skills
- Improving receptive language skills

5. On December 31, 2015, United Healthcare denied the request for speech therapy services. The denial notice stated the following:

Your child's doctor asked for speech therapy. Your child's health plan requires certain information from the doctor to show your child needs this service. This includes:

- Details about your child's speech progress
- New speech skills that are used at home and school
- Goals that have not yet been met
- How your child is actively taking part in the therapy

We did not get this information from your child's doctor. We need to know what symptoms your child is having and what treatments your child has tried. This request is not approved. Once we get this information from your child's doctor, we will look at this request again.

6. The petitioner initiated an internal grievance/appeal with United Healthcare on or about January 22, 2016 to contest the denial decision. United Healthcare upheld the initial decision on February 19, 2016. The petitioner subsequently requested a fair hearing and this proceeding followed.

7. The respondent's witness, Dr. Fishman, stated the request for ST services was denied due to lack of information submitted with the request for services. She also stated the health plan did recently receive the requested information, but a more recent

assessment was now needed since the last assessment was performed one year ago in September, 2015.

8. The petitioner's witness, [REDACTED], stated that the provider did submit the additional documentation such as the evaluation and plan of care in September, 2015.

9. ST service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent AHCA's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

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 Fla. Stat. § 120.80.

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 respondent since the petitioner was previously approved for ST services and the respondent had denied or terminated the continuation of those services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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.

15. The petitioner has requested ST 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.

16. 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.

17. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you¹ must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established

¹ "You" in this manual context refers to the state Medicaid agency.

periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

18. The service the petitioner has requested (ST services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

Any service under this section shall be provided only when medically necessary ...

19. 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.

20. 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.

21. Based upon the information submitted by the petitioner's provider, United Healthcare completed a prior authorization review to determine medical necessity for the requested ST services.

22. In the petitioner's case, United Healthcare denied the requested services since its position is that no supporting documentation such as an assessment and plan of care was submitted with the request

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

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

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

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

24. 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.

25. ST services, also referred to as speech-language pathology services, are described on page 1-4 of the Therapy Handbook as follows:

Speech-language pathology services involve the evaluation and treatment of speech-language disorders.

Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and

enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

26. The Therapy Handbook on page 2-2 sets forth the requirements for ST services, as follows:

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

27. The Petitioner's physician ordered a ST service frequency greater than that approved by CCN. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

28. The respondent's position is that the services were properly denied since supporting documentation was not submitted to establish the need for services.

Although the health plan has recently received that documentation, its position now is that a new assessment is needed since the last assessment was performed one year ago.

29. The petitioner's therapy provider stated the required documentation was submitted to United Healthcare in September, 2015.

30. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the respondent has demonstrated the denial of the request for ST services was correct. Since the plan did not receive the requested documentation in 2015, it could not make a determination regarding medical necessity for the requested services. The petitioner should obtain a new ST

evaluation/assessment and plan of care at this time and re-submit the service request to the health plan for review.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 16 day of November , 2016,

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

FINAL ORDER (Cont.)

16F-04175

PAGE - 11

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

Nov 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-04263

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on October 10, 2016, at 3:15 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner

For the Respondent:

Robert Walker
Regulatory Research Coordinator
Staywell

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for direct member reimbursement ("DMR") for [REDACTED] [REDACTED] in the amount of \$240.00?

PRELIMINARY STATEMENT

Phillip Stellas, R.Ph., Senior Director of State Pharmacy at Staywell Health Plan of Florida ("Staywell"), appeared as a witness on behalf of the respondent, Staywell ("respondent"). Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration ("AHCA" or "Agency"), was present solely for observation.

The respondent introduced Exhibits "1" through "12", inclusive, at the hearing. All of the exhibits 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 an adult male who resides in [REDACTED], Florida.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding. There has been no erroneous denial or termination of his Medicaid eligibility.
3. The petitioner is an enrolled member of Staywell Health Plan of Florida. Staywell is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida. The petitioner's effective date of enrollment with Staywell is June 1, 2014.
4. In early December 2015, Staywell notified the petitioner that it intended to change its preferred pharmacy network effective January 1, 2016.

5. Staywell gave its members a 90-day transition of care period, effective January 1, 2016. The purpose of the transition of care period was to allow members time to change to a network pharmacy.

6. The petitioner had a prescription for [REDACTED] (quantity of 120) for a 30-day supply filled at [REDACTED] Pharmacy on April 21, 2016.

7. [REDACTED] Pharmacy is not a part of the Staywell network; it is an out of network pharmacy.

8. The petitioner incurred a \$240.00 out-of-pocket cost for the prescription.

9. The petitioner contacted Staywell on May 10, 2016 to request reimbursement for the [REDACTED]. The Staywell representative advised the petitioner to submit a request for pharmacy reimbursement.

10. On May 12, 2016, Staywell received a Direct Member Reimbursement ("DMR") request from the petitioner requesting reimbursement for [REDACTED] [REDACTED] (quantity of 120) for a 30-day supply in the amount of \$240.00 which was filled on April 21, 2016.

11. Staywell mailed the petitioner a notice of action letter dated May 16, 2016 advising him his request for reimbursement was denied. The letter explains:

The following medication(s) have been denied:

[REDACTED] 10-325 MG TABLET #120 FILLED ON
4/21/2016

The medication(s) were denied because:

Our records indicate that the dispensing pharmacy for the claim you are requesting is not in our pharmacy network. Out-of-network prescription drug services are not eligible for reimbursement.

12. The Staywell Medicaid Direct Member Reimbursement procedure (*Resp. Exhibit 10*) is designed to ensure that Staywell is in compliance with all federal and state regulations and states as follows:

If a Medicaid member submits a request for Direct Member Reimbursement for prescription drugs obtained from non-network providers in a non-emergency situation, the member is advised that he or she has received “out-of-network prescription drug services” and is not reimbursed. These requests are denied through the standard DMR process.

13. The Staywell member handbook addresses prescription drug coverage on Page 26. It refers members to the Staywell Preferred Drug List (“PDL”) for a list of the drugs it covers and explains the PDL also lists limitations for certain drugs.

14. Drugs not appearing on the Preferred Drug List require prior authorization. [REDACTED] 10-325 appeared on the Preferred Drug List and does not require prior authorization.

15. The petitioner purchased the medication on April 21, 2016 using a new prescription. Although Staywell had paid for this prescription for the petitioner in the previous month, drugs in this class require a new prescription each month. The prescriptions may not be written with refills.

16. There are at least three in-network pharmacies within two miles of the petitioner’s home in [REDACTED], including one at the Sam’s Club membership warehouse.

17. The petitioner was unaware that he could use the pharmacy at Sam’s Club without being a warehouse member.

18. The petitioner went to many different pharmacies on that day before he found one that had the [REDACTED] in the required dosage in stock.

19. The petitioner testified he traveled 150 miles in one day trying to get the prescription filled.

20. The petitioner needed to get the prescription filled because he was in pain.

21. If a pharmacy does not have a medication in stock, it can order the drug from its warehouse; however, delivery can take more than one day.

CONCLUSIONS OF LAW

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

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

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

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

26. 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.).

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

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

(a) “Medical necessary” or “medical necessity” means that medical or allied care, goods or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider. . .

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

29. The Florida Medicaid Provider General Handbook – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code Rule 59G-5.020. 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.

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

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

32. 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.”

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

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

The State of Florida Legislature, in 409.912 (37)(a) 4, F.S., has authorized Medicaid to limit its pharmacy network based on need, competitive bidding, price negotiations, credentialing, or other similar criteria. If the Agency for Health Care Administration (AHCA or the Agency), Medicaid Division, has a sufficient number of Medicaid providers, AHCA is allowed to impose a moratorium on Medicaid pharmacy enrollment. AHCA can terminate any Medicaid contract with 30 days notice without cause. All terms of the contract will remain in force for the full 30 days.

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

59G-5.110 Direct Reimbursement to Recipients.

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

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

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

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

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

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

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

36. In the present case, the petitioner purchased his medication from an out-of-network pharmacy after being advised of the transition to a new preferred pharmacy network. The petitioner could have filled the prescription at an in-network pharmacy. If an in-network pharmacy did not have the drug available, it could have ordered it from its warehouse or contacted other in-network pharmacies to determine who had the drug in stock. There has been no erroneous denial or termination of Florida Medicaid eligibility.

37. Pursuant to the above, the petitioner has not met his burden of proof to demonstrate the respondent incorrectly denied his request for reimbursement.

DECISION

The petitioner's appeal is hereby DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of 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 November, 2016,

in Tallahassee, Florida.

Peter J. Tsamis

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

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

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

FILED

Nov 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04408

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 October 20, 2016 at 1:10 p.m.

APPEARANCES

For the Petitioner: [REDACTED] MedAssist, designated representative

For the Respondent: Pat Hernandez, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 13, 2016 and October 5, 2016 denying the petitioner's application for retroactive SSI-Related Medicaid for August 2015 and September 2015. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for hearings on August 11, 2016, August 25, 2016, September 8, 2016 and September 16, 2016. The petitioner requested these hearings be rescheduled each time as they were working with the Department and the Division of Disability Determinations (DDD) in attempts to resolve the matter without proceeding to hearing. As the matter was not resolved, the case was scheduled for final hearing on October 20, 2016.

Upon convening the hearing, the petitioner withdrew the appeal request for August 2015 eligibility for the petitioner.

The respondent submitted evidence on August 10, 2016. Pages 26 through 44, 81, and 110 through 124 were removed from this evidence as relating specifically to August 2015 and no longer necessary. The remainder of this evidence was entered as Respondent's Exhibit 1.

The respondent submitted supplemental evidence on October 10, 2016. Pages 28 through 37 were omitted from the evidence as relating specifically to August 2015 eligibility and no longer necessary. The remainder of this evidence was entered as Respondent's Exhibit 2.

The petitioner submitted evidence on October 6, 2016, which was contained within the two packets submitted by the Department. This evidence was not entered into the record as it duplicated the respondent's evidence.

The record closed on October 20, 2016.

FINDINGS OF FACT

1. The petitioner applied for SSI-Related Medicaid on August 10, 2015.
2. The petitioner is a 38-year-old male with no dependent children listed on his application. According to the application, he was claiming disability, but had not been established as disabled. He also had not been denied by Social Security Administration (SSA).
3. The Department issued a Notice of Case Action on August 14, 2015 denying the petitioner's application for SSI-Related Medicaid, as "You or a member of your household do not meet the disability requirement.
4. The Department issued a Notice of Case Action on September 4, 2015 denying the petitioner's application for SSI-Related Medicaid as "No household members are eligible for this program.
5. The petitioner admitted to the hospital on September 7, 2015. According to his medical records for this admission, the chief complaint was [REDACTED]
[REDACTED]
[REDACTED] Medical records also indicate petitioner was unable to speak during this hospital admission.
6. The petitioner was discharged from the hospital to [REDACTED] Hospice on November 10, 2015.
7. The petitioner died on November 18, 2015. According to his death certificate his cause of death was [REDACTED]".
8. The petitioner filed a new application for SSI-Related Medicaid on December 10, 2015.

9. The Department submitted a Disability Determination Transmittal on December 16, 2015 to the Division of Disability Determinations (DDD).

10. DDD responded on December 30, 2016 that the petitioner is established as disabled effective October 10, 2015. The DDD representative noted the petitioner was not disabled in August 2015 per MER review. The representative further noted SSA denied on October 9, 2016 with reason code N36, making earliest available retro as October 10, 2016.

11. The Department explained the reason code "N36" from SSA means "Non-pay – insufficient or no medical data furnished."

12. The Department issued a Notice of Case Action on January 13, 2016 approving the petitioner for SSI-Related Medicaid beginning October 2015. In the same notice, the Department denied the petitioner's eligibility for August 2015, September 2015 and January 2016, as "No household members are eligible for this program."

13. The petitioner submitted a request for retroactive Medicaid for August and September 2015. The respondent included a copy of the petitioner's medical bills for these months.

14. The Department submitted a fax request to DDD for SSA Disability Status and Disability Determination and Transmittal on August 10, 2016.

15. DDD responded on September 29, 2016 that the petitioner was not disabled.

16. DDD Case Analysis submitted on September 29, 2016 states:

Claimant died 11/18/2015, with COD on DC listed as [REDACTED]
[REDACTED] He is met posthumously to listing 11.04.

Claimant was denied *[sic]* on SSA application 10/08/2015 for failure to cooperate. N36.

Medicaid application received in DDD for posthumous allowance on 12/22/2015. RETRO was not applied. And case documentation notes: Clt *[sic]* was admitted to ER for SOB on 8/9/2015 and discharged the next day. He had past hx of [REDACTED] and at that time was not taking [REDACTED] when it ran out. At discharge clt has no dizziness or SOB and ambulating on his own. Clt was not disabled in 8/2015.

There is no new evidence presented and based on previous decision, RETRO is denied.

17. The Department issued a Notice of Case Action dated October 5, 2016 denying the petitioner's request for SSI-Related Medicaid, as "You or a member of your household do not meet the disability requirement."

18. A representative from DDD was requested to appear at the hearing. The Department was notified by DDD that there would be no representative appear for this hearing as it was for retroactive Medicaid only.

19. The petitioner maintains belief of being eligible for Medicaid for September 2015 due to admission to the hospital was for the same cause as his death.

CONCLUSIONS OF LAW

20. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to 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.

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

22. The undersigned explored eligibility first under Family-Related Medicaid groups as the petitioner's application was marked for "Family-Related Medicaid". The petitioner does not have a minor child in the home according to his May 2, 2016 application. The Family-Related Medicaid Program benefit rules are set forth in the Florida Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid program; the petitioner must be pregnant or have a dependent minor child residing in the home. The undersigned concludes the petitioner does not meet the criteria for Family-Related Medicaid Program benefits.

23. The definition of Med-AD Demonstration Waiver is found in Fla. Admin. Code R. 65A-1.701 (20) and states:

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

24. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), 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).

25. 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.

26. 42 C.F.R. § 435.5541 “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:

(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.

(d) Basis for determinations. The agency must make a determination of disability as provided in paragraph (c) of this section—

(1) On the basis of the evidence required under paragraph (e) of this section; and

(2) In accordance with the requirements for evaluating that evidence under the SSI program specified in 20 CFR 416.901 through 416.998.

(e) Medical and nonmedical evidence. The agency must obtain a medical report and other nonmedical evidence for individuals applying for Medicaid on the basis of disability. The medical report and nonmedical evidence must include diagnosis and other information in accordance with the requirements for evidence

applicable to disability determinations under the SSI program specified in 20 CFR part 416, subpart I.
(emphasis added)

27. Fla. Admin. Code R. 65A-1.702 “Special Provisions” states in relevant part:

(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:

...

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.

(emphasis added)

28. The findings show the Social Security Administration (SSA) denied the petitioner’s disability on October 9, 2015 due to insufficient medical information. DDD did not make a determination of disability for dates prior to October 9, 2015 because of the SSA ruling. However, the findings show DDD did determine the petitioner disabled effective October 10, 2015. As no DDD representative was present at the hearing, the undersigned concludes the decision was based on the petitioner’s death on November 18, 2016.

29. The findings show the petitioner's cause of death was the same as the same condition as he was admitted to the hospital with on September 7, 2015. The undersigned therefore concludes the petitioner was disabled on September 7, 2015. The undersigned concludes DDD failed to make an accurate determination on disability begin date in this case.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED. The Department is to determine the petitioner's Medicaid eligibility with the factor of disability beginning September 7, 2015.

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 November, 2016,

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

FINAL ORDER (Cont.)

16F-04408

PAGE - 11

Email: Appeal.Hearings@myflfamilies.com

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

FILED

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

Nov 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-04571

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 two administrative hearings by phone in the above-referenced matter on August 5, 2016 at 2:06 p.m.; and on September 19, 2016 at 10:30 a.m.

APPEARANCES

For Petitioner: [REDACTED], pro se

For Respondent: Jonathan Daniels, Economic Self Sufficiency Specialist II
Nicole Nurridin, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the respondent's action to terminate the petitioner's Transitional Medicaid (MEI) benefits and then enroll her in the Medically Needy (MN) Medicaid Program with a monthly share of cost (SOC) amount. Respondent was assigned the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified at both hearings. Petitioner submitted no exhibits at the hearings. At the August 5, 2016 hearing, the respondent was represented by Jonathan Daniels with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). Mr. Daniels testified. At the August 5, 2016 hearing, the respondent submitted seven exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” – “7”. At the September 19, 2016 hearing, the respondent was represented by Nicole Nurridin with DCF. Ms. Nurridin testified.

At the August 5, 2016 hearing, the undersigned left the record open until August 12, 2016 to allow the respondent to submit additional documentation. On August 23, 2016, the undersigned issued an Order to Reopen the Record and Reconvene the Hearing as the respondent did not submit the additional documentation. On September 7, 2016, the petitioner submitted documentation, which was accepted as evidence and marked as Petitioner’s Exhibit “1”.

At the September 19, 2016 hearing, the undersigned left the record open until October 5, 2016 to allow the respondent to submit the documentation requested at the August 5, 2016 hearing. On October 4, 2016, the respondent submitted the additional documentation, which was accepted into evidence and marked as Respondent’s Exhibits “8” – “10”. The record closed on October 5, 2016.

FINDINGS OF FACT

1. Petitioner's full Family-Related Medicaid benefits ended effective July 2015. Petitioner received Transitional Medicaid (MEI) benefits from August 2015 through May 2016.
2. On January 13, 2016, the petitioner completed an application for Food Assistance (FA) and Medicaid benefits. Petitioner's MEI Medicaid benefits were not affected during the processing of her January 2016 application.
3. During the processing of the petitioner's January 2016 application, the respondent determined her husband's monthly earned income as \$1,682.20.
4. On May 27, 2016, the respondent terminated the petitioner's MEI benefits.
5. On May 31, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner was not eligible for full Medicaid benefits.
6. On May 27, 2016, the petitioner completed an application for Food Assistance (FA) and Medicaid benefits. FA benefits are not an issue under appeal. The application listed the petitioner, her husband, and their four children as the only household members; the petitioner as thirty-five years old; and her husband's earned income as the only source of income for the household.
7. On June 1, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's Medicaid application dated May 27, 2016 was approved for the Medically Needy (MN) Medicaid Program with a monthly share of cost (SOC) of \$1,065 for June 2016 and \$1,296 for July 2016 and ongoing.
8. Respondent did not submit into evidence the MN Medicaid budgets that reflect the petitioner's SOC amounts of \$1,065 and \$1,296.

9. On June 14, 2016, the respondent mailed the petitioner a Notice of Case Action indicating she was eligible for MN Medicaid benefits with a monthly share of cost of \$1,544 effective July 2016 and ongoing.

10. Respondent calculated the petitioner's MN SOC amount as \$1,544 effective July 2016 and ongoing as follows:

\$2,327.74	husband's earned income
\$2,327.74	total countable income
<u>-\$ 783.00</u>	<u>MNIL for a household of six</u>
\$1,544.00	share of cost

11. The gross earnings for the husband's paystubs were \$1,249.67 for May 20, 2016 and \$1,078.06 for June 3, 2016. The respondent considered both paystubs as representative when converting the petitioner's husband's bi-weekly income to a monthly amount. The respondent calculated the husband's earned income as \$2,327.74 per month or \$2,327.74 divided by two = \$1,163.87 multiplied by two = \$2,327.74.

12. Petitioner explained that her husband was paid fourteen dollars per hour and worked between thirty-seven to thirty-nine hours per week. Petitioner's husband worked overtime for the pay period reflected in the paystub dated May 20, 2016; however, overtime is not ongoing and available for the petitioner's husband.

13. Petitioner did not agree with the respondent's determination that she was not eligible for full Medicaid benefits as she has a medical condition that requires medications, physician visits, and various tests. Petitioner explained she cannot afford to pay for all of her medical expenses and requires Medicaid to pay for them.

14. Petitioner and her husband are jointly filing taxes and are claiming all their four children as tax dependents. Furthermore, the petitioner is not pregnant and is not disabled.

15. Respondent determined the petitioner was not eligible for twelve months of MEI Medicaid as her husband's earned income had significantly increased since the January 2016 application for benefits.

CONCLUSIONS OF LAW

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

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

As to the termination of the petitioner's MEI Medicaid effective May 2016

18. Section 445.029(1), Florida Statutes, Transitional Medical benefits defines the criteria to receive MEI Medicaid and states:

- (1) A family that loses its temporary cash assistance due to earnings shall remain eligible for Medicaid without reapplication during the immediately succeeding 12-month period if private medical insurance is unavailable from the employer or is unaffordable.
 - (a) The family shall be denied Medicaid during the 12-month period for any month in which the family does not include a dependent child.
 - (b) The family shall be denied Medicaid if, during the second 6 months of the 12-month period, the family's average gross monthly earnings during the preceding month exceed 185 percent of the federal poverty level.

19. Pursuant to the above authority, a family is eligible for up to twelve months of MEI Medicaid if the aforementioned criteria are met. Petitioner began receiving MEI

Medicaid effective August 2015. Petitioner's MEI Medicaid ended effective May 2016 due to a significant increase in her husband's earned income.

20. In order for a family to receive the second six months of MEI Medicaid, the household's average gross income must not exceed 185 percent of the federal poverty level during the preceding month.

21. Fla. Admin. Code R. 65-1.716(1), Income and Resource Criteria, sets 185 percent of the federal poverty level for a household of six as \$4,871.

22. Pursuant to the above authority, the petitioner and her family are eligible for the second six months of MEI Medicaid if her household's income is below \$4,871.

23. Federal Medicaid Regulations 42 C.F.R. § 435.603, Application of modified adjusted gross income states, in part:

(a) Basis, scope, and implementation...

(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...

(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...

(f) Household—

(2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent...

(4) Married couples. In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the Code or whether one spouse expects to be claimed as a tax dependent by the other spouse. . .

24. Pursuant to the above authority, the petitioner, her husband, and their four children are considered as “the petitioner’s household”.

25. Fla. Admin. Code R. 65-1.707, 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...”

26. Pursuant to the above authority, the petitioner’s husband’s earned income must be included in the calculation of the petitioner’s Family-Related Medicaid benefits.

27. Federal Medicaid Regulations 42 C.F.R. § 435.603, Application of modified adjusted gross income states, in part:

(h) Budget period—

(2) Current beneficiaries. For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must

be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at § 435.940 through § 435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections...

28. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2430.0500, Income Averaging (MFAM), states, in part:

Income averaging is a method used to adjust for fluctuations in income when the income is not verified through the Federal Data Services Hub (FDSH) or State Wage Information Collection Agency (SWICA) data, converted to a monthly amount.

When earned income is received more frequently than monthly, a four week average is used. When income is received semimonthly, the computation is averaged based on the most recent available one month of pay. When the income is received monthly, use the most recent one month pay, if representative.

When using an average, use only the weeks in the average that represent the ongoing pattern of employment. If there are significant breaks of one week or more without pay and the breaks are not expected to recur at four week intervals, the breaks will be disregarded in computing the average. Such a break without pay might be due to illness, a death, vacation, employer leaving town, and the like. When such breaks are part of the pattern of the applicant/recipient's employment, the weeks are taken into consideration in computation of the average (for example, construction workers)...

29. Pursuant to the above authorities, only the paystubs that represent the ongoing pattern of employment for an individual are considered when averaging earned income. Petitioner's husband is paid bi-weekly, so the two paystubs utilized by the respondent when averaging the household's monthly earned income are May 20, 2016 and June 3, 2016. The husband's paystub dated May 20, 2016 included overtime hours; however, overtime hours for the petitioner's husband are not consider ongoing or available. Respondent incorrectly considered the May 20, 2016 paystub as representative when calculating the husband's monthly earned income.

30. The Policy Manual, CFOP 165-22, passage 2430.0509, Income more often than monthly (MFAM), states, in part:

The following procedure to calculate the average of earned or unearned income received in varying amounts more frequently than monthly is the same for all programs:

1. Add the gross income amounts for the past four weeks to get the total.
2. If income is received weekly, add four pay periods and divide by four to get the weekly average.
3. If income is received bi-weekly, add two pay periods and divide by two to get the bi-weekly average.
4. If income is received semimonthly, add two pay periods and divide by two to get the semimonthly average.
5. If income is received monthly, use the most recent month if representative.

The result of the above is called the averaged amount. With the exception of monthly amounts, the averaged amount described above must be converted to a monthly amount...

31. Pursuant to the above authority, the respondent utilizes the monthly gross income amounts to determine eligibility for Family-Related Medicaid benefits. To convert bi-weekly income to monthly income, the respondent first adds the past four weeks of earned income, then divides the sum by two, and then multiplies the sum by two. Only the husband's paystub dated June 3, 2016 (gross amount of \$1,078.06) is considered representative. Respondent should have calculated the husband's monthly earned income as \$2,156.12 or $\$1078.06 \times 2$.

32. In January 2016, the respondent calculated the household's monthly earned income as \$1,682.20. In May 2016, the respondent should have calculated the household's monthly earned income as \$2,156.12.

33. Petitioner's first six months of MEI Medicaid is from August 2015 through January 2016. Her second six months of MEI Medicaid is from February 2016 through

July 2016. Respondent did not submit into evidence the household's monthly earned income prior to January 2016.

34. Petitioner's household's monthly earned income does not exceed the 185 percent of the federal poverty level during either the end of the first six months of the petitioner's MEI Medicaid time period or during the second six months of her MEI Medicaid time period.

35. In careful review of the cited authorities and evidence, the undersigned concludes the respondent has not met its burden of proof to indicate the petitioner's MEI (Transitional) Medicaid was correctly terminated effective May 31, 2016. Respondent is ordered to approve the petitioner MEI Medicaid for the months of June 2016 and July 2016.

36. Fla. Admin. Code R. 65-1.702, Special Provisions, states, in 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...

(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.

37. Pursuant to above authority, when a recipient's Medicaid benefits are terminated, the respondent is to determine their eligibility for another type of Medicaid benefit.

Respondent correctly determined the petitioner eligible for another type of Medicaid benefit when her MEI Medicaid was terminated.

As to the petitioner's eligibility for full Medicaid benefits effective August 2016 and ongoing

38. Fla. Admin. Code R. 65A-1.710 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 which 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.

39. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, the petitioner must be considered disabled or over the age of 65. Petitioner is not eligible for SSI-Related Medicaid benefits as she is under the age of 65 and is not disabled.

40. 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...

41. 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 or she must be pregnant. Petitioner lives in a household with children under the age of eighteen, so she meets the technical requirements to be eligible for Family-

Related Medicaid benefits.

42. 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.

43. The Policy Manual, CFOP 165-22, passage 2630.0108, Budget Computation (MFAM), states:

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).

44. The Policy Manual, CFOP 165-22, Appendix A-7, defines the Family-Related Medicaid income limits for a household of six for adults is \$487; the Standard Disregard is \$296; and the Medically Needy Income Limit (MNIL) is \$783.

45. Pursuant to the above authorities, the petitioner is not eligible for full Family-Related Medicaid benefits as the household's monthly income (\$2,156.12) minus the standard disregard (\$296) is more than the income limit of \$487. Therefore, the petitioner is correctly enrolled in the Medically Needy Medicaid Program with a monthly share of cost amount.

46. In careful review of the cited authorities and evidence, the undersigned concludes the respondent has met its burden of proof to indicate the petitioner is not eligible for full Family-Related Medicaid benefits; and instead, is eligible for the Medically Needy Medicaid Program with a monthly share of cost amount effective August 1, 2016 and ongoing.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is PARTIALLY GRANTED. Respondent is ORDERED to approve Transitional Medicaid (MEI) benefits for the months of June 2016 and July 2016 for the

petitioner and her family. However, the petitioner's appeal for full Medicaid benefits for August 2016 and ongoing 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 10 day of November , 2016,

in Tallahassee, Florida.

Mary Jane Stafford

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

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

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

FILED

Nov 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04645

PETITIONER,

Vs.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 8, 2016 at 10:50 a.m.

APPEARANCES

For the Petitioner: [REDACTED], attorney ad litem

For the Respondent: Kristal Beharry, Esq.

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to receive Prescribed Pediatric Extended Care (PPEC) services through Medicaid. The petitioner holds the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts with eQ Health Solutions (eQ) to conduct prior services authorizations for certain Medicaid services, including PPEC services.

The hearing was initially scheduled to convene telephonically on August 15, 2016 at 10:00 a.m. The proceeding was continued in order for the parties to complete discovery. The hearing was held on November 8, 2016.

The respondent filed a Motion to Dismiss on October 27, 2016, asserting that the appeal should be dismissed because the hearing was requested by a non-authorized individual, the petitioner's medical foster care parent. The petitioner's attorney ad litem acknowledged a miscommunication occurred and the parties mistakenly believed the foster parent should file the hearing request. However, the error was harmless and soon remedied by the attorney ad litem calling into the August 15, 2016 proceeding as the petitioner's appointed representative and subsequently filing a Notice of Appearance. The undersigned concluded that the matter was rehabilitated and made moot by the attorney ad litem filing a Notice of Appearance and assuming her representative role. The respondent's motion was denied on the record.

By notice dated April 22, 2016, eQ informed the petitioner that his request for PPEC services for the certification period April 20, 2016 – October 16, 2016 was denied in-part. eQ approved only three months of PPEC services, instead of the six months

requested by the petitioner. eQ's decision notice reads in part: "the services are not medically necessary."

The petitioner requested reconsideration.

By notice dated May 12, 2016, eQ informed the petitioner that the original decision was upheld.

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

Present as witnesses for the petitioner: [REDACTED], dependency case manager with [REDACTED]; [REDACTED], dependency case manager supervisor with [REDACTED]; [REDACTED], medical foster parent; [REDACTED], mother; [REDACTED], medical foster care social worker with [REDACTED]; and [REDACTED], case coordinator with the [REDACTED]. The petitioner did not submit documentary evidence.

Present as witnesses for the respondent: Sheila Broderick, registered nurse specialist with AHCA and Dr. Ellyn Theophilopoulos, senior medical director and physician reviewer with eQ. Dr. Theophilopoulos was qualified an expert in Medicaid medical necessity. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

Administrative notice was taken of the following:

- Sections 409.905, 409.913, 409.9131 Florida Statutes
- Florida Administrative Code Rules 59G-1.010.
- The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013

The record was closed on November 8, 2016.

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 8) is a Florida Medicaid recipient. He is enrolled in Florida's Medical Foster Care Program. The purpose of the Medical Foster Care Program is to provide care for foster children with complex medical conditions in family settings, with caregivers trained to meet the children's health care needs.

2. The petitioner's diagnoses includes [REDACTED] and [REDACTED] syndrome (a [REDACTED]). The petitioner is considered medically fragile; he has both a [REDACTED] and a [REDACTED] for feeding and administration of medication. The petitioner requires assistance with all the activities of daily living. In addition, he requires supervision and monitoring.

3. Until late 2015, the petitioner lived in the family home with his mother. The petitioner was taken into custody by the Department of Children and Families (DCF) and admitted in the Medical Foster Care Program in November 2015. DCF contracts with the Community Partnership for Children (CPC) to coordinate services its foster children.

4. In early 2016, CPC and the petitioner's medical foster parent began to explore his appropriateness for public school. The Volusia County school system determined that there were insufficient health care services available to care for the petitioner during emergency situations, such as the need for [REDACTED] care, in a school setting.

5. In an ongoing effort to find educational and medical day programs for the petitioner, CPC and the medical foster parent sought PPEC (specialized medical day program for children with complex medical) services. The petitioner attended PPEC programs in the past, while living with his biological mother; his support team felt this was a viable option for him.

6. The PPEC application process begins with the applicant's physician submitting a request to eQ, the respondent's contracted prior service authorization agent. The petitioner's treating physician submitted a service request to eQ on or about April 13, 2016 for eight hours of PPEC services daily, five days per weeks for six months (April 2016 – October 2016). All Medicaid services must be medically necessary as determined through a prior service authorization process. eQ reviews the authorization request form and supporting documentation.

7. In the instant case, eQ reviewed the request form, petitioner's Plan of Care (a document which defines the patient's need for Medicaid services and the service goals), physician medical necessity letter, and PPEC clinical notes to make the eligibility decision.

8. The Plan of Care is dated April 5, 2016 and describes the petitioner as medically fragile, severely developmentally delayed, and in need of continuous nursing care.

9. The petitioner's treating physician wrote a letter of medical necessity which reads in pertinent part:

[Petitioner]...is medically complex...His diagnoses include [REDACTED] dependence, [REDACTED], [REDACTED] dependence for all

nutrition, [REDACTED]
[REDACTED] He requires skilled nursing care around the clock. He is currently in medical foster care....He is at increased risk for falls, aspiration, respiratory failure, and infection. His care also requires a significant amount of equipment, oxygen, and supplies to keep his as health as possible. He requires skilled personnel to perform [REDACTED] [REDACTED] and the ability to intervene and change the [REDACTED] if a life-threatening [REDACTED] obstruction occurs. Medication and feeding administration require an individual skilled in safely accessing his gastrostomy tube....

10. The clinical notes from the chosen PPEC provider, Pediatric Health Choice, read in pertinent part:

[Petitioner] is a 7 year old male with [REDACTED], a [REDACTED] for all nutritional intake [REDACTED]
[REDACTED] His medical history includes multiple hospitalizations for [REDACTED]
[REDACTED] He requires skilled nursing to perform [REDACTED] feedings and care, medication administration [REDACTED] care and [REDACTED], monitor for high risk of falls, aspiration, infection and respiratory failure. Skilled nursing intervention is necessary to promote health and prevent sequela resulting from medical condition and potential risks.

11. eQ approved 90 days of PPEC services for the petitioner, April 2016 – July 2016. Dr. Ellyn Theophilopoulos, expert witness for the respondent, explained that short term PPEC services are approved under certain circumstances: 1) to provide continuity of care to medically fragile children who are transitioning from the family home to foster care; 2) to evaluate a child's medical condition and need for health services to determine the appropriate level of care; and 3) during unexpected crisis situations, such as an incapacitated caregiver. eQ determined that additional PPEC services were not medically necessary because the petitioner receives medical foster care services from a provider who is trained to meet his health care needs during the requested PPEC service hours. In addition, the petitioner receives eight hours of

private duty nursing services each night (so the medical foster parent can sleep). Medicaid is already providing the petitioner with around the clock medical services. PPEC services would be duplicative of services the petitioner is already receiving. Medicaid rules prohibit duplication of services

12. The petitioner's witnesses acknowledged that the medical foster parent is capable of meeting his medical care needs. However, they argued that the petitioner also has educational, socialization, and therapy (physical, occupational, etc.,) needs which cannot met by the foster parent. The petitioner can receive all those services at one location, the PPEC center. In addition, the foster mother has three other medically complex children in her home who require her time and attention. There is insufficient time in the day for her to meet the needs of all the children without additional support services, like PPEC services.

13. The petitioner's witnesses argued that he thrived in other PPEC programs, while living with his mother, and believe he would benefit greatly from further participation in the program.

14. In rebuttal, the respondent asserted that education, socialization, and therapy services are not the purpose of the PPEC program. The purpose of PPEC is to provide skilled nursing care to medically fragile children. PPEC provides additional services, such as physical therapy, etc., but those services are adjunct and not the primary program purpose.

15. Dr. Theophilopoulos noted that Volusia County provides home tutoring for children unable to attend school for medical reasons. In addition, there are outpatient

therapy services and social groups (like Special Olympics) to address the petitioner's other needs. Dr. Theophilopoulos noted that it may be more convenient to receive all needed services at one location, however, Medicaid rules prohibit the provision of services for reasons of convenience.

CONCLUSIONS OF LAW

16. 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.

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

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

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

20. 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.).

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

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

“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.

23. 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.

24. 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.

25. Page 1-1 of the PPEC Handbook notes that, “[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical...care at a non-residential pediatric center.”

26. On page 2-1 thru 2-2, the PPEC Handbook lists the requirements for PPEC services.

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

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

27. Fla. Admin. Code R. 59G-1.010 defines “medically complex” and “medically fragile” as follows:

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

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

28. The respondent denied the petitioner's request for six months of PPEC services, eight hours daily, five days per week. The respondent determined that ongoing PPEC the services were not medically necessary because Medicaid already provides skilled medical care to the petitioner via the Medical Foster Care Program.

29. The petitioner argued that he also has educational, socialization and therapy needs which can be met in one location, at the PPEC, versus him traveling to a separate location for each service. The respondent concluded that these services can be obtained through other programs and providers.

30. The petitioner is medically fragile and requires continuous skilled medical care. These facts are not disputed. The evidence proves that Medicaid is funding medical care during the day via the Medical Foster Care Program and at night via private duty nursing (so the medical foster parent can sleep). Medicaid is already providing the petitioner with around the clock medical care. Additional daytime medical care, via the PPEC Program, would be duplicative of services already being provided by Medicaid. Medicaid rule prohibits duplication of services. While it would be more convenient for the petitioner to receive all needed services at one location, it is not medically necessary. Medicaid rules prohibit the provision of services for convenience of the recipient or the recipient's caregiver.

31. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not prove by a preponderance of the evidence that it is medically necessary that he receive PPEC services.

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 10 day of November, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Nov 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05850

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on September 28, 2016 at 10:05 a.m. and reconvened on October 26, 2016 at 10:41 a.m.

APPEARANCES

For the petitioner:

[REDACTED]
Daughter

For the respondent:

Lisa Sanchez,
Medical/Healthcare Program Analyst
Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is AHCA's action, through the Sunshine Health Long-Term Care plan, to deny petitioner's request for an additional 33 packets of wipes per month (33 packets x 48 wipes per packet = 1,584 wipes). Because the matter at issue involves a request for an increase in services, petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Appearing as respondent's witnesses from petitioner's Long-Term Care (LTC) plan, Sunshine Health, on September 28, 2016 were: Dr. Heather Lutz, Medical Director; Joerosa David, Manager for Grievance and Appeals; Angie Milord, LTC Coordinator; Tammy Swan, Director for LTC; Missy Kimsey-Hickman, Case Manager Supervisor; Paula Daley, Appeals and Grievance Coordinator II; Kimberly Bouchette, Clinical Appeals Coordinator; and Jennifer Guy, Vice President for External Relations.

Appearing as respondent's witnesses from petitioner's LTC plan, Sunshine Health, on October 26, 2016 were: Dr. John Carter, LTC Medical Director; Joerosa Davis, Manager for Grievance and Appeals; Kizzy Alleyne, Paralegal; Shonda Salisbury, Supervisor for LTC; Angie Milord, LTC Coordinator; Tammy Swan, Director for LTC; Missy Kimsey-Hickman, Case Manager Supervisor; Paula Daley, Appeals and Grievance Coordinator II; and Kimberly Bouchette, Clinical Appeals Coordinator.

Respondent's Exhibits 1 and 2 were entered into evidence. Petitioner's Exhibit 1 was entered into evidence.

FINDINGS OF FACT

1. Petitioner is an 83 year-old recipient of the Medicaid program. She enrolled with Sunshine Health LTC plan effective September 1, 2015. Petitioner is also covered by Medicare.

2. Petitioner is diagnosed with [REDACTED] disease and [REDACTED]. She has been prescribed [REDACTED] three times daily as a means to rid her liver of toxins.

3. On May 25, 2016, Sunshine Health received petitioner's request for thirty-three (33) additional packages of wipes per month for a total of thirty-six (36) packages per month.

4. On May 31, 2016, Sunshine Health sent the petitioner a Notice of Action denying her request for the additional packages of wipes as not medically necessary. In relevant part, the notice explains: "The member currently receives 3 packs of Wipes per month (each case contains 12 packages of wipes with 48 individual wipes in each package), which is adequate to meet the member's present care needs."

5. Based on Sunshine's Notice of Action, petitioner was approved a total of 1,728 individual wipes ($3 \times 12 \times 48 = 1,728$). This amount of approved wipes was repeated in Sunshine Health's August 17, 2016 Medicaid Fair Hearing Summary.

6. Petitioner filed a timely request for a fair hearing on August 2, 2016.

7. Petitioner's daughter explained petitioner is receiving three (3) packets monthly containing forty-eight (48) wipes for a total of 144 (3×48) individual wipes. Petitioner's daughter could not understand why her mother was receiving 144 individual wipes, when the notices sent by Sunshine Health stated she was approved for 1,728. Her request for an additional 33 packages was submitted in order to receive the 1,728 wipes she understood were approved.

8. Petitioner's daughter explained her mother has up to four bowel movements daily. The daughter normally uses six (6) wipes per incident. For the biggest clean ups, she uses forty-eight (48) wipes.

9. Respondent explained that using different terms (packs, packages, packets, cases) to explain the number of wipes approved has contributed to confusion on the amount of wipes Sunshine Health has approved. Petitioner was approved for 144 wipes per month. This is what petitioner has been receiving.

10. Sunshine Health's medical director stated that his medical specialty is internal medicine and geriatric medical care. He has extensive experience with patients with urinary and bowel incontinence.

11. The medical director explained that wipes are a supplement to keep a patient clean. Wash clothes and toilet paper are the primary cleaning supplies.

12. The medical director noted that 144 wipes per month averages to 5 wipes per day. After re-reviewing the petitioner's needs, he approved 624 wipes per month, for an average daily use of 20 wipes. He opined this was more than an adequate supply of wipes.

13. Petitioner's daughter insisted she needs 1,728 wipes per month because the wipes are very thin and multiple wipes are needed for each cleaning.

CONCLUSIONS OF LAW

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

15. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code § 65-2.056.

16. 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).

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

18. Fla. Admin. Code 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

19. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook July 2010 (DME Handbook) is promulgated into Rule 59G-4.070, Florida Administrative Code.

20. On page 1-2 of the Handbook, the following definition of medical supplies is provided: “Medical supplies are defined as **medically-necessary** medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient’s home [emphasis added].”

21. The Florida Medicaid Home Health Services Coverage and Limitations Handbook October 2014 (HH Handbook) is promulgated into Rule 59G-4.130, Florida Administrative Code.

22. On Page 2-12 of the HH Handbook, it describes covered services for adults as follows: Medicaid reimburses the following services provided to eligible recipients age 21 and older: • Licensed nurse and home health aide visits, • Limited durable medical equipment and **supplies** [emphasis added], • Limited therapy evaluations.

23. The Florida Medicaid Provider General Handbook (Provider General) July 2012 is promulgated into Rule 59G-5.020, Florida Administrative Code. The Provider General 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.

24. Page 1-28 of the Provider General Handbook provides a list of HMO covered services. These services include medical supplies.

25. Petitioner's daughter asserts she needs 1,728 individual wipes each month to keep her mother clean. She states her mother has four (4) bowel movements (BM) each day. She usually uses six (6) wipes for each BM.

26. Respondent has determined that 634 individual wipes are medically necessary for the petitioner. With 31 days per month used, this allocation equates to 20 wipes per day. For petitioner's four BMs, this would equate to an average of 5 wipes allocated per incident. Because four (4) months have 30 days, this allows for 20 'allocated' wipes for each of these months, or a total of 80 'allocated' wipes, to be available for those incidents requiring more than five (5) wipes.

27. Respondent emphasized wipes are a supplement to cleaning the petitioner, after using a wash cloth, paper towels, and other cleaning aids. Full weight is being given to the medical expert's analysis. The above authority makes it clear Medicaid services cannot be in excess of the patient's needs and must be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.

28. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer concludes the petitioner has not met her burden of proof. The 624 wipes per month approved by Molina appears sufficient, in addition to

the use of wash clothes, towels, to meet petitioner's needs. Petitioner's request for 1,728 wipes per month appears excessive and not medically necessary.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 07 day of November , 2016,

in Tallahassee, Florida.



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

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

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

FILED

Dec 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04894
APPEAL NO. 16F-09808

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 [REDACTED]
UNIT: 88317

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on November 15, 2016 at 2:52 p.m.

APPEARANCES

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

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

ISSUE

At issue is the respondent's action on May 19, 2016 to deny the petitioner's application for Family-Related Medicaid for his spouse.

Also at issue is the respondent's action to deny the petitioner's application for Temporary Cash Assistance (TCA) benefits.

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

PRELIMINARY STATEMENT

The hearing was originally scheduled for August 16, 2016 at 10:15 a.m. The petitioner presented additional issues with the Food Assistance Program (FAP) and the TCA program. The petitioner requested to reschedule as he did not receive the evidence from the respondent. His request was granted and the hearing was rescheduled to September 20, 2016 at 1:30 p.m.

On September 14, 2016, the petitioner submitted a request for a continuance to allow additional time to prepare for the hearing. His request was granted and the hearing was rescheduled to November 8, 2016 at 9:00 a.m.

The hearing convened as scheduled. The petitioner presented additional testimony that required verifications to be sent to the Department for review. Therefore, the hearing was continued and rescheduled to November 15, 2016 at 2:45 p.m.

The hearing convened as scheduled. The petitioner stated on the record that he no longer has an issue with the FAP benefits and that he will accept the newly determined FAP benefit allotment in the amount of \$349. The petitioner also had an issue with his enrollment in the Medically Needy (MN) program. The Department completed an ex-parte process and determined that the petitioner was eligible for Transitional Medicaid for himself beginning July 2016 through December 31, 2016. The petitioner stated during this hearing that the issue with the MN program is now resolved. The petitioner has remaining issues with the denial of Medicaid for his wife and the denial of TCA.

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

The record was held open until 5:00 p.m. on November 21, 2016 to allow the petitioner and the respondent to submit additional evidence.

Evidence was received and entered as the Respondent's Exhibit 3.

On November 21, 2016, the undersigned received correspondence from the petitioner requesting to leave the record open for an additional week. The petitioner's request was granted and the record was held open until 5:00 p.m. on November 28, 2016.

On November 28, 2016, the petitioner requested to leave the record open for an additional period of time. The petitioner's request was granted and the record was held open until 5:00 p.m. on December 5, 2016.

The record was closed at 5:00 p.m. on December 5, 2016.

FINDINGS OF FACT

1. On May 16, 2016, the petitioner, age 59, applied for FAP, Family-Related Medicaid, and TCA benefits for himself, age 59, spouse, age 35, and child, age 1. The petitioner reported on his application that he is self-employed and that his rent is \$863. The petitioner reported during the hearing that he earns approximately \$300 each week in self-employment income and receives retirement benefits in the amount \$335.09.

2. The petitioner's wife entered the United States on September 7, 2013 on a fiancé visa from the Philippines. The Department's records indicate that the petitioner's wife became a lawful permanent resident (LPR) on April 22, 2014. The LPR is required

to reside in the United States for five years in order to be eligible for Medicaid. The petitioner did not provide any evidence to show that his wife is a qualified noncitizen. The Department determined that the petitioner's spouse is ineligible for TCA and Family-Related Medicaid due to being a nonqualified citizen in the United States. Therefore, the petitioner's wife was not included as part of the TCA assistance group (AG), making the AG consist of two persons rather than three for the TCA program.

3. The Department's calculations for the TCA benefits included the petitioner's self-employment income in the gross amount of \$1103. The Department previously did not deduct the petitioner's business expenses from his gross self-employment income. The petitioner provided receipts for his self-employment business expenses which were included in the Petitioner's Exhibit 1. The Department calculated the petitioner's business at \$523. The self-employment income was deducted by the business expenses to result in self-employment adjusted gross earnings in the amount of \$588.88. The petitioner's retirement income in the amount of \$335.09 resulted in a total gross income in the amount of \$915.97. Department's position is that the petitioner's total gross income was compared to the TCA grant for a household size of two in the amount of \$241. The Department contends that since the petitioner's total gross income exceeded the TCA grant of \$241, his household was ineligible for TCA benefits for a household size of two.

4. The petitioner argues that the Department committed several violations of the rules that govern the TCA program. The petitioner believes that the Department should have forwarded his TCA application to the Regional Workforce Board (RWB) to allow a

determination of eligibility for the upfront diversion grant. The petitioner argues that he believes he is entitled to receive the upfront diversion in the amount of \$1000 because he has to make repairs to his vehicle so that he may continue working to support his family. The petitioner also argues that he needs the upfront diversion in order to pay for other expenses, such as his driver's license, utility bills, clothing, and tools necessary to maintain his employment.

5. The petitioner does not understand the Department's calculations in determining that he is ineligible for TCA benefits. The petitioner reported during the hearing that he has business expenses. The petitioner also reported during the hearing that he pays child support payments to children who reside outside of his home in the amount of \$280 for one child and \$50 each for two other children. The Petitioner's Exhibits 1 through 3 include copies of the money orders showing the dates he has paid child support to his children who live outside of his home.

6. The Department explained that the petitioner is required to meet the income standards for the TCA program in order to be potentially eligible for the upfront diversion. The Department explained that the up-front diversion is handled by the RWB.

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.

The Medicaid denial for the petitioner's spouse will be addressed:

9. The Code of Federal Regulations at 42 C.F.R. § 435.406, Citizenship and alienage sets forth:

- (a) The agency must provide Medicaid to otherwise eligible residents of the United States who are—
- (1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and
 - (ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in § 435.407...

10. The Department's ACCESS Program Policy Manual (Policy Manual), CFOP 165-22, passage 1430.0106 Lawful Permanent Resident (MFAM), states:

A lawful permanent resident (LPR) is a noncitizen who lawfully immigrates to the U.S. and has permission to live and work in the U.S. LPRs may be eligible for Medicaid based on citizenship if they entered the U.S.:

1. prior to 8/22/96 and have remained continuously present,
2. on or after 8/22/96 under a prior asylee, refugee, Amerasian, deportation withheld, or Cuban/Haitian Entrant status, or
3. on or after 8/22/96 and have lived in the U.S. as a qualified noncitizen for at least five years...

Note: LPRs who entered after 8/22/96 are subject to the five-year ban, unless otherwise noted.

LPRs who are in the five-year ban may be eligible for Emergency Medicaid for Aliens, (EMA).

11. According to the above, the individual must provide satisfactory documentary evidence of citizenship or qualified alien status to be eligible for Medicaid benefits. The petitioner's spouse confirmed that his spouse entered the US on a fiancé visa in 2013. There was no evidence presented to show that the petitioner's spouse met the requirements to qualify for Medicaid as a qualified alien.

12. Based on the above findings and conclusions of law, the undersigned concludes the respondent correctly denied the petitioner's request for Medicaid benefits for his spouse due to her not meeting the citizenship requirements for the Family-Related Medicaid program.

The denial of the application for TCA and non-referral to RWB for the upfront diversion will now be addressed:

13. Section 414.095 Florida Statutes, Determining eligibility for temporary cash assistance, states in part:

(1) ELIGIBILITY.—An applicant must meet eligibility requirements of this section before receiving services or temporary cash assistance under this chapter, except that an applicant shall be required to register for work and engage in work activities in accordance with s. 445.024, as designated by the local workforce development board, and may receive support services or child care assistance in conjunction with such requirement. The department shall make a determination of eligibility based on the criteria listed in this chapter...

(2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—

(a) To be eligible for services or temporary cash assistance and Medicaid:

1. An applicant must be a United States citizen, or a qualified noncitizen, as defined in this section.

2. An applicant must be a legal resident of the state.

3. Each member of a family must provide to the department the member's social security number or shall provide proof of application for a social security number. An individual who fails to provide a social security number, or proof of application for a social security number, is not eligible to participate in the program.

4. A minor child must reside with a parent or parents, with a relative caretaker who is within the specified degree of blood relationship as defined by 45 C.F.R. part 233, or, if the minor is a teen parent with a child, in a setting approved by the department as provided in subsection (14).

5. Each family must have a minor child **and** meet the income and resource requirements of the program (**emphasis added**).

(3) ELIGIBILITY FOR NONCITIZENS.—A "qualified noncitizen" is an individual who is admitted to the United States as a refugee under s. 207 of the Immigration and Nationality Act or who is granted asylum under s. 208 of the Immigration and Nationality Act; a noncitizen whose deportation

is withheld under s. 243(h) or s. 241(b)(3) of the Immigration and Nationality Act; a noncitizen who is paroled into the United States under s. 212(d)(5) of the Immigration and Nationality Act, for at least 1 year; a noncitizen who is granted conditional entry pursuant to s. 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980; a Cuban or Haitian entrant; or a noncitizen who has been admitted as a permanent resident. In addition, a “qualified noncitizen” includes an individual who, or an individual whose child or parent, has been battered or subject to extreme cruelty in the United States by a spouse, a parent, or other household member under certain circumstances, and has applied for or received protection under the federal Violence Against Women Act of 1994, Pub. L. No. 103-322, if the need for benefits is related to the abuse and the batterer no longer lives in the household. A “nonqualified noncitizen” is a nonimmigrant noncitizen, including a tourist, business visitor, foreign student, exchange visitor, temporary worker, or diplomat. In addition, a “nonqualified noncitizen” includes an individual paroled into the United States for less than 1 year. A qualified noncitizen who is otherwise eligible may receive temporary cash assistance to the extent permitted by federal law. The income or resources of a sponsor and the sponsor’s spouse shall be included in determining eligibility to the maximum extent permitted by federal law.

(10) DETERMINATION OF LEVEL OF TEMPORARY CASH ASSISTANCE.—Temporary cash assistance shall be based on a standard determined by the Legislature, subject to availability of funds. There shall be three assistance levels for a family that contains a specified number of eligible members, based on the following criteria:

- (a) A family that does not have a shelter obligation.
- (b) A family that has a shelter obligation greater than zero but less than or equal to \$50.
- (c) A family that has a shelter obligation greater than \$50 or that is homeless.

The following chart depicts the levels of temporary cash assistance for implementation purposes:

THREE-TIER SHELTER PAYMENT STANDARD

Family Size	Zero Shelter Obligation	Greater than Zero Less than or Equal to \$50	Greater than \$50 Shelter Obligation
-------------	-------------------------	--	--------------------------------------

Family Size	Zero Shelter Obligation	Greater than Zero Less than or Equal to \$50	Greater than \$50 Shelter Obligation
2	\$158	\$205	\$241

(11) DISREGARDS.—

(a) As an incentive to employment, the first \$200 plus one-half of the remainder of earned income shall be disregarded. In order to be eligible for earned income to be disregarded, the individual must be:

1. A current participant in the program; or
2. Eligible for participation in the program without the earnings disregard.

(12) CALCULATION OF LEVELS OF TEMPORARY CASH ASSISTANCE.—

(a) Temporary cash assistance shall be calculated based on average monthly gross family income, earned and unearned, less any applicable disregards. The resulting monthly net income amount shall be subtracted from the applicable payment standard to determine the monthly amount of temporary cash assistance.

(b) A deduction may not be allowed for child care payments.

(c) The department may adopt rules governing the administration of this subsection and may establish criteria pertaining to types of budgeting, conversion factors, verification of income, treatment of self-employment income, treatment of child-support income, and treatment of other sources of income.

14. The Fla. Admin. Code R. 65A-4.209 sets forth income budgeting in:

(2) To be financially eligible for TCA, the total average gross monthly income less any applicable disregards of the standard filing unit cannot exceed the applicable payment standard for the assistance group. These standards and disregards are found in Sections 414.095(10) and (11), F.S. Monthly net income is calculated based on average gross monthly family income, earned and unearned, less any applicable disregards in accordance with Section 414.095(12)(a), F.S. The monthly amount of the TCA payment is determined by subtracting the monthly net income from the applicable payment standard.

(b) Total gross monthly income includes earned and unearned income from all sources.

15. The Policy Manual, CFOP 165-22, passage 2420.0300 Income Disregards (TCA) states: "Income disregards are amounts subtracted from the gross earned income. Some examples are: 1. earned income disregard, 2. standard disregard..."

16. The Policy Manual, 165-22 at section 2420.0315 Eligibility for \$200 and 1/2 Disregard (TCA) states:

In order for a member of a Temporary Cash Assistance (TCA) standard filing unit (SFU) to receive the \$200 and 1/2 disregard, the individual must:

1. have been eligible for and received TCA in one of the past four months; or
2. have gross countable income (including earned and unearned income), less the \$90 standard earned income disregard, which is less than the applicable payment standard.

17. The above authorities explain that the applicant is required to meet all eligibility requirements, including citizenship and income, in order to receive services or TCA benefits. The applicant must be a United States citizen, or qualified non-citizen, in order to qualify for TCA benefits or other services. The findings show that the petitioner's spouse is a non-qualified citizen based on her date of entry as an LPR and is ineligible for TCA benefits. Therefore, the undersigned concludes that the Department is correct to establish the petitioner's household size as two, to include the petitioner and his child. The level of TCA is determined by the household size and the amount paid in the monthly shelter obligation. For households which pay more than \$50 in shelter obligation, such as rent or mortgage, or those who are homeless, are eligible for the highest payment standard. The statute sets the \$241 maximum payment standard for a two person household that pays more than \$50 in rent. The findings show that the petitioner pays more than \$50 for rent. Therefore, the undersigned

concludes that the Department was correct to establish that the \$241 payment standard is applicable to the petitioner's household size of two persons.

18. The above authorities also explain that in order for an assistance group to be financially eligible for TCA, the gross income, less the applicable earned income disregards, may not exceed the applicable payment standard for the assistance group,. Two of the income disregards are the earned income disregard and the standard disregard. The first \$200 plus one-half of the remaining earned income could be disregarded as an incentive of employment for the TCA program. In order to be eligible to receive the 200 and ½ disregard, the individual must have received Cash Assistance in one of the past four months or have gross countable income, minus the \$90 standard earned income disregard, that is less than the applicable payment standard. The undersigned could not find a provision to allow deductions for any child support payments made to children outside of the household.

19. There was no evidence petitioner received Cash Assistance in one of the past four months. The petitioner's total gross income is \$915.97. The petitioner's total gross income after the standard earned income disregard of \$90 results in \$825.97 in countable income. The petitioner's income is greater than the payment standard for two persons.

20. After careful review, the undersigned concludes that the respondent correctly determined the petitioner to be ineligible for TCA benefits as his income exceeded the payment standard for a household size of two persons.

21. Fla. Admin. Code R. 65A-4.212 Up-Front Diversion states:

(1) Pre-screening. Individuals applying for temporary cash assistance (TCA) or up-front diversion will complete the CF-ES 2066, Request for Assistance, Jun 98, incorporated by reference in Administrative Rule 65A-1.400, F.A.C., and will be pre-screened to determine if due to an unexpected circumstance or emergency situation they have short-term barriers to obtain and maintain employment or child support that could be met through up-front diversion or if ongoing TCA is needed. Pre-screening includes a determination that **all requirements for TCA eligibility would most likely be met**; the applicant has an unexpected circumstance or emergency situation that may be addressed through short-term assistance such as up-front diversion instead of ongoing TCA; **and** the applicant may be interested in up-front diversion.

(b) If the pre-screening information indicates the applicant meets TCA eligibility criteria, up-front diversion may address the applicant's needs; and, the applicant wants to pursue up-front diversion, **the applicant will complete the up-front diversion eligibility determination process through the regional workforce board (RWB) designee.**

(2) The RWB designee is responsible for determining up-front diversion eligibility and approval on a case-by-case basis for the receipt of up-front diversion services, payment, or both in accordance with Section 445.017, F.S. Applicants who are pre-screened by the department as **potentially TCA eligible**, appear to have short-term barriers to obtain and maintain employment or child support, and want to apply for up-front diversion are to be referred to the RWB designee using the completed CF-ES 2066 for up-front diversion eligibility determination and approval. Eligibility criteria for up-front diversion include:

- (a) The applicant has a child(ren) under age 19 residing in the home or a pregnant woman in the family **and meets TCA eligibility criteria**;
- (b) An explanation by the family of the unexpected circumstance or emergency situation and what may be needed to resolve it; **and**
- (c) A determination by the RWB designee and the applicant whether or not the up-front diversion intervention will assist the family to overcome barriers to employment or child support and eliminate the need for ongoing TCA **(emphasis added)**.

22. The above rule explains that the applicant for TCA benefits must be prescreened to determine if he or she has a barrier in obtaining and maintaining employment due to an emergency situation. The prescreening process also includes

determining if the applicant is potentially eligible for TCA benefits. If the applicant is determined to meet the TCA eligibility criteria, he or she will be referred to the RWB for the up-front diversion using the form CF-ES 2066. The findings show that the petitioner has barriers in maintaining his employment due to expenses, such as his automobile repairs. However, the petitioner did not meet the income standards for the TCA program. Therefore, the undersigned concludes that the Department was correct to not refer his case to the RWB for a determination of eligibility for the up-front diversion.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, both appeals are 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 28 day of December , 2016,
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

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

FILED

Dec 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04903
16F-04904

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS.

/

FINAL ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 25, 2016 at 11:30 a.m. and on October 13, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's claims for a doctor's visit and lab tests was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

A hearing was initially convened on July 25, 2016. The record was subsequently held open to allow the petitioner to submit copies of medical bills which she believed she had received. Since no documents were received, the hearing was re-convened on October 13, 2016. The record was held open again to allow the petitioner to submit the documents. The documents were subsequently received and marked as Petitioner Exhibit 1.

Appearing as a witness for the respondent was Mindy Aikman, Grievance and Appeals Specialist for Humana, which is the petitioner's managed health care plan. Humana was included as an additional respondent in this proceeding since it is the petitioner's health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibit 1: case summary and denial notices for the denied claims.

FINDINGS OF FACT

1. The petitioner is a twenty (20) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana.
2. The petitioner stated she called Humana in April, 2016 to request permission for a doctor's visit with a gynecologist. She subsequently attended the doctor's visit and also had laboratory work performed. She stated she later received bills from the providers for services rendered.

3. Ms. Aikman from Humana stated the doctor's visit would be a covered benefit under the health plan, but the claim was denied since there was no referral from the petitioner's primary care physician (PCP). She stated the claim for the lab work was denied since it was not a covered service under the plan. However, with regard to both claims, Ms. Aikman also stated the petitioner should have no financial liability and she should not be billed by the providers.

CONCLUSIONS OF LAW

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

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

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

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

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

9. The documents submitted by the petitioner which she believed to be bills from the providers are not actually bills. The documents are from Humana advising her of

the denial of the claims and are clearly marked "This Is Not a Bill". No provider bills have been submitted.

10. The undersigned concludes that the issues for the hearing are moot since the petitioner received the services at issue and she bears no financial responsibility for the services.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DISMISSED as moot.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of 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 01 day of December, 2016,

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

FINAL ORDER (Cont.)

16F-04903/-04904

PAGE - 5

Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

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

FILED

Nov 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04913

PETITIONER,

Vs.

UNITED HEALTH CARE OF FLORIDA, INC.
and AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENTS.

/

AMENDED FINAL ORDER

This Amended Final Order is issued to correct a scrivener's error in the Final Order dated November 2, 2016. [REDACTED] was incorrectly listed as an observer, when it was, in fact, Dianne Soderlind who observed the hearing. The remainder of the Order remains unchanged.

Pursuant to notice, the undersigned convened an administrative hearing in the above-styled matter on September 29, 2016 at approximately 1:00 p.m. in Tampa, Florida.

APPEARANCES

For Petitioner: [REDACTED]
Petitioner's mother

For United : Dr. Marc Kaprow
Executive Director, Long-Term Care Program

STATEMENT OF ISSUE

At issue is whether or not Respondent's partial approval of Petitioner's request for 84 hours per week of home health services was correct. Petitioner requested 84 hours and 35 hours were approved. Prior to the hearing, Petitioner's hours were increased to 45 hours. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner was physically present in the hearing room but was represented by her mother. United presented the following witnesses by telephone:

- Dr. Marc Kaprow – Executive Director, Long-Term Care Program – UnitedHealthcare
- Susan Frishman – Senior Compliance Analyst – UnitedHealthcare

Dianne Soderlind, Registered Nurse Specialist with the Agency for Health Care Administration ("AHCA" or "Agency") and Allison Smith-Doussou, Hearing Officer with the Office of Appeal Hearings observed the hearing.

Petitioner moved Exhibits 1 – 5 into evidence. Respondent moved Exhibits 1 – 5 into evidence. The record was held open until October 20, 2016 in order for both parties to submit additional evidence, if desired. Neither party submitted additional evidence.

Administrative notice was taken of the following:

- Florida Administrative Code Rules 59G-1.010 and 59G-1.053.
- The October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook.

FINDINGS OF FACT

1. Petitioner is a 19-year-old female. She is enrolled with UnitedHealthcare ("United") as her Long Term Care ("LTC") plan.

2. Petitioner's medical history includes the following:

- [REDACTED]

3. Petitioner requires total assistance with all her Activities of Daily Living ("ADLs") and Instrumental Activities of Daily Living ("IADLs"), and needs 24/7 supervision. She lives with her mother and her 11-year-old brother.

4. On May 25, 2016, Petitioner received an LTC Functional Assessment (Respondent's Exhibit 3). The assessment recommended services for Petitioner and provided a range of recommended minutes per day for each service. Dr. Sloan Karver, Medical Director with United, then subsequently approved a certain amount of services. For example, in section 3.1, regarding bathing, the recommended range of minutes was 31-50 minutes per day and Dr. Karver approved 50 minutes.

5. The sum total of the minimum amount of time for each recommended service, based upon the range provided for each service, is 1,375 minutes per week, which is 29.9 hours per week. The sum total of the maximum amount of recommended time

is 2,075 minutes per week, which is 34.58 hours per week. Dr. Karver approved 2,075 minutes per week, the maximum amount.

6. At hearing, Dr. Kaprow testified that there were errors in the LTC Assessment, including section 3.5 regarding feeding, where the assessment says Petitioner does not require any care, when in fact United stipulated she requires total care for everything. A similar error was made in section 3.19 regarding meal preparation. Dr. Kaprow stated this was the reason Petitioner's hours were increased from 35 per week to 45 hours.

7. Petitioner requested 84 hours per week of home health services. On May 27, 2016, United issued a Notice of Action. (Respondent's Exhibit 1). The Notice stated, in pertinent part:

The facts that we used to make our decision are: 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 resources.

The total number of hours approved [is] 35 hours a week.

8. Petitioner does not attend school. Her mother stated that when she was in school she would get pneumonia and require hospitalization. She also said her case manager advised her that Petitioner could be placed in a nursing home. She thinks placing her in a nursing home would also cause her to get sick.

9. Petitioner's mother said she is a physician and single mom. In a typical work week, she leaves the home at approximately 6:45 a.m. and returns as late as 7:00 p.m., Monday through Friday. Therefore she is out of the home for approximately 61.75 hours per week. She is also on call every other weekend, however, she only receives phone calls and does not leave the home.

10. Petitioner's mother says she needs a sitter to supervise Petitioner on Saturdays and Sundays so that she can take care of her son, go shopping, and attend to personal needs. She said she has been paying out-of-pocket for additional hours of home health that United is not covering.

CONCLUSIONS OF LAW

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

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

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

14. 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.).

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

Respondent, AHCA, is the single state agency that administers the Medicaid Program.

16. Section 409.978(2) of the 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....”

17. 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.

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

19. 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.

20. 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.

21. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children include:

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

22. Under the above statute, the Agency offers home health services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

23. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore*

v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include “reasonable standards ... for determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

24. Consistent with these requirements, the state is obligated to provide services to recipients under 21 years of age, but only to the extent such services are medically necessary. The definition of medical necessity for services provided under the EPSDT benefit is established by the state and the state is authorized to establish the amount, duration, and scope of such services.

25. It is undisputed that Petitioner requires total assistance with all of her ADLs and IADLs. It may also be true that Petitioner would be better suited for a nursing home, as suggested by her case manager. However, her mother wishes for her to remain at home.

26. 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.

27. In the instant-matter, United determined that the requested 84 hours is in excess of Petitioner's needs. The undersigned agrees. Her mother is out of the home for approximately 61.75 hours per week. Rounding to the next hour, as was done in United's Notice of Action, yields 62 hours per week.

28. Although 84 hours a week is excessive, Petitioner must be supervised at all times. Therefore she requires a caregiver during the time her mother is away at work. The undersigned concludes Petitioner has met her burden of proof to show that 62 hours of home health services are not in excess of her needs and are medically necessary. Additional hours would be for the convenience for her mother.

29. While the undersigned is sympathetic to her mother's situation regarding activities on the weekend, and believes additional hours to cover this time would be desirable, the law prohibits a service from being provided for the convenience of the caretaker.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED IN PART and DENIED IN PART. Respondent is directed to provide Petitioner with 62 hours per week of home health services.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 03 day of November, 2016,

in Tallahassee, Florida.



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

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

Dec 27, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-04958

PETITIONER,

Vs.

COVENTRY, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on November 23, 2016 at approximately 10:30 a.m.

APPEARANCES

Petitioner: [REDACTED]

For Coventry: Dr. Darwin Caraballo
Medical Director
Florida Long-Term Care Plan, Coventry/Aetna

STATEMENT OF ISSUE

At issue is whether or not Coventry was correct in terminating Petitioner's hospice care. The burden of proof is assigned to Coventry.

PRELIMINARY STATEMENT

Petitioner represented herself at the hearing. Petitioner gave oral testimony, but did not move any exhibits into evidence. Petitioner presented the following witnesses:

- [REDACTED] – Petitioner's Daughter

- [REDACTED] – Social Worker – Vitas

The following individuals were present on behalf of Coventry:

- Melody Gordon – Utilization Manager
- Maureen McNamara – Manager of Grievances & Appeals

Coventry moved Exhibits 1 – 10 into evidence. Lisa Sanchez, Medical/Health Care Program Analyst with the Agency for Health Care Administration (“AHCA” or “Agency”) observed the hearing. The record was held open for Petitioner to submit additional evidence and for Coventry to submit a response, if desired. Petitioner submitted evidence, entered as Exhibit 1. Coventry did not submit a response.

FINDINGS OF FACT

1. Petitioner is a 64-year-old female. Petitioner is enrolled with Coventry as her Long-Term Care (“LTC”) plan.
2. Petitioner’s primary diagnoses related to the hospice care are [REDACTED] and end-stage [REDACTED]. Dr. Caraballo stated that “end-stage” means a condition is irreversible, but not necessarily terminal. She has been receiving hospice care since May of 2013.
3. Petitioner currently receives two (2) to three (3) liters of continuous oxygen per day. She said she has difficulty taking a few steps to her portable toilet because she will experience shortness of breath.
4. Petitioner has a home health aide come to bathe her and change her bed sheets five (5) days per week. She also has a nurse come three (3) times per week to take care of the oxygen, as well as medication management. Her social worker typically comes once a month to check on her, but has recently been visiting twice a week to

help her with the mental health aspects of her condition. She only sees a primary care physician ("PCP"), not a pulmonologist. Her PCP typically visits her once a month, but has increased to an as-need basis. She has both a cane and a wheelchair at home.

5. Coventry received Petitioner's request for continued hospice care on June 10, 2016. On June 20, 2016, Coventry issued a Notice of Action ("Notice"),

Respondent's Exhibit 5, denying the request, stating:

Your request for hospice services is denied. Per Florida Medicaid Guidelines, you must have a terminal diagnosis with life expectancy of 6 months or less if the terminal condition progresses at its normal course with documented clinical progression of the terminal disease, recent impaired nutrition and a recent functional decline. You have been under hospice care since May 14 of 2013, and your medical condition is stable. You are still able to eat a full meal and have not had any recent infections, wounds, worsening of chronic respiratory problems, increased in a need for more oxygen or delirium. You are independent with all of your activities of daily living in the home and are able to walk around the house by yourself and without assistance. You may continue living at home or in an Assisted Living Facility if you wish but under custodial care and not under hospice care.

6. Coventry used the October 2003 Florida Medicaid Hospice Services Coverage and Limitations Handbook ("Handbook") as the guidelines for making its decision. The Handbook was replaced by the Florida Medicaid Hospice Services Coverage Policy, effective June 2, 2016.

7. Petitioner stated that some of the information contained in the Notice is incorrect. She said that she does not live alone, but lives with her 85-year-old mother, who recently had surgery related to a car accident and is unable to lift her. Her daughter assists when she is able, however, she cannot drive. Petitioner said she gets

around the house as best as she can. She is not completely independent with her ADL's.

8. Dr. Caraballo stated there is no dispute that Petitioner needs assistance, but that her needs can be met at a lower level of care. He said her oxygen and medications can be provided outside of hospice care. He said instead of her PCP coming to visit her, transportation can be provided for her to go visit the PCP, and that a companion can be provided to accompany her. He said as long as she continues with her oxygen and medication then she should remain stable.

9. Petitioner was unaware that these services can be provided outside of hospice care. She said that she is very appreciative of the care she has received over the years.

CONCLUSIONS OF LAW

10. 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.

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

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

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

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

AHCA, is the single state agency that administers the Medicaid Program.

15. Section 409.978 (2) of the 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...”

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

17. The June 2016 Florida Medicaid Hospice Services Coverage Policy (“Hospice Policy”) is promulgated into law by Chapter 59G of the Florida Administrative Code.

18. The Hospice Policy replaced the Handbook, effective June 2, 2016. Petitioner’s request was received by Coventry on June 10, 2016, and the Notice was issued on June 20, 2016. Because the Handbook had been replaced, Coventry incorrectly used the guidelines found in the Handbook when rendering its decision instead of the guidelines found in the Hospice Policy. Since the Hospice Policy was in place at the time of the request and the date of the Notice, the undersigned must review Coventry’s action in relation to the Hospice Policy, rather than the Handbook.

19. Section 4.2 of the Hospice Policy lists the Specific Criteria required for hospice coverage, stating:

Florida Medicaid reimburses for 365/6 days of hospice services per year, per recipient, when the following criteria are met:

- The provider conducts an initial assessment in accordance with 42 CFR 418.54

- The provider develops and maintains a plan of care in accordance with section 400.6095, F.S.
- Services are rendered in accordance with 42 CFR 418.202 and 42 CFR 418.302

20. Section 400.6095 (2) of the Florida Statutes provides, in pertinent part:

“Admission to a hospice program shall be made upon a diagnosis and prognosis of terminal illness by a physician....” Section 400.601 of the Florida Statutes defines “terminally ill” as “the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.” The Statute’s one (1) year requirement differs from the six (6) month requirement indicated in the Notice, which was based upon the Handbook. The Hospice Policy requires that all services provided be medically necessary.

21. 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.

22. Dr. Caraballo made it clear that "end-stage" [REDACTED] does not necessarily mean terminal. It only means that the condition is irreversible. He further stated that Petitioner can receive her services at a lower level of care.

23. The Florida Statutes specifically require an individual to be terminally ill in order to receive hospice care. Terminally ill means that the individual's life expectancy is one (1) year or less. Petitioner has been receiving hospice care for over three (3) years. She is currently stable, and Dr. Caraballo said she should remain stable as long as she continues to receive her oxygen and take her medication.

24. The undersigned concludes Coventry has met its burden of proof to show terminating Petitioner's hospice care was proper.

25. Coventry did not dispute that Petitioner requires assistance. Dr. Caraballo simply said her needed services could be provided outside of hospice. Petitioner is encouraged to work with Coventry to determine what services she requires to have in order to replace her hospice care and still meet her needs.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Coventry'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

FINAL ORDER (Cont.)

16F-04958

PAGE - 8

of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 27 day of December, 2016,

in Tallahassee, Florida.



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

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

FILED

Dec 27, 2016

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-04958

PETITIONER,

Vs.

COVENTRY, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENTS.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on November 23, 2016 at approximately 10:30 a.m.

APPEARANCES

Petitioner: [REDACTED]
For Coventry: Dr. Darwin Caraballo
Medical Director
Florida Long-Term Care Plan, Coventry/Aetna

STATEMENT OF ISSUE

At issue is whether or not Coventry was correct in terminating Petitioner's hospice care. The burden of proof is assigned to Coventry.

PRELIMINARY STATEMENT

Petitioner represented herself at the hearing. Petitioner gave oral testimony, but did not move any exhibits into evidence. Petitioner presented the following witnesses:

- [REDACTED] – Petitioner's Daughter

- [REDACTED] – Social Worker – Vitas

The following individuals were present on behalf of Coventry:

- Melody Gordon – Utilization Manager
- Maureen McNamara – Manager of Grievances & Appeals

Coventry moved Exhibits 1 – 10 into evidence. Lisa Sanchez, Medical/Health Care Program Analyst with the Agency for Health Care Administration (“AHCA” or “Agency”) observed the hearing. The record was held open for Petitioner to submit additional evidence and for Coventry to submit a response, if desired. Petitioner submitted evidence, entered as Exhibit 1. Coventry did not submit a response.

FINDINGS OF FACT

1. Petitioner is a 64-year-old female. Petitioner is enrolled with Coventry as her Long-Term Care (“LTC”) plan.
2. Petitioner’s primary diagnoses related to the hospice care are [REDACTED] and end-stage [REDACTED]. Dr. Caraballo stated that “end-stage” means a condition is irreversible, but not necessarily terminal. She has been receiving hospice care since May of 2013.
3. Petitioner currently receives two (2) to three (3) liters of continuous oxygen per day. She said she has difficulty taking a few steps to her portable toilet because she will experience shortness of breath.
4. Petitioner has a home health aide come to bathe her and change her bed sheets five (5) days per week. She also has a nurse come three (3) times per week to take care of the oxygen, as well as medication management. Her social worker typically comes once a month to check on her, but has recently been visiting twice a week to

help her with the mental health aspects of her condition. She only sees a primary care physician ("PCP"), not a pulmonologist. Her PCP typically visits her once a month, but has increased to an as-need basis. She has both a cane and a wheelchair at home.

5. Coventry received Petitioner's request for continued hospice care on June 10, 2016. On June 20, 2016, Coventry issued a Notice of Action ("Notice"),

Respondent's Exhibit 5, denying the request, stating:

Your request for hospice services is denied. Per Florida Medicaid Guidelines, you must have a terminal diagnosis with life expectancy of 6 months or less if the terminal condition progresses at its normal course with documented clinical progression of the terminal disease, recent impaired nutrition and a recent functional decline. You have been under hospice care since May 14 of 2013, and your medical condition is stable. You are still able to eat a full meal and have not had any recent infections, wounds, worsening of chronic respiratory problems, increased in a need for more oxygen or delirium. You are independent with all of your activities of daily living in the home and are able to walk around the house by yourself and without assistance. You may continue living at home or in an Assisted Living Facility if you wish but under custodial care and not under hospice care.

6. Coventry used the October 2003 Florida Medicaid Hospice Services Coverage and Limitations Handbook ("Handbook") as the guidelines for making its decision. The Handbook was replaced by the Florida Medicaid Hospice Services Coverage Policy, effective June 2, 2016.

7. Petitioner stated that some of the information contained in the Notice is incorrect. She said that she does not live alone, but lives with her 85-year-old mother, who recently had surgery related to a car accident and is unable to lift her. Her daughter assists when she is able, however, she cannot drive. Petitioner said she gets

around the house as best as she can. She is not completely independent with her ADL's.

8. Dr. Caraballo stated there is no dispute that Petitioner needs assistance, but that her needs can be met at a lower level of care. He said her oxygen and medications can be provided outside of hospice care. He said instead of her PCP coming to visit her, transportation can be provided for her to go visit the PCP, and that a companion can be provided to accompany her. He said as long as she continues with her oxygen and medication then she should remain stable.

9. Petitioner was unaware that these services can be provided outside of hospice care. She said that she is very appreciative of the care she has received over the years.

CONCLUSIONS OF LAW

10. 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.

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

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

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

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

AHCA, is the single state agency that administers the Medicaid Program.

15. Section 409.978 (2) of the 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....”

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

17. The June 2016 Florida Medicaid Hospice Services Coverage Policy (“Hospice Policy”) is promulgated into law by Chapter 59G of the Florida Administrative Code.

18. The Hospice Policy replaced the Handbook, effective June 2, 2016. Petitioner’s request was received by Coventry on June 10, 2016, and the Notice was issued on June 20, 2016. Because the Handbook had been replaced, Coventry incorrectly used the guidelines found in the Handbook when rendering its decision instead of the guidelines found in the Hospice Policy. Since the Hospice Policy was in place at the time of the request and the date of the Notice, the undersigned must review Coventry’s action in relation to the Hospice Policy, rather than the Handbook.

19. Section 4.2 of the Hospice Policy lists the Specific Criteria required for hospice coverage, stating:

Florida Medicaid reimburses for 365/6 days of hospice services per year, per recipient, when the following criteria are met:

- The provider conducts an initial assessment in accordance with 42 CFR 418.54

- The provider develops and maintains a plan of care in accordance with section 400.6095, F.S.
- Services are rendered in accordance with 42 CFR 418.202 and 42 CFR 418.302

20. Section 400.6095 (2) of the Florida Statutes provides, in pertinent part:

“Admission to a hospice program shall be made upon a diagnosis and prognosis of terminal illness by a physician....” Section 400.601 of the Florida Statutes defines “terminally ill” as “the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.” The Statute’s one (1) year requirement differs from the six (6) month requirement indicated in the Notice, which was based upon the Handbook. The Hospice Policy requires that all services provided be medically necessary.

21. 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.

22. Dr. Caraballo made it clear that “end-stage” [REDACTED] does not necessarily mean terminal. It only means that the condition is irreversible. He further stated that Petitioner can receive her services at a lower level of care.

23. The Florida Statutes specifically require an individual to be terminally ill in order to receive hospice care. Terminally ill means that the individual’s life expectancy is one (1) year or less. Petitioner has been receiving hospice care for over three (3) years. She is currently stable, and Dr. Caraballo said she should remain stable as long as she continues to receive her oxygen and take her medication.

24. The undersigned concludes Coventry has met its burden of proof to show terminating Petitioner’s hospice care was proper.

25. Coventry did not dispute that Petitioner requires assistance. Dr. Caraballo simply said her needed services could be provided outside of hospice. Petitioner is encouraged to work with Coventry to determine what services she requires to have in order to replace her hospice care and still meet her needs.

DECISION

Based upon the foregoing, Petitioner’s appeal is DENIED and the Coventry’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

FINAL ORDER (Cont.)
16F-04958
PAGE - 8

of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 27 day of December, 2016,

in Tallahassee, Florida.



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

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

FILED

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES Nov 07, 2016
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05128

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 [REDACTED]

CO-RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on October 18, 2016 at 11:36 a.m. and reconvened on the same day at 3:44 p.m.

APPEARANCES

For the petitioner: [REDACTED],
Father

For the respondent: Lisette Knott,
Program Administrator,
Agency for Health Care Administration

STATEMENT OF ISSUE

The petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny petitioner's request for the following dental procedures:

- D6750: crown-porcelain fused high noble for tooth 13 and 15;

- D6240: pontic-porcelain fused-high noble (a bridge) for missing tooth 14;
- D2750: crown-porcelain fused to high noble metal for tooth 27 and 31;
- D5214: partial lower denture and
- D5213: partial upper denture.

The burden of proof is assigned to the petitioner.

PRELIMINARY STATEMENT

Appearing as respondent's witness from Humana was Mindy Aikman, Grievance and Appeals Specialist. Appearing as respondent's witnesses from DentaQuest were Dr. Susan Hudson, Dental Consultant, and Jackelyn Salcedo, Complaints and Grievance Specialist. In addition to the father, petitioner's mother, [REDACTED], appeared as a witness. Petitioner appeared for the morning proceeding but not the afternoon proceeding.

Respondent's Composite Exhibit 1 was entered into evidence. Within the exhibit is a Dental Consultant Review Form dated July 20, 2014 indicating dental services D5213 and D5214 (upper and lower partial dentures) have been approved. Therefore, the outstanding issues to be addressed are respondent's denial of the crowns for tooth 13, 15, 27 and 31 and the bridge for tooth 14.

FINDINGS OF FACTS

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

1. Petitioner is a 20 year-old Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider. He will turn 21 years-old later this month.

2. Humana requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.

3. Petitioner's dentist sent a prior authorization request for crowns for tooth 13, 15, 27, 31, and a bridge for tooth 14.

4. DentaQuest sent a Notice of Action to petitioner on June 9, 2016 denying the requested services as not medically necessary and not covered services.

5. Petitioner filed a timely fair hearing request on July 6, 2016.

6. Petitioner's parents state the crowns and bridge are needed to prevent future infection of the teeth. They argue the dental services should be covered because Humana's member handbook states full dental services are covered for members age 20 and below.

7. Respondent explained a determination of medical necessity was needed for dental services requiring a prior authorization. In the instant case, respondent's dental consultant determined the crowns and bridge are not medically necessary. The bridge is not medically necessary because the approved partial denture will address the vacant space for tooth 14. The crowns are not medically necessary because the teeth are not unhealthy – except two teeth may need a filling. The dental consultant stated the EPSDT requirements were considered in making this determination.

CONCLUSIONS OF LAW

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

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

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

11. Sections 409.971 – 409.973, Florida Statutes, establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

12. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

13. Fla. Admin. Code R. 59G-1.010 defines “prior authorization” as: “Prior authorization” means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

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

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

....

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service [emphasis added].

15. The May 2016 Florida Medicaid Dental Services Coverage Policy (Policy) has been promulgated into rule by Fla. Admin. Code R. 59G-4.060, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593> .

16. Pages 4 and 5 of the Policy explain the Early and Periodic Screening, Diagnosis, and Treatment requirements:

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

17. Petitioner asserts crowns are needed on his teeth to prevent future infection.

18. Respondent explained there is no medical necessity for the crowns or the bridge. The bridge is not medically necessary because the approved partial denture will address the vacant space for tooth 14. The crowns are not medically necessary because the teeth are not unhealthy – except two teeth may need a filling.

19. The undersigned has considered the totality of the documentary evidence and testimony, as well as the above cited definitions of medical necessity and EPSDT requirements. Testimony by respondent's dental consultant was given full weight. The undersigned finds the respondent correctly determined petitioner's requests for crowns for tooth 13, 15, 27 and 31, as well as a bridge for tooth 14, are not medically necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)

16F-05128

PAGE - 7

DONE and ORDERED this 07 day of November, 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
[REDACTED] Via email
Humana Hearings Unit

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

FILED

Dec 08, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05176

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 the above-referenced matter telephonically on November 3, 2016, at 3:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's brother

For the Respondent: Michelle Riegler
Compliance Officer
Magellan Complete Care

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for various categories of speech therapy, occupational therapy, and physical therapy?

PRELIMINARY STATEMENT

The following individuals appeared as witnesses on behalf of Magellan Complete Care, the respondent: Gabriel Novoa, M.D., Medical Director of Magellan Complete Care; and Samantha Lorenzo, Appeals Manager at Magellan Complete Care. Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Liaison at the Agency for Health Care Administration, was present solely for the purpose of observation.

The respondent introduced respondent's Exhibits "1" through "5", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on November 17, 2016 to allow both parties an opportunity to submit additional information. Once received from the petitioner, his information was accepted into evidence and marked as petitioner's Exhibit "1". Once received from the Agency, its information was accepted into evidence and marked as respondent's Exhibit "6". The hearing record was closed on November 17, 2016.

Based on the testimony of the parties at the beginning of the hearing, the hearing officer stated that the burden of proof in this matter would be assigned to the respondent. However, after looking more closely at the services requested after the hearing, it appears the CPT codes denied were not previously approved by the respondent. Therefore, the burden of proof for this appeal will be assigned to the petitioner.

FINDINGS OF FACT

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

1. The petitioner is a 59-year-old male. He resides in a long-term care facility.
2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.
3. The Agency for Health Care Administration is the State Agency 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. On February 26, 2016, the petitioner’s health care provider submitted a prior authorization request to Magellan Complete Care for a Speech Therapy Evaluation (CPT Code 92523 – Evaluation Speech Sound Product Language Comprehension). Magellan Complete Care approved this request on March 2, 2016.
7. On May 9, 2016, the petitioner’s health care provider submitted a prior authorization request to Magellan Complete Care for speech therapy (CPT Code 92507 – TX Speech Lang Voice Comm &/ Auditory Proc Ind). Magellan Complete Care approved this request on May 9, 2016.
8. On May 9, 2016, the petitioner’s health care provider submitted a prior authorization request to Magellan Complete Care for an Occupational Therapy Evaluation (CPT Code 97003 – Occupational Therapy). Magellan Complete Care approved this request on May 9, 2016.

9. On May 9, 2016, the petitioner's health care provider submitted a prior authorization request to Magellan Complete Care for occupational therapy (CPT Code 97530 – Therapeutic Activity Direct Pt Contact 15 min each). Magellan Complete Care approved this request on May 9, 2016.

10. On May 9, 2016, the petitioner's health care provider submitted a prior authorization request to Magellan Complete Care for occupational therapy (CPT Code 97110 – Therapy PX 1+ Areas Each 15 Min). Magellan Complete Care approved this request on May 9, 2016.

11. On June 23, 2016, the petitioner's health care provider submitted a prior authorization request to Magellan Complete Care for physical therapy (CPT Code 97110). Although Magellan Complete Care initially denied this request, it subsequently approved 28 units for the certification period October 17, 2016 to November 17, 2016.

12. On June 23, 2016, the petitioner's health care provider submitted a prior authorization request to Magellan Complete Care for occupational therapy (CPT Code 97530). Although Magellan Complete Care initially denied this request, it subsequently approved 60 units for the certification period October 17, 2016 through November 17, 2016.

13. On June 23, 2016, the petitioner's health care provider submitted a prior authorization request to Magellan Complete Care for speech therapy (CPT Code 92507). Magellan Complete Care denied this request on the grounds that this CPT Code is not covered by Medicaid for any age group and that the services contemplated by the Code are duplicative of those covered by CPT Code 92523, which was previously approved.

14. On June 23, 2016, the petitioner's health care provider also submitted prior authorization requests to Magellan Complete Care for the following additional CPT Codes: 97112; 97140; 97532; 97535; 97760; and G02836. The Magellan Complete Care Medical Director testified at the hearing that these CPT Codes were denied either because the Codes were not listed in the Florida Medicaid Therapy Services Coverage and Limitations Handbook or because they were considered redundant of services already approved or unnecessary for the petitioner.

15. Dr. Novoa testified that Magellan Complete Care places the best interests of its recipients over anything else but it must still comply with the Therapy Services Coverage and Limitations Handbook ("Handbook").

16. Dr. Novoa testified the physical therapy, occupational therapy, and speech therapy services available to recipients aged 21 years or older in the Handbook are very limited and that most of the services contained in the Handbook are for the benefit of children. Despite that, he explained Magellan Complete Care evaluates a request for such services on a case by case basis and, if it determines the service requested will provide a real benefit to the petitioner, it will approve the service even if it is not contained in the Handbook. Consequently, Magellan Complete Care will sometimes approve CPT Codes that are generally available only for children for adult recipients. He testified that this is what occurred in this case.

17. The petitioner's representative expressed concerned about the number of units approved for his brother. He explained that once his brother begins to get better with the units he is receiving, the units run out and they need to reapply.

18. The petitioner's representative testified that the units Magellan Complete Care approved were helping his brother get better. However, he also explained that his brother's condition regresses when he is not receiving services.

19. In response to the concerns of the petitioner's representative, Dr. Novoa testified Magellan Complete Care purposely limits the number of units approved as a means to monitor short-term and long-term progress. Magellan Complete Care periodically monitors both the short-term and long-term progress of a patient and, once the patient reaches maximum medical improvement, it terminates the services so that unnecessary services are not being provided.

20. Magellan Complete Care follows the same criteria for the approval of occupational therapy, physical therapy, and speech therapy as the Agency for Health Care Administration. These criteria are contained in the Florida Medicaid Therapy Services Coverage and Limitations Handbook (August 2013).

CONCLUSIONS OF LAW

21. 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.

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

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

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

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

26. The Florida Medicaid 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.

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

28. 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.”

29. In order for therapy services to be approved, the services must not only be medically necessary but must also meet all requirements set forth in the Florida Medicaid Therapy Services Coverage and Limitations Handbook.

30. The Florida Medicaid Therapy Services Coverage and Limitations Handbook August 2013 is incorporated by reference in the Medicaid Services Rules by Fla. Admin. Code R. 59G-4.320.¹

31. The Florida Medicaid Therapy Services Coverage and Limitations Handbook August 2013 implements certain limitations for therapy services covered by Medicaid.

32. Page 2-2 of the Therapy Services Coverage and Limitations Handbook states services are to be provided only when medically necessary.

33. 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

¹ The Florida Medicaid Therapy Services Coverage and Limitations Handbook August 2013 was replaced by multiple Handbooks in November 2016. However, as the original Handbook was in effect at the time the decisions in this matter were made and at the time of the hearing, this appeal will be evaluated in accordance with the provisions in effect at the time the decisions were made.

care, goods or services medically necessary, or a medical necessity, or a covered service.

34. 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.

35. 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.

36. “Occupational therapy” is defined on Page 1-3 of the Therapy Services Coverage and Limitations Handbook as follows:

Occupational therapy is the provision of services that address the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development.

Occupational therapy services include evaluation and treatment to prevent or correct physical and emotional deficits, minimize the disabling effect of these deficits, maintain a level of function, acquire a skill set or restore a skill set. Examples are perceptual motor activities, exercises to enhance

functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.

37. "Physical therapy" is defined on Page 1-3 of the Therapy Services

Coverage and Limitations Handbook as follows:

Physical therapy is a specifically prescribed program to develop, maintain, improve or restore neuro-muscular or sensory-motor function, relieve pain, acquire a skill set, restore a skill set, or control postural deviations to attain maximum performance.

Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.

38. "Speech-Language Pathology", commonly referred to as speech

therapy, is defined on Page 1-4 of the Therapy Services Coverage and Limitations

Handbook as follows:

Speech-language pathology services involve the evaluation and treatment of speech-language disorders.

Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

Examples are techniques and instrumentation to evaluate the recipient's condition, remedial procedures to maximize the recipient's oral motor functions and communication via augmentative and alternative communication (AAC) systems.

39. Page 1-2 of the Therapy Services Coverage and Limitations Handbook sets forth the purpose of the therapy services program as follows:

The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech-language pathology (SLP) services **to recipients under the age of 21**. [Emphasis added] The therapy services program also provides limited services to recipients age 21 and older specifically SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings.

40. Page 2-20 of the Therapy Services Coverage and Limitations Handbook sets forth the covered speech-language pathology services for recipients age 21 and older. It states as follows:

AAC initial evaluations, fittings, adjustments and training are reimbursed through the Medicaid therapy services program for recipients age 21 and older. Fittings, adjustments, and training are only reimbursed for recipient owned AAC devices. AAC evaluation services provided to recipients age 21 and older are reimbursed only when provided by speech language pathologists.

41. Page 2-34 of the Therapy Services Coverage and Limitations Handbook addresses wheelchair evaluations and fittings. It states as follows:

Medicaid reimburses physical and occupational therapists for an initial evaluation of a recipient's need for a wheelchair and follow-up evaluations after it is delivered to make adjustments and to properly fit the wheelchair to the recipient.

42. In the present case, the services requested by the petitioner do not fall within the parameters of Medicaid allowable services for recipients age 21 and older. Therefore, the respondent correctly denied the services. The respondent's witness testified that requests for therapy services are evaluated on a case-by-case basis and that services outside the scope of what are generally available to recipients age 21 and

older will be approved if it is determined the services will provide a benefit to the patient. The respondent's witness also testified that the services denied in this case were not approved because they were duplicative of already approved services or determined to be medically unnecessary.

43. Pursuant to the above, the petitioner has not met his burden of proof to demonstrate beyond a preponderance of the evidence that the respondent incorrectly denied his request.

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 08 day of December, 2016,
in Tallahassee, Florida.



Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

16F-05176

PAGE - 13

Office: 850-488-1429

Fax: 850-487-0662

Email: Appeal.Hearings@myflfamilies.com

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

Nov 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05238

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 88222

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:00 noon on September 27, 2016.

APPEARANCES

For the Petitioner: [REDACTED], Authorized Representative (AR)
Arbor Village Nursing Facility, Supervisor

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiently Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Uncovered Medical Expense Deduction (UMED) for April 2015, May 2015 and July 2015 is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was scheduled to convene on August 22, 2016. On August 22, 2016, the petitioner's AR requested that the hearing be rescheduled. The request was granted, the hearing was rescheduled and convened on September 23, 2016. At the September 23, 2016 hearing, the parties agreed to reconvene on September 27, 2016.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on September 27, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner submitted an Institutional Care Program (ICP) Medicaid application dated November 4, 2015. The Department approved the petitioner ICP benefits retroactive to August 2015 (three months prior to the November 4, 2015 application).
2. On May 11, 2016, the Nursing Facility submitted a change, requesting UMED on behalf of the petitioner for April 2015 and May 2015.
3. Petitioner's AR stated that the Nursing Facility is also seeking UMED for July 2015. The UMED are for the petitioner's room and board expenses at the Nursing Facility for April 2015, May 2015 and July 2015, when the petitioner was not eligible for ICP benefits.
4. On May 16, 2016, the Department mailed the petitioner a Notice of Case Action, notifying that the petitioner's patient responsibility was reduced to zero for May 2016.
5. Respondent's representative stated that retroactive UMED is only available when applications are submitted. And change requests are for the month the change was

requested and going forward. Therefore, the petitioner is not eligible for UMED coverage for April 2015, May 2015 and July 2015.

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 Fla. Admin. Code R. 65A-1.7141(1), pertaining to SSI-Related Medicaid Post Eligibility Treatment of Income, in part states:

(i) Uncovered medical expense deduction. The following policy will be applied in considering medical deductions for institutionalized individuals and individuals receiving HCBS services to calculate the amount allowed for the uncovered medical expense deduction:

1. For institutionalized persons or residents of medical institutions and intermediate care facilities, the deduction includes:

a. Any premium, deductible, or coinsurance charges or payments for health insurance coverage.

b. For other incurred medical expenses, the expense must be for a medical or remedial care service and be medically necessary as specified in subsection 59G-1.010(166), F.A.C., and be recognized in state law. For medically necessary care, services and items not paid for under the Medicaid State Plan, the actual billed amount will be the amount of the deduction, not to exceed the maximum payment or fee recognized by Medicare, commercial payors, or any other third party payor, for the same or similar item, care, or service.

2. **The expense must have been incurred no earlier than the three month period preceding the month of application providing eligibility.** (emphasis added)

3. The expense must not have been paid for under the Medicaid State Plan.

9. The above authority explains that the expenses seeking UMED “must have been incurred no earlier than the three month period preceding the month of application

providing eligibility”.

10. The evidence submitted establishes that the petitioner submitted an ICP application on November 4, 2015. And the Department approved the petitioner ICP benefits retroactive to August 2015 (three months prior to the November 2015 application).

11. Petitioner’s AR is seeking UMED for room and board expenses incurred in April 2015, May 2015 and July 2015, which is earlier than the third month (August 2015) preceding the November 4, 2015 month of application.

12. In careful review, of the cited authority and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the Department’s action to deny the petitioner UMED for April 2015, May 2015 and July 2015 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 01 day of November, 2016,

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

Dec 19, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05243

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 [REDACTED]
UNIT: 88072

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on November 15, 2016 at approximately 2:30 p.m. CST.

APPEARANCES

For the Petitioner: [REDACTED] *pro se*
[REDACTED] husband
[REDACTED], resolution specialist, Change Healthcare
[REDACTED], disability worker, Adreama

For the Respondent: John Roche, operations and management consultant

STATEMENT OF ISSUE

Petitioner is appealing the Department's action taken June 15, 2016 denying Medically Needy Program (MNP) eligibility citing, "no household members are eligible for this program" for the retro months of October and November 2015. The petitioner

carries the burden of proof by the preponderance of evidence concerning the June denial.

PRELIMINARY STATEMENT

The hearing was originally scheduled for September 29, 2016 and was postponed because of Hurricane Hermine. The hearing was reschedule for October 6, 2016 and was postponed because of Hurricane Matthew.

The petitioner submitted a packet of information that was entered into evidence and marked as Petitioner's Exhibits "1" through "6".

The respondent (aka, the Department) submitted a packet of information that was entered into evidence and marked as Respondent's Exhibits "1" through "13". The record was left open for the respondent to submit more information. That information was submitted and entered into evidence marked as Respondent's Exhibits "6" through "13". The record was closed November 18, 2016.

Lauren Coe, Division of Disability Determination program operations administrator, appeared as a witness for the respondent.

Hearing Officer Pamela Vance observed the hearing with no objection.

Verlon Carter, medical disability examiner with the Division of Disability Determination, observed the hearing with no objection.

The hearing took place in two parts separated by an off-the-record conference of more than 55 minutes to which the hearing officer was not party.

The petitioner agreed that the concern over the petitioner's inaction concerning a November 12, 2015 and a February 26, 2016 application is moot as a decision had been made prior to the convening of this proceeding. Notices were being sent to the

petitioner and not to their representative, hence the representative's hearing request for delay. Whether or not the DDD decision was correct remains the petitioner's concern.

FINDINGS OF FACT

1. Petitioner is a 44 year-old lawful permanent resident in the United States less than five years. Her household consists of herself and her husband, a Social Security Disability Insurance recipient.
2. On March 9, 2016, petitioner applied electronically for SSI-Related Medicaid for herself (Petitioner's Exhibit 2).
3. On April 18, 2016, the petitioner requested additional assistance, Medicaid, requiring a Division of Disability Determination (Petitioner's Exhibit 2).
4. On June 14, 2016, the respondent received a Disability Determination and Transmittal, CF-ES 2909, denying disability status to the petitioner using the basis code N32, "Impairment of insufficient severity to preclude individual's engaging in all SGA" (Petitioner's Exhibits 2 and 5).
5. The primary diagnosis considered was [REDACTED]. The second diagnosis was [REDACTED] (Petitioner's Exhibit 5).
6. On June 15, 2016, a notice of case action (NOCA) was mailed to the petitioner denying enrollment in the MNP with the reason, "No household members are eligible for this program" (Petitioner's Exhibit 1).
7. There was a lengthy off-the-record conference, and an on-the-record discussion that concluded in a consensus that all of the petitioner's medical conditions had been considered by DDD when making the decision, including, "unconsidered conditions" that were explained as being symptoms rather than a condition or not severe enough to

meet a listing. Even with such a consensus, the petitioner requested a decision from this hearing officer for her to close her record.

8. On November 23, 2015, the Social Security Administration (SSA) made a determination of non-disability. This denial was coded N13, “Non-pay – Not a citizen or an eligible alien” (Respondent’s Exhibit 6).

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

10. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

12. Federal Regulations at §435.541, Determinations of disability, states in part: “(a)(2) The agency may not make an independent determination of disability if SSA has made a **disability** determination...” [emphasis added]

13. The Department’s Program Policy Manual, CFOP 165-22, Passage 1440.0006, SSI-Related Technical Factors (MSSI, SFP), states in relevant part, “The technical factors that may be considered are: (1) Citizenship/noncitizen status...”

14. The decision from SSA was based on technical criteria rather than medical factors; therefore, it was appropriate for DDD to make its determination as the above referenced N13 reason concerning citizenship is a technical factor of eligibility.

15. The parties agreed after a lengthy and detailed discussion that all the medical conditions were considered by DDD and that the supposed unconsidered conditions were not severe enough to meet a disability listing or were actually symptoms rather than conditions.

16. Fla Admin Code R. 65A-1.711 SSI-Related Medicaid Non-Financial Eligibility Criteria, states in part: "To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference)...(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference)."

17. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (by either the respondent or SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs. Because petitioner has been determined non-disabled by SSA and the respondent, she does not meet the technical criteria to be eligible for SSI-Related Medicaid; therefore, the respondent correctly denied the request for Medicaid at issue.

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

FINAL ORDER (Cont.)

16F-05243

PAGE -6

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 December, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Dec 08, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05271

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in this matter on November 23, 2016 at approximately 3:30 p.m.

APPEARANCES

For Petitioner:

[REDACTED]
Petitioner's Mother

For Respondent:

Lisa Sanchez
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is Respondent's termination of Petitioner's Prescribed Pediatric Extended Care Services ("PPEC"). The burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

A Spanish language interpreter was present. Dr. Darlene Calhoun, Physician Reviewer with eQHealth Solutions (“eQHealth”) appeared as a witness for Respondent. Petitioner’s mother gave oral testimony, but did not move any exhibits into evidence. Respondent moved Exhibits 1 – 5 into evidence.

Administrative notice was taken of the Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

FINDINGS OF FACT

1. Petitioner is a 3-year-old female. She lives with her mother and father. She has no other family in the United States.

2. Petitioner’s health conditions include:

- [REDACTED]

3. Petitioner currently receives PPEC services. Petitioner receives speech therapy and occupational therapy as part of her PPEC services. Those services can be provided on an outpatient basis.

4. PPEC is for children who need special medical care, such as skilled-nursing care throughout the day, that ordinary day care or babysitting cannot provide. Ordinary day care cannot administer medications. All of Petitioner’s medications can be taken at

home in the morning and evening, which the exception of [REDACTED], which is inhaled as needed for chest congestion. Petitioner requires [REDACTED] approximately three (3) times per week.

5. Petitioner's mother works from 8:00 a.m. until approximately 6:00 p.m., Wednesday through Sunday. She does not have a set clock-out time. Petitioner's father works from 7:00 a.m. to 7:00 p.m., Wednesday through Sunday.

6. Dr. Calhoun said Petitioner has many chronic conditions, but that the conditions are well-controlled by medication. She said there is nothing in Petitioner's Plan of Care for PPEC Services that requires skill nursing care. (Resp. Exh. 5 at p. 125). She stated Petitioner's Patient Care Flow Sheet regarding what services she receives throughout the day at PPEC are not skilled nursing services. (Resp. Exh. 5 at p. 166). She said the only thing Petitioner requires is monitoring since her therapies can be provided on an outpatient basis.

7. Dr. Calhoun said Petitioner is currently in a gap period, where she can be cared for by a regular day care or babysitter while her parents are at work. She said Petitioner is likely to require a home health aide later in life due to her developmental delay, but that she is currently age appropriate. All 3-year-old children require constant monitoring.

8. eQHealth is the Quality Improvement Organization ("QIO") contracted with the Agency for Health Care Administration to review PPEC requests for medical necessity.

9. A request for continued PPEC services was submitted. On July 8, 2016, eQHealth issued a Notice of Outcome – Denial Prescribed Pediatric Extended Care Services, which terminated Petitioner's PPEC services in full. (Resp. Exh. 4). The Clinical Rationale for the Decision was as follows:

The patient is a 3 year old with Turner Syndrome, GERD, seizures, cystic kidney disease and VUR. The patient receives therapies while attending PPEC. The patient's seizures are well controlled and there are no reported seizures noted while attending PPEC. The patient was recently diagnosed with thyroid disease. The patient is on an age-appropriate diet and has had significant weight gain. The clinical information provided does not support the medical necessity of the requested PPEC service. There does not appear to be any skilled needs.

10. Petitioner requested a hearing on July 12, 2016.

CONCLUSIONS OF LAW

11. By agreement between the Agency for Health Care Administration ("AHCA" or "Agency") and the Department of Children and Families, the Office of Appeal Hearings has jurisdiction over this matter pursuant to Section 120.80, Florida Statutes.

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

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

14. 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.).

15. 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.

16. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 ("PPEC Handbook") is promulgated into law by Florida Administrative Code Rule 59G-4.260.

17. Page 2-1 of the PPEC Handbook lists the requirements for receiving PPEC services. Page 2-1 states:

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

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

18. Fla. Admin Code R.59G-1.010 defines “medically complex” and “medically fragile” as follows:

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

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

19. Section 409.905, Florida Statutes, “Mandatory Medicaid services,” states, in pertinent part: “Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law.”

20. 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.

21. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPDST) requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children include:

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

22. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore v.*

Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

[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).

23. 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.

24. In the instant matter, the testimony and documentary evidence fails to establish the medical necessity of PPEC services for Petitioner. While it is true Petitioner has several chronic conditions, they are well-controlled by medication. The [REDACTED] is given on an as-needed basis. The day and time Petitioner might require [REDACTED] is unknown. She simply requires monitoring and supervision. All 3-year-old children require monitoring and supervision. Petitioner does not require skilled nursing care throughout the entire day, every day.

25. Petitioner's current level of illness does not reach the level of "medically complex" or "medically fragile," as defined in the Florida Administrative Code. PPEC services are only provided when the recipient's condition is severe.

26. The undersigned has reviewed EPSDT and medical necessity requirements and concludes Respondent has met its burden of proof, by the greater weight of the evidence, in terminating Petitioner's PPEC services.

27. Dr. Calhoun made it clear that Petitioner's needs for speech therapy and occupational therapy can be provided on an outpatient basis. She also said that Petitioner is likely to require a home health aide later in life and that she is currently in a gap period. Petitioner's mother is encouraged to work with the Agency to procure the speech and occupational therapy services, and to monitor her daughter's condition to see if skilled nursing care is required in the future, which can be requested at that time.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Agency's action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 08 day of December, 2016,

in Tallahassee, Florida.



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

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

FILED

Nov 14, 2016

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. 16F-05299
16F-05300
16F-05301

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 88007

RESPONDENT.

/

FINAL ORDER OF DISMISSAL DUE TO ABANDONMENT

Pursuant to notice, an in-person administrative hearing was scheduled to convene on August 8, 2016, in the above-referenced matter. On August 5, 2016, the petitioner requested a continuance, due to family medical issues. The hearing was rescheduled (in-person) for August 25, 2016. On August 24, 2016, the petitioner requested another continuance, due to family medical issues; he also requested that the in-person hearing be changed to a telephonic hearing. The hearing was rescheduled telephonically for September 12, 2016. On September 12, 2016, Hearing Officer Perez, the petitioner and the respondent, Brandy Jancewicz (BJ), ACCESS Integrity Program Investigator appeared. The parties agreed to reconvene on September 13, 2016, due to missing documents. On September 13, 2016, Hearing Officer Perez, the petitioner and the respondent (BJ) appeared. During the hearing, the petitioner requested recusal of Hearing Officer Perez; Hearing Officer Perez recused herself on the record.

The above appeals were reassigned to Hearing Officer Peterson. The hearing was rescheduled (telephonically) for October 6, 2016. On October 6, 2016, Ms. Sanchez (Hearing Officer Peterson's Supervisor) dialed into the hearing, as the office was closed due to Hurricane Matthew and waited 15 minutes for the petitioner. The respondent, Richard Lyon (RL), ACCESS Integrity Program Investigator, also appeared, the petitioner did not appear. Due to the office being closed, the hearing was rescheduled (telephonically) for November 2, 2016. On November 2, 2016, the undersigned and the respondent (RL) appeared and waited 15 minutes for the petitioner, the petitioner did not appear. To date, the petitioner has not called the Office of Appeal Hearings nor the undersigned regarding the abandoned hearings or to request a reconvene.

Fla. Admin. Code R. 65-2.061, Failure to Appear, in part states "abandonment may be deemed to have occurred if the appellant, without good cause therefor, fails to appear by himself or an authorized representative at the Hearing schedule for such appellant..."

In accordance with the above authority, the appeals are hereby dismissed as abandoned.

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 November, 2016,

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

Nov 21, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-05462

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 the above-referenced matter telephonically on October 13, 2016, at 10:35 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

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

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied her request for a crown on Tooth #8?

PRELIMINARY STATEMENT

The following individuals appeared as witnesses on behalf of Humana: Jackelyn Salcedo, Complaints and Grievances Specialist with DentaQuest; and Daniel Dorrego, D.D.S., Dental Consultant with DentaQuest. Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration, and Sajjan George, Hearing Officer with the Office of Appeal Hearings at the Department of Children and Families, were present solely for the purpose of observation.

The respondent introduced Exhibits "1" through "7", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on October 14, 2016 for the respondent to provide the Agency for Health Care Administration guidelines regarding the approval of crowns. Once received, this information was accepted into evidence and marked as respondent's Exhibit "8". The hearing record was thereafter closed on October 14, 2016.

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 43-year-old female. She resides in [REDACTED] County.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. Petitioner is an enrolled member of Humana. Humana is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.

4. Humana provides certain dental benefits to its members.

5. Humana has contracted DentaQuest to be its dental vendor. In its capacity as vendor, DentaQuest completes prior authorization reviews of requests for dental services submitted to it by Humana members or their providers.

6. On May 2, 2016, the petitioner's dentist submitted a preauthorization request to DentaQuest for procedure code D2751 (crown – porcelain fused to predominantly base metal) for petitioner's Tooth #8.

7. Tooth #8 is the central incisor in the upper right jaw. It is the middle tooth on the upper right side.

8. In a Notice of Action dated May 4, 2016, DentaQuest informed the petitioner it was denying her request for a crown for Tooth #8.

9. The Notice of Action states, in part:

We made our decision because:

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.

...

The facts that we used to make our decision are:

- Your x-rays show that your tooth is not bad enough to receive a crown. Your tooth has to have been badly broken or decayed to receive this service. There are other things your dentist can do to fix your tooth. We have told your dentist this also. Please talk to your dentist about other possible treatment plans for your tooth.

The DentaQuest guideline or policy used to support this decision was:

- DentaQuest Clinical Criteria for Crowns

10. The petitioner testified that she is in pain and needs a crown on Tooth #8 because Tooth #8 is causing the pain.

11. The respondent's dentist testified that the petitioner should feel no pain associated with Tooth #8 because the nerve should have been removed when the root canal was performed on the tooth.

12. The petitioner testified a root canal was never performed on Tooth #8.

13. The remark on the Dental Claim Form submitted by the petitioner's dentist requesting prior authorization states as follows: "#8 HAS HAD RCT. ALL CUSPS UNDERMINED. NEEDS CROWN...."

14. The radiograph submitted by the petitioner's dentist indicates a root canal was performed on Tooth #8. It distinctly shows the hole in the crown of the tooth which was opened to perform the work and thereafter closed. It also shows a filling inside the tooth where the infected portion of the tooth was removed.

15. A Peg lateral is an incisor which is abnormally small in size.

16. The petitioner testified Tooth #8 is a Peg lateral and that the white mass in the radiograph which appears to be a filling implanted after a root canal is actually the tooth itself, and that everything else depicted in the radiograph with respect to Tooth #8 is a temporary partial tooth placed over the Peg.

17. There is no narrative or photographs supplied by the petitioner's dentist supporting the petitioner's testimony that Tooth #8 is a Peg lateral.

18. The petitioner's request was reviewed by a DentaQuest dental director after the initial denial. The secondary reviewer upheld the initial denial. The dental director stated as follows:

This service is DENIED because the tooth does not appear to have significant breakdown, ie., documentation provided does not demonstrate that there is more than 50% of the incisal edge (with incisal angle involvement) fractured or decayed and/or 4 or more surfaces involved OR is there significant decay or restorations on the mesial and/or distal of the tooth, or cusp fractures on posteriors due to decay or trauma. Discoloration, deformation (Peg Laterals), Diastemas, completed RCT treatment with minimal access openings, and/or Attrition/Abrasion/Erosion of anterior teeth does not fulfill the criteria for approval for a crown under this plan.

19. The dentist appearing as a witness for the respondent testified he concurs with the decision to deny the crown. He testified DentaQuest criteria for the approval of a crown require at least 50 percent of the incisal edge must be broken down from decay or trauma and that four or more surfaces of decay or trauma must be present.

20. Petitioner's Tooth #8 has more than 50 percent of the incisal edge remaining and only one surface of decay or trauma is present. The one surface of decay or trauma is the hole that was opened to complete the root canal.

CONCLUSIONS OF LAW

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

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

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

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

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

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

27. 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...

28. 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.

29. 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.

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

31. 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.

32. 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....”

33. 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.”

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

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

36. Section 4.2.8 of the Dental Services Coverage Policy limits the receipt of restorations and crowns to recipients under the age of 21 years.

37. The DentaQuest criteria for the approval of cast crowns for anterior teeth require the following: "Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge."

38. Since restorative services, including crowns, are not available to recipients over the age of 21 under the Medicaid State Plan administered by the Agency for Health Care Administration, Humana's policy is not more restrictive than that of the Agency for Health Care Administration.

39. In the present case, the petitioner does not meet DentaQuest criteria for the approval of a crown. Petitioner's Tooth #8 has more than 50 percent of the incisal edge remaining and only one surface of decay or trauma is present. Although the petitioner provided credible testimony that she is experiencing pain, there is nothing in the evidence to support a conclusion that the pain is associated with Tooth #8. There is also nothing in the evidence tending to show a Peg lateral which may require a crown.

40. Pursuant to the above, the petitioner has not shown by a preponderance of the evidence that the respondent incorrectly denied her request for a crown on Tooth #8.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of 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 21 day of November, 2016,

in Tallahassee, Florida.

Peter J. Tsamis

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

Copies Furnished To:

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

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

FILED

Dec 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05463

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 [REDACTED]

AND

HUMANA AMERICAN ELDERCARE (HUMANA)

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 29, 2016 at 10:16 a.m.

APPEARANCES

For the Petitioner: [REDACTED], wife

For the Respondent: Dr. Pablo Calzada, Humana medical director

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to receive a whole-home generator through Medicaid. 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. Medicaid rules require that most recipients receive their Medicaid services through the Managed Care Plan. The Agency contracts with numerous health care organizations to provide medical services to its program participants. Humana is the contracted health care organization in the instant case.

By notice dated June 17, 2106, Humana informed the petitioner that his request for a whole-home generator was denied.

The petitioner requested reconsideration.

By notice dated July 8, 2016, Humana informed the petitioner that the original denial decision was upheld.

The petitioner timely requested a hearing to challenge the denial decision on July 19, 2016.

The hearing was scheduled to convene on September 16, 2016, but was continued at the petitioner's request, due to a scheduling conflict. The hearing was next scheduled to convene on October 14, 2016, but was continued at the petitioner's request for additional time to prepare. The hearing was next scheduled to convene on October 26, 2016. Humana, the co-respondent, did not appear. An Order to Show Good Cause Reason was issued to Humana. Humana filed a response citing scheduling conflicts and technical issues as the reasons it failed to appear at the hearing and requesting that the hearing be rescheduled. The hearing convened on November 29, 2016.

Present as witnesses for the petitioner: [REDACTED], sister-in-law and [REDACTED] [REDACTED] chief executive officer of Disability Solutions for Independent Living. 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 Humana: Stacey Larsen, service operations specialist. Present as an observer: Sheila Broderick, registered nurse specialist with AHCA. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until close of business on December 13, 2016 for the submission of additional evidence. Evidence was timely received from both parties and admitted into the record as Petitioner's Composite Exhibit 2 and Respondent's Composite Exhibit 2. The hearing record was closed on December 13, 2016.

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 74) is a Florida Medicaid recipient. The petitioner is enrolled in Humana's Long Term Care Program (LTCP). LTCP provides home health goods and services to individuals who would otherwise require nursing home placement.

2. The petitioner's diagnoses includes "[REDACTED], [REDACTED]

[REDACTED]

[REDACTED]

The petitioner

requires total physical assistance with all the activities of daily living. The petitioner lives in the family home with his wife (age 65). She is his primary caregiver; he also receives personal care services through Humana's LTCP.

3. The petitioner requires mechanical devices to maintain life: oxygen variable positive airway pressure (VPAP) device and an oxygen compressor. He also uses other mechanical devices for health reasons: semi-electric hospital bed, electric air mattress, electric Hoyer lift; electric wheelchair, and window air conditioning unit.

4. On May 18, 2016, the petitioner's wife requested a whole-home generator on, his behalf, through on Medicaid. The petitioner's wife explains the rationale for the request in a written statement: "request...a whole-home generator for his life support in case of power outage and/or emergency in home."

5. Humana verbally approved the petitioner's request. Humana's contact notes for the petitioner's case, dated May 26, 2016, reads: "CM [case manager] made TCT member's wife...advised the generator request was approved, CM will work on getting quotes so we can move forward with installation..."

6. Before issuing a written notice, Humana re-reviewed the request. Humana case notes dated June 17, 2016 reads: "CM emailed PRS to request guidance on providers that install generators. CM received email from PRS to hold off on moving forward as she has to review."

7. After further review, Humana concluded that it would not provide the generator.

8. Humana issued a denial notice to the petitioner on June 17, 2016. The notice reads in pertinent part: "The requested service is not a covered benefit."

9. The petitioner requested consideration of the denial decision.

10. Humana denied the reconsideration request in a notice dated July 8, 2016.

The notice reads in pertinent part:

Our medical director reviewed the information and determined the denial should be upheld. Specifically, he stated, "You have [REDACTED]. You have asked Humana for a home generator in case of a power failure. The medical record shows that you have [REDACTED] and [REDACTED] and are dependent on having electricity to work your refrigerator and power lift. The Florida Medicaid Agency for Health Care Administration (AHCA) Durable Medical Equipment (DME) and Medical Supply Services and Coverage Limitations Handbooks on page 2-9 defines DME as "All DME, medical supplies, and orthotics and prosthetic devices must be: Medically necessary, Functionally appropriate for the individual recipient, and Adequate for the intended medical purpose, and For conventional use, and For the exclusive use of the recipient." Also, National Coverage Determination (NCD) for Durable Medical Equipment Reference List (280.1) says that "Precautionary services are considered nonmedical in nature and as such are not covered by Medicare. This item is precautionary and does not meet the definition of durable medical equipment. The requested service is not medical necessary under Medicaid and the Humana plan, and the initial determination is upheld."

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

12. The petitioner's wife asserted that he "relies on medical equipment powered by electricity for life support." It is critical for the petitioner to have a backup source of electricity in case of power outages (due to natural disasters or other service interruptions). The family home experiences random, short term power outages, for reasons unknown. In addition, during hurricane Matthew, which skirted the coast of Florida in October 2016, the family home was without power for several days. The local

emergency shelters were not equipped to care for the petitioner due to his medical needs. The petitioner was placed briefly in a nursing home.

13. The petitioner's wife was not satisfied with the level of care he received at the nursing home and wanted to bring him home. The petitioner's son rented a portable generator which provided electricity to all petitioner's medical equipment and the home refrigerator. The portable generator provided back-up electricity which allowed the petitioner to safely remain in the family home until the power was restored several days later.

14. Seeking to confirm a continual source of electricity for the petitioner, his wife consulted with the local power company, but it could not guarantee a "source of power to operate medically necessary electric equipment in case of a power outage and/or emergency..." She also consulted a local hospital about admitting the petitioner during power outages and was told "[petitioner] can only remain in the hospital if he has an illness which warrants hospitalization..."

15. The petitioner's wife provided letters from three treating physicians attesting to the diagnoses described in the above findings and recommending "a home generator system to support the electric equipment [petitioner] uses on a daily basis should there be an emergency power outage."

16. Dr. Pablo Calzada, medical director of Humana's Long Term Care Division, reviewed the petitioner's request and supporting documentation, including medical records, assessments, and physician attestation letters. Dr. Calzada concluded that the petitioner had complex medical issues and required medical equipment to maintain life.

Dr. Calzada agreed that the petitioner required back-up electricity during power outages. Medicaid rule includes the provision of special equipment, like generators, needed to support life. At question was device medically necessary to meet the petitioner's needs.

17. Dr. Calzada, the only medical expert to appear at the hearing, explained that Medicaid rules prohibit the provision of goods and services in excess of a recipient's needs. The petitioner needs back-up electricity that will operate his medical equipment during temporary power outages. Dr. Calzada opined that it is not medically necessary to provide electricity to the petitioner's entire home during the temporary power outages, just power to his medical equipment. Dr. Calzada opined that the petitioner's needs could be met with a portable generator. A whole-home generator exceeds the petitioner's medical needs.

18. The petitioner's wife (age 65) argued that the portable generator used to power his medical equipment during hurricane Matthew was a temporary solution to address the emergency situation. She asserted that a portable generator is not a long term solution. She was not able to operate the pull-handle of the portable generator alone, due to back issues. (Her back issues are not disabling and do not prevent her from being able to care for the petitioner.) The petitioner's son (who lives close by) had to come to the home and start the generator for them. The petitioner's wife argued that whole-home generators would come on automatically and within seconds of a power outage. She, as the petitioner's primary caregiver, would not have to exert herself physically if the house was equipped with a whole-home generator. The petitioner's

wife was also concerned about the possibility of carbon monoxide poisoning related to use of portable generators.

19. Dr. Calzada explained that there are many different types of portable generators, Humana would work with the petitioner's wife to find one that she is capable of operating. In addition, Humana provides home health services, including home health aides, to the petitioner. The home health aides could assist with operating the portable generator.

20. In response to Dr. Calzada's testimony, the petitioner's wife asserted that an electrician examined the home electrical system recently and concluded that the system was not compatible with any of the portable generators currently on the market. The record was held open for her to provide a written statement from the electrician and for Humana to determine if the additional evidence altered its denial decision.

21. The petitioner provided statements from the owner of [REDACTED] and an electrician employed with [REDACTED]. The statements did not conclude that the petitioner's home electrical system was incompatible with all portable generators currently on the market. The statements concluded that whole-home generators are superior to portable generator because, "portable generators are not compatible with hands free transfer of power for the whole house, nor could it power much in the house other than a few circuits" and "[portable generators] will not start automatically. They have a manual transfer switch attached to the existing service panel which has to be turned on manually to transfer power to the generator."

22. Humana reviewed the electrician statements and filed the following response:

Humana concurs with the opinion of providing a portable generator with an automatic transfer switch that will power a few circuits in the home in order to operate the member's medically necessary equipment....We are glad to continue discussions on options that will still meet the member's needs. Our goal is to provide a level of service that can be safely furnish care, for which no equal effective and more conservation, or less costly treatment is available statewide. Humana has reviewed several generator options that will protect life but not be in excess of [petitioner's] needs. These alternatives to facility care allow [petitioner] to remain in the home and remain consistent with his abilities, natural supports and diagnosis.

CONCLUSIONS OF LAW

23. 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.

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

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

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

27. 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.).

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

29. 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.

30. The respondent denied the petitioner’s request for a whole-home generator to operate his medical equipment during temporary power outages. The respondent concluded that a whole-home generator was in excess of the petitioner’s needs and therefore prohibited by Medicaid rules.

31. Dr. Calzada, the only expert to appear at the hearing, opined that the petitioner’s needs could be met with a portable generator that will power his medical equipment.

32. The petitioner's wife asserted that the home electrical system was not compatible with the use of portable generators.

33. The evidence provided by the petitioner does not prove that the home electrical system is incompatible to all portable generators. The evidence proves that whole-home generators are easier to operate because they come on automatically. In addition, they provide power to the entire house.

34. Direct evidence proves that the petitioner's medical equipment can be safely powered by a portable generator for several days, as evidenced by the performance of the portable generator he used during the hurricane Matthew related power outage in October 2016. Humana has agreed to work with the family to secure a device that can be safely operate by the petitioner's wife and/or home health aides.

35. Medicaid rules prohibit the provision of goods and services in excess of a patient's needs. The undersigned concludes that a whole-home generator is in excess of the petitioner's needs.

36. 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 a whole-home generator.

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

FINAL ORDER (Cont.)

16F-05463

PAGE - 12

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

DONE and ORDERED this 28 day of December , 2016,

in Tallahassee, Florida.



Leslie Green

Hearing Officer

Building 5, Room 255

1317 Winewood Boulevard

Tallahassee, FL 32399-0700

Office: 850-488-1429

Fax: 850-487-0662

Email: Appeal.Hearings@myflfamilies.com

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

FILED

Nov 23, 2016

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. 16F-05572

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:10 p.m. on October 19, 2016.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant 1

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was scheduled to convene on September 2, 2016. Both parties appeared at the September 2, 2016 hearing, the respondent's representative requested

that the hearing be rescheduled, the Department's witness was unable to attend, due to severe weather conditions. The hearing was rescheduled and convened on October 19, 2016.

Laruen Coe, Department of Health Division of Disability Determination (DDD), Program Operations Administrator, appeared as a witness for the respondent.

Petitioner did not submit any exhibits. Respondent submitted nine exhibits, entered as Respondent Exhibits "1" through "9". The record was closed on October 19, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received Family-Related Medicaid, due to having a child under age 18. On April 30, 2016, the petitioner's Family-Related Medicaid was terminated, due to her youngest child turned 18 years of age.
2. On May 12, 2016, the petitioner (age 51) submitted a web application to add Medicaid for herself.
3. To be eligible for SSI-Related Medicaid (also referred to as adult Medicaid), the petitioner must be age 65 or older, blind or considered disabled by the Social Security Administration (SSA) or DDD. DDD is responsible for determining disability eligibility on behalf of the Department.
4. Petitioner explained her disabilities as having had a [REDACTED] in 2014 and a [REDACTED] [REDACTED] in 2015.
5. Petitioner applied for disability through the SSA in 2014, SSA denied the petitioner disability in January 2015 and in May 2015. Petitioner, through her attorney, appealed the SSA denial decisions and is awaiting a hearing with an Administrative Law Judge (ALJ).

6. Petitioner's attorney has all of the petitioner's medical records and will present the SSA with all of the petitioner's records at the hearing.

7. On June 1, 2016, the Department sent the petitioner's disability documentation to DDD for review.

8. DDD utilizes a Federal Regulation five-step sequential evaluation process in determining disability. DDD reviews each step to determine whether the petitioner is disabled. DDD terminates the five-step process when one of the five steps determines that the petitioner is either disabled or not disabled.

9. DDD completed a Physical Residual Functional Capacity (PRFC) Assessment by reviewing the petitioner's January 2016 through April 2016 medical records. DDD concluded that the petitioner has a light PRFC.

10. Respondent's witness stated that the petitioner's latest two physical examinations (April 8, 2016 and April 29, 2016) indicate her motor strengths are normal and she has clear speech.

11. DDD determined that the petitioner's primary diagnosis is [REDACTED] and her second diagnosis is [REDACTED].

12. The following are the petitioner's results (in bold) of DDD's five-step evaluation:

Step 1: Determines if the claimant is presently engaging in substantial gainful employment. **No**

Step 2: Determines severity of claimant's impairment(s). **Yes**

Step 3: Determines if impairment(s) meet or equal listings set forth in federal regulations. **No**

Step 4: Determines if the claimant is able to return to previous work. **Yes**

Step 5: **Not completed**

13. Petitioner was last employed as a cook in 2014; therefore, she is not presently engaging in substantial gainful employment, in Step 1.

14. Petitioner's impairments considered severe in Step 2 are: [REDACTED],

[REDACTED]

15. DDD determined that the petitioner's severe impairments listed in Step 2 did not meet or equal listings in Step 3 set forth in federal regulations.

16. DDD stopped the five-step evaluation on Step 4, because it determined the petitioner is able to return to previous work, as an assembly press operator.

17. Respondent's witness explained that DDD did not evaluate whether the petitioner could return to her last employment as a cook, because DDD is required to look at her previous employment for the past 15 years. And the information provided by the petitioner to the SSA indicates that she was an assembly press operator in NJ between 2003 and 2005 for Petron.

18. Petitioner did not recall being an assembly press operator. Petitioner recalled the following previous employments: in PA at a cheese factory, in NJ at a warehouse, in NY at a factory and in FL as a cook.

19. On July 14, 2016, DDD denied the petitioner Medicaid Disability. And on July 19, 2016, the Department mailed the petitioner a Notice of Case Action, denying her May 12, 2016 Medicaid application.

CONCLUSIONS OF LAW

20. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

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.

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

22. Federal Regulation 20 C.F.R. § 416.920, Evaluation of Disability of Adults, explains the five-step sequential evaluation process used in determining disability. The regulation states in part:

(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. See §416.920b.

(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)...

23. In accordance with the above authority, DDD utilized the five-step sequential evaluation process in determining the petitioner's disability. The following are the results of DDD's evaluation process:

First Step Met, petitioner is not employed.

Second Step Met, petitioner's medical severe impairments include

[REDACTED]

Third Step Not met, petitioner's severe impairments did not meet or equal listings set forth in federal regulations.

Fourth Step Not met, petitioner is able to return to previous work as an assembly press operator.

Fifth Step not completed

24. Federal Regulation 20 C.F.R. § 416.960, When we will consider your vocational background, in part states:

(b) Past relevant work. We will first compare our assessment of your residual functional capacity with the physical and mental demands of your past relevant work. See § 416.920(h) for an exception to this rule.

(1) Definition of past relevant work. Past relevant work is work that you have done within the past 15 years, that was substantial gainful activity, and that lasted long enough for you to learn to do it.

25. In accordance with the above Federal Regulation, DDD stopped the petitioner's sequential evaluation on Step 4, due to determining that the petitioner was able to

return to work as an assembly press operator; one of her 15 year previous employments.

26. Petitioner did not recall being an assembly press operator. However, the petitioner did recall the following employments: in PA at a cheese factory, in NJ at a warehouse, in NY at a factory and in FL as a cook.

27. Respondent's witness testified that the petitioner reported to SSA she was an assembly press operator in NJ from 2003 through 2005.

28. The evidence submitted establishes that DDD did not deny the petitioner disability due to adopting the SSA 2015 disability denial.

29. Federal Regulation 42 C.F.R. § 435.541, Determinations of disability, in part 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)(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations...

30. The evidence submitted establishes that the SSA has not refused reconsideration or reopening of its disability decision or to consider new allegations. Petitioner testified that she is appealing SSA's denial decisions (through an attorney) and is awaiting a hearing with an ALJ.

31. In careful review of the cited authorities, evidence and testimonies, the undersigned concludes the petitioner did not meet the burden of proof. The undersigned concludes that the Department's action to deny the petitioner Medicaid Disability is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of November, 2016,

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

Nov 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05629

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 [REDACTED]

CO-RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on September 19, 2016 at 1:39 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Mother

For the Respondent: Lisa Sanchez,
Medical/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through Dental Health and Wellness, to deny her request for dental procedures D8080-comprehensive orthodontic treatment (braces) and D8670-periodic orthodontic treatment (monthly visits for the braces). Because the issue under appeal involves a request for services, Petitioner is assigned the burden of proof.

PRELIMINARY STATEMENT

Tracey Thomas, Appeals Coordinator, and Kizzy Alleyne, Paralegal, appeared as Respondent's witnesses from Petitioner's managed care plan Sunshine Health. Dr. Previs Sullivan, Chief Dental Officer, and Dr. William Kochesour, Orthodontic Consultant, appeared as Respondent's witnesses from Dental Health and Wellness (Dental Health). Respondent's Exhibit 1 was entered into evidence.

The record was held open to September 27, 2016 for the agency representative to provide the authority for continuing to use the Medicaid Orthodontic Initial Assessment Form (IAF) and requiring a score of 26 points or higher for a member to qualify for braces. Respondent requested and received an extension for providing the authority citation to October 6, 2016. As of the date of this Final Order, the authority citation was not provided. Therefore, the decision relies on the authority in effect at the time of Respondent's initial decision, as well as Medicaid's definition of medical necessity.

FINDINGS OF FACTS

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

1. Petitioner is a ten year-old Medicaid recipient enrolled with Sunshine Health (Sunshine), a Florida Health Managed Care provider.
2. Sunshine requires prior authorization for services related to dental care and has subcontracted with Dental Health to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for dental procedures D8080: comprehensive orthodontic treatment (braces); and D8670: periodic orthodontic

treatment visit. In support of the request, the dentist submitted a Medicaid Orthodontic Initial Assessment form (IAF) with a score of 30 and checked the following condition on the form: Deep impinging overbite when lower incisors are destroying the soft tissue.

No other conditions were checked and scored on the form.

4. Dental Health received the request on April 14, 2016.

5. Dental Health made its determination on April 27, 2016 denying procedures D8080 and D8670. Notice was sent to the Petitioner providing the following denial reason: The requested services are not medically necessary. The notice provided the additional basis for the decision:

The request for braces is denied. Braces are medically necessary if there is information showing severe orthodontic abnormality resulting in an HLD¹ index score of 26 or greater. The information sent by your dentist did not show this condition.

6. Petitioner filed an appeal with Sunshine Health on May 3, 2016.

7. On May 20, 2016, Sunshine Health issued a notice upholding the initial denial and providing the same explanation.

8. On July 28, 2016, Sunshine Health issued a revised notice upholding the denial but providing the following basis for its decision: There is no destruction of tissue noted with the submitted documentation. The HLD index score is 12. Member does not meet the threshold for approval.

9. Petitioner filed a timely fair hearing request on July 25, 2016.

¹ The Florida Medicaid Dental Handbook, Appendix A, page 4, provides directions for using the Handicapping Labio-Lingual Deviation (HLD) Index. This criteria is not cited in the May 2016 Dental Policy.

10. Petitioner's upper front teeth are aligned in a V shape and her upper teeth are crowded. Correction of her teeth requires braces. Petitioner suffers self-esteem issues because her peers at school are teasing and bullying her about her teeth.

11. Respondent's dentist explained the request for braces was denied because: (a.) Petitioner's dentist only checked an overbite with lower incisors destroying the soft tissue of the upper palate on the IAF form. The supporting documentation submitted does not indicate any damage to the soft tissue of the upper palate; and (b) a minimum score of 26 is needed on the IAF form to meet Medicaid's definition of medical necessity for braces. Petitioner does not meet this minimum score.

12. Respondent's dentist explained that Petitioner could benefit from braces, however, Medicaid limits braces to the most handicapping conditions and uses the IAF to assess severity.

CONCLUSIONS OF LAW

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

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

15. 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).

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

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

18. Section 409.905, Florida Statutes, "Mandatory Medicaid services," states, in relevant part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law"

19. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

20. Section 409.912, Florida Statutes, provides the Agency may mandate prior authorization for Medicaid services.

21. Fla. Admin. Code R. 59G-1.010 defines "prior authorization" as: "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

22. Fla. Admin. Code R. 59G-1.010 (166) provides:

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

23. Because the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

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

24. 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** [emphasis added]. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.” (6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients (citations omitted).

25. The Florida Medicaid Dental Services Coverage and Limitations Handbook- November 2011(Dental Handbook)² is promulgated into rule under 59G-4.060 of the Florida Administrative Code.

² The Dental Handbook was in effect at the time of Respondent’s April 27, 2016 action. The Florida Medicaid Dental Policy replaced the Dental Handbook effective May 2016.

26. On page 2-15 of the Dental Handbook, the following description of Orthodontic Services is provided:

Prior authorization is required for all orthodontic services. **Orthodontic services are limited to those recipients with the most handicapping malocclusion** [emphasis added]. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to mal-positions of the teeth.

27. On page 2-17, the Dental Handbook explains the use of the Medicaid Orthodontic Initial Assessment Form (IAF):

The Medicaid Orthodontic Initial Assessment Form (IAF) is to be completed by the orthodontic provider at the initial evaluation of the recipient.

The IAF is:

- Designed for use as a guide by the provider in the office to determine whether a prior authorization (PA) request should be sent to the Medicaid orthodontic consultant; and
- A means by which the orthodontic provider may communicate to Medicaid's orthodontic consultant all the distinctive details pertaining to an individual case.

....

The conditions listed in the IAF index should be considered in the context of whether they contribute to a disabling malocclusion [emphasis added]. The provider scores each applicable condition and totals the recipient's index score.

Special or mitigating circumstances, such as deep bites with palatal trauma or occlusion related temporomandibular joint dysfunction (TMD) must be described in detail. Include description of limited mobility history (locking open or closed) and other severe symptoms of TMD.

28. On page 2-18 of the Dental Handbook, the required index score on the IAF is explained:

A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request to Medicaid for consideration of orthodontic services. A score of 26 or greater on the IAF is not a guarantee of approval. It is used by the provider to determine whether diagnostic records should or should not be sent to the orthodontic consultant.

....

A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied.

This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

29. The testimony and documentary evidence in the instant case do not establish medical necessity for braces. The evidence fails to show Respondent has a handicapping malocclusion. She does not have the required severity to meet Medicaid's definition of medical necessity. Petitioner's request for correcting her overbite did not include supporting documentation that the soft tissue of her upper palate was damaged. Additionally, the request for braces did not score any other dental conditions. Petitioner's HLD score on the IAF was 12 and not the 26 or higher score needed to establish medical necessity.

30. After carefully reviewing the EPSDT and medical necessity requirements set forth above, the undersigned concludes Respondent has demonstrated by a preponderance of the evidence that it correctly denied Petitioner's request for braces.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 01 day of November, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Nov 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05634

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 10th, 2016 at 10:03 a.m. in the [REDACTED] 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 denial of 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

The hearing was originally scheduled for September 6th, 2016 at 8:30 a.m., but the petitioner requested that it be changed to a face-to-face proceeding. The hearing was rescheduled to September 12th, 2016 at 10:30, but the petitioner was unable to appear. The hearing was rescheduled for a second time and the hearing convened as described above.

Petitioner's exhibits 1 through 8 were admitted into evidence.

Respondent's exhibits 1 through 8 were admitted into evidence.

The record was left open until the close of business, October 17th, 2016, to allow the petitioner to provide additional evidence. The petitioner submitted evidence timely and all additional documents were admitted as a composite numbered exhibit 8, and the record was closed.

The petitioner's daughter, [REDACTED], appeared as a witness for the petitioner.

By way of a Notice of Case Action dated May 12th, 2016, the respondent informed the petitioner that her application for SSI-Related Medicaid dated February 25th, 2016, was denied because she did not meet the disability requirement. On July 25th, 2016, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner applied for SSI-Related Medicaid on February 25th, 2016. 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 for purposes of the eligibility process and was age 58 years of age at the time of the application. There are no children under the age of 18 years living in the petitioner's household.

3. The petitioner applied for disability through the Social Security Administration (SSA) in February 2016 but was unsure of the exact date. SSA denied the petitioner's application in May 2016, but neither the petitioner nor the respondent was able to provide the date of denial. The reason for this denial was not established. The petitioner appealed the SSA's decision and her appeal was denied on September 16th, 2016. On September 27th, 2016 the petitioner appealed the SSA denial a second time through an attorney. A hearing date has not yet been scheduled.

4. The petitioner described her condition as a [REDACTED] and noted a variety of accompanying symptoms. The petitioner's condition worsened in September 2016, resulting in a hospital stay. The hospital stay took place after the respondent denied the SSI-Related Medicaid application. The petitioner states the September 2016 episode has been reported to her attorney.

5. On March 28th, 2016, the respondent forwarded the petitioner's disability documents to the Department of Disability Determination (DDD) for review. DDD denied the petitioner's Disability Medicaid on May 10th, 2016 due to adopting the previous SSA denial decision.

6. The petitioner applied for SSI-Related Medicaid for a second time on July 22nd, 2016. No new or worsening conditions were reported on the application. Therefore, the respondent denied the application.

7. The respondent issued a NOCA dated July 26th, 2016 informing the petitioner that her application for SSI-Related Medicaid dated July 22nd, 2016 was denied because she did not meet the disability requirement.

8. The petitioner is concerned that the respondent did not review her medical records in their entirety prior to denying her applications. The respondent's position is that it does not make an independent decision and must rely on the decision from DDD.

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 §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. As established in the Findings of Fact, the petitioner's condition is described as a kidney problem and the symptoms that accompany that issue. According to the respondent's evidence, DDD reviewed the condition along with another unreported condition when making its determination and adopted SSA's denial. The petitioner acknowledged no new conditions and no worsening conditions until after both SSI-Related Medicaid applications were denied. The petitioner's concerns are noted. However, the hearing officer concludes that the respondent's actions to deny the petitioner's SSI-Related Medicaid applications were 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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 16 day of November, 2016,

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

Nov 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05755

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: 5 [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 1:58 p.m. on October 5, 2016, in Orlando, Florida.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant 1

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was scheduled to convene telephonically on September 7, 2016. On August 25, 2016, the petitioner requested that the hearing take place in person.

6. On July 22, 2016, the Department mailed the petitioner a Notice of Case Action, notifying her June 23, 2016 Medicaid application was denied, due to not meeting the disability requirements.

7. Petitioner contends that her spontaneous hemorrhage and neuropathy are new medical conditions that the SSA does not know about and her other disabilities have worsened. Petitioner has provided her attorney with all her medical records of her new and worsened medical records.

8. Petitioner alleges that her attorney has not submitted all of her medical records to the SSA. And she unable to retain another attorney because her current attorney will not release her.

9. Respondent's representative suggested that the petitioner submit her medical records directly to the SSA.

10. Petitioner agreed to submit all her medical records directly to the SSA and plans on attend the SSA hearing.

11. Petitioner's witness testified that due to the petitioner's disabilities she provides care for the petitioner. She states she also buys the petitioner's medication because the petitioner does not have money.

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 Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations of Disability in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

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

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

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

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-

(A) Has applied to SSA for reconsideration or reopening of its disability

decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but
may meet the State's nondisability requirements for Medicaid eligibility...

15. The above authority explains that the SSA determination is binding on the
Department.

16. In accordance with the above authority, the Department adopted the SSA denial
decision and also denied the petitioner's Medicaid Disability.

17. In careful review of the cited authority and evidence, the undersigned concludes
that the petitioner did not meet the burden of proof. The undersigned concludes that the
Department's action to deny the petitioner Medicaid Disability is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner
disagrees with this decision, the petitioner may seek a judicial review. To begin the
judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency
Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee,
FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with
the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days
of the date stamped on the first page of the final order. The petitioner must either pay
the court fees required by law or seek an order of indigency to waive those fees. The
petitioner is responsible for any financial obligations incurred as the Department has no
funds to assist in this review.

FINAL ORDER (Cont.)

16F-05755

PAGE - 6

DONE and ORDERED this 17 day of November, 2016,
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

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

FILED

Nov 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05773

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION

CIRCUIT: 06 [REDACTED]

UNIT:

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above referenced matter telephonically on October 4, 2016, at 2:55 p.m.

APPEARANCES

For the petitioner:

[REDACTED]
Petitioner's Mother

For the respondent:

Stephanie Shupe
Regulatory Research Coordinator
Staywell

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for orthodontic treatment in the form of braces?

PRELIMINARY STATEMENT

██████████, the petitioner's mother, appeared on behalf of the petitioner, ██████████ ("petitioner"). ██████████ may sometimes hereinafter be referred to as the petitioner's "representative".

Stephanie Shupe, Regulatory Research Coordinator with Staywell, appeared on behalf of the respondent, Staywell. The following individuals appeared as witnesses on behalf of the respondent: Michelle Hadley, National Ancillary Account Coordinator with Staywell; and Richard Hague, D.M.D., Dental Director with Liberty Dental Plan. Stephanie Lang, 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 Exhibits "1" through "3", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "11", inclusive, 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 October 7, 2016 for the respondent to provide a copy of the prior authorization form submitted by the petitioner's orthodontist. Staywell did not forward this information to the Office of Appeal Hearings within the allotted time after the hearing. The hearing record was closed on October 7, 2016.

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 14-year-old male.

2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. Petitioner is an enrolled member of Staywell. Staywell is a health maintenance organization contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in the State of Florida.

4. The petitioner's effective date of enrollment with Staywell is January 1, 2016.

5. Staywell provides certain dental and orthodontic benefits to its members. Staywell has contracted Liberty Dental Plan to review prior authorization requests for dental and orthodontic services.

6. On or about June 15, 2016, the petitioner's orthodontist submitted a prior authorization request for a pre-orthodontic treatment examination to monitor growth and development; comprehensive orthodontic treatment of the adolescent dentition (Q01); comprehensive orthodontic treatment of the adolescent dentition (Q02); fixed appliance therapy (Q01); fixed appliance therapy (Q02); and periodic orthodontic treatment visits.

7. On June 17, 2016, Staywell sent a letter to the petitioner informing him that his pre-orthodontic treatment examination to monitor growth and development was approved.

8. However, in a Notice of Action also dated June 17, 2016, Staywell informed the petitioner that it was denying the remainder of his request for orthodontic treatment.

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*)

9. Both the Agency for Health Care Administration and Liberty Dental Plan used the Medicaid Orthodontic Initial Assessment Form (“IAF”) to evaluate a Medicaid recipients’ need for orthodontic treatment prior to May 3, 2016.

10. In order to be determined eligible for the receipt of braces pursuant to the Initial Assessment Form, an individual had to attain a score of at least 26 on the Initial Assessment Form or have at least one of the qualifying conditions listed on the form.

11. The petitioner’s orthodontist completed an Initial Assessment Form for the petitioner and submitted this information to DentaQuest. The Initial Assessment Form completed by the petitioner’s orthodontist reflects a Total Score of 13.

12. The Initial Assessment Form completed by the petitioner’s orthodontist does not indicate that the petitioner has any of the qualifying conditions that would automatically qualify him for the receipt of braces.

13. Liberty Dental Plan’s orthodontic consultant revised the petitioner’s Total Score on the Initial Assessment Form to eight after reviewing the documents submitted by the petitioner’s orthodontist along with the IAF.

14. The petitioner’s orthodontist sent a letter to the Dental Director at Liberty Dental Plan on August 15, 2016 asking Liberty Dental to reconsider its previous denial of the petitioner’s request. The letter states, in part:

As you know [Petitioner] was seen in our office 05/20/2016 for an evaluation of orthodontic treatment. He has deep impinging overbite that could result in soft tissue damage if left untreated. He is also missing #20 and #29. I recommend full orthodontic treatment with mandibular and maxillary braces to correct spacing and align the teeth. I also recommend an appliance to help with mandibular jaw growth to correct his overjet to prevent future orthognathic surgery. Having spacing between the teeth and a overjet affects brushing and the overall health of the teeth. By closing the space with braces and the use of the appliance to correct the

negative overjet will help with the ability to keep his teeth clean. Also it will help prevent any grinding or TMJ issues in the future.

15. On August 22, 2016, Liberty's Dental Director, a licensed dentist who did not participate in the initial decision, completed a secondary review of the pre-treatment authorization and all available documentation. The Dental Director determined that the initial denial of the orthodontic treatment for the petitioner was appropriate and in accordance with the petitioner's Staywell Child Medicaid Plan Benefits.

16. The letter from Liberty's Dental Director to Staywell regarding his review of the petitioner's request states, in part, as follows:

According to FL [Florida] AHCA Staywell guidelines and criteria, a total of 26 points must be scored on the Medicaid Orthodontic Initial Assessment Form; however, the chart records support [Petitioner] only scored a total of 13 points. Additionally, the narrative from the office indicates that [Petitioner]'s deep impinging overbite "could" cause tissue trauma; however, the IAF form specifically states that the tissue destruction of the palate must be clearly visible in the mouth, which the photos provided by the office failed to support. Therefore, LIBERTY recommends that the denial of the aforementioned services requested on pre-treatment authorization #9857709 remain upheld.

17. The petitioner's representative requested an administrative hearing in a timely fashion to dispute the denial of the petitioner's request for orthodontic services. This proceeding ensued.

18. The petitioner's representative argued the petitioner experiences difficulty while eating. The correspondence from the petitioner's representative labeled petitioner's Exhibit "1" states, in pertinent part: "...He chews food and because his teeth are too far away from his bottom teeth his food gets jammed into the roof of his mouth, jabbing the roof of his mouth. He also bites his tongue when eating food on a regular basis as well."

19. The petitioner is missing two congenital teeth, one on each side of his lower arch.

20. On the right side of the petitioner's lower arch, the teeth surrounding the area of the absent tooth have shifted to reduce the space where the congenital tooth is absent.

21. On the petitioner's lower left arch, the remnants of an extraction are visible in the area where the congenital tooth is missing. There is a gap of approximately six to seven millimeters where food is getting stuck while the petitioner is eating.

22. There is a possibility that the petitioner's molars will shift forward to further close the area where the petitioner's congenital teeth are missing but there is no way to reasonably determine whether this will occur or not.

23. The petitioner's representative also discussed the potential psychological and social consequences of a child the petitioner's age having imperfect teeth.

24. It is the respondent's position that, although the petitioner may have a malocclusion, his score on the Initial Assessment Form is below that which can qualify him for braces.

CONCLUSIONS OF LAW

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

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

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

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

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

32. 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.

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, 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.

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

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

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

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

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. 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.

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. Rule 59G-4.060, Florida Administrative Code addresses dental services and states, in part:

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference.

42. The respondent incorrectly relied on the previously promulgated Florida Medicaid Dental Services Coverage and Limitations Handbook, November 2011 in the presentation of its case. This Handbook discussed by the respondent were preempted by the new Dental Services Coverage policy that was promulgated into Rule effective May 3, 2016.

43. The Florida Medicaid Dental Services Coverage Policy, May 2016 addresses orthodontic services beginning in Section 4.2.4 which starts on Page 3 and explains:

Orthodontic Services

Florida Medicaid reimburses for orthodontic services for recipients under the age of 21 years with handicapping malocclusions as follows:

Twenty-four units within a 36 month period, which includes the removal of the appliances and retainers at the end of treatment

One replacement retainer(s) per arch, per lifetime

44. The Florida Medicaid Dental Services Coverage Policy, May 2016 discusses the criteria for the approval of orthodontic services in Section 7.2 on Page 6, which states as follows:

Specific Criteria

Providers must obtain authorization from the quality improvement organization for orthodontic and prosthodontic related services when indicated on the applicable Florida Medicaid fee schedule(s).

Providers must include the following additional information with the authorization request for orthodontic services:

- Orthodontic initial assessment
- Clinical photographs (prints or slides) showing:
 - Frontal view, relaxed, teeth in occlusion
 - Profile, right or left
 - Intraoral, right or left sides, teeth in occlusion
 - Intraoral, frontal, teeth in occlusion
 - Occlusal view (if photos are submitted without complete records)
- Study models
- Lateral cephalometric radiograph
- Panoramic radiograph

45. Section V.A.1.a.(8).a.b. of the Medicaid MMA [Managed Medical Assistance] Contract, the contract between the Agency for Health Care Administration, in its discussion of dental services states as follows:

Dental Services

- (a) The Managed Care Plan shall provide Dental Services to enrollees under the age of 21 years, emergency dental services to enrollees age

21 and older, and denture and denture-related services and oral and maxillofacial surgery services to all enrollees. The Managed Care Plan shall provide medically-necessary, emergency dental procedures to alleviate pain or infection to enrollees age 21 and older. Emergency dental care for enrollees 21 years of age and older is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable partial dentures and denture-related services are also covered services for enrollees 21 years of age and older. The Managed Care Plan shall provide full dental services for all enrollees age 20 and below. The Managed Care Plan shall provide medically necessary oral and maxillofacial surgery for all eligible Medicaid recipients regardless of age.

(b) The Managed Care Plan shall comply with provisions of the Medicaid Dental 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 Dental Services Coverage and Limitations Handbook.

46. The Staywell MMA Handbook address dental care for members under age 21 on Page 20. It lists orthodontic treatment as a covered service for children under the age of 21.

47. Staywell orthodontic policy is not more restrictive than that of the Agency for Health Care Administration.

48. In the present case, the respondent relied solely on the scoring of the Initial Assessment Form in the presentation of its case. However, based on the relevant discussion during the hearing, it is unclear whether the Initial Assessment Form is still a valid assessment tool. Testimony and evidence presented by the petitioner shows the petitioner has a deep impinging overbite that could result in soft tissue damage if left untreated. The petitioner is also missing two of his congenital teeth which has resulted in spaces in his mouth where food is getting stuck. The Liberty Dental Plan Dental Director

testified on cross-examination that he is not an orthodontist. However, the petitioner's provider, who is an orthodontist, recommended full orthodontic treatment to correct spacing and align the teeth. In addition, the petitioner's orthodontist feels that orthodontic treatment at the present time will prevent any grinding or TMJ issues in the future as well as improve the overall health of the petitioner's teeth. Finally, the EPSDT requirements discussed above in detail support early diagnosis and treatment to reduce or potentially eliminate more severe problems in the future.

49. Pursuant to the above, the petitioner has demonstrated by a preponderance of the evidence that the respondent incorrectly denied his request for orthodontic treatment.

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.)
16F-05773
PAGE - 15

DONE and ORDERED this 03 day of November, 2016,
in Tallahassee, Florida.

Peter J. Tsamis

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

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

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

FILED

Dec 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05778

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 [REDACTED]
UNIT: AHCA

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 8, 2016 at 11:42 a.m.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Lisa Sanchez, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's request for continued Prescribed Pediatric Extended Care (PPEC) services for full days (up to twelve hours), Monday through Friday for the certification period of July 11, 2016 to January 6, 2017, was correct. Because the matter under appeal involves a termination of PPEC services, the burden of proof is assigned to the Respondent.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Dr. Rakesh Mittal, Board-Certified Pediatrician and Physician Consultant for eQHealth Solutions. Respondent's Exhibits 1 and 2 were entered into evidence.

Petitioner has been administratively approved to continue receiving PPEC services 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 three-year-old female Medicaid recipient. She is diagnosed with

[REDACTED]

[REDACTED]

2. Petitioner has a history of [REDACTED] and an episode of near drowning. She is status-post tracheal scar removal in October 2015.

3. Petitioner lives with her mother who works full time.

4. Petitioner's medications include:

- [REDACTED]

5. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization

review determines the medical necessity of the hours requested pursuant to the requirements and limitations of the Medicaid State Plan.

6. A request for service is submitted by a provider along with all information and documentation necessary for the QIO to make a determination of medical necessity for the level of service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

7. On July 8, 2016, a request to continue PPEC full services (up to 12 hours) Monday through Friday was submitted by the provider on behalf of the Petitioner for the certification period July 11, 2016 to January 1, 2017.

8. On July 13, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A Notice of Outcome-Denial Prescribed Pediatric Extended Care Services was issued to Petitioner on July 14, 2016, which notified Petitioner that PPEC full services were denied. The rationale for the denial was that PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code.

9. On July 14, 2016, a "Notice of Outcome-Denial" was issued to Petitioner's provider and provided the clinical rationale as:

The patient is a 3-year-old with a history of [REDACTED] and an episode of near drowning. The patient is status post tracheal scar removal in October 2015. The patient receives scheduled [REDACTED] and as needed nebulizer treatments. The patient is on an age-appropriate diet. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical necessity requirement of PPEC services.

10. Petitioner requested a reconsideration review on July 15, 2016.

11. On August 9, 2015, eQHealth sent a Notice of Reconsideration Determination to Petitioner upholding the initial denial.

12. On August 9, 2015, eQHealth also sent a Notice of Reconsideration Determination to Petitioner's provider. The notice provides the medical basis for the reconsideration decision which includes the same explanation provided in the clinical rationale of the original decision. In addition, the notice states:

For the Reconsideration Review, the provider did not submit any additional documentation. Because no new information was provided and review of the previous review indicating prn needed [REDACTED] treatments and daily [REDACTED], insufficient skilled nursing needs have been identified in order to support the medical necessity needed for PPEC services.

13. On July 26, 2016, Petitioner requested an administrative fair hearing.

14. Respondent's physician consultant reviewed the documentation submitted by Petitioner in support of the request for PPEC services. He noted there was no information documenting the need for skilled nursing intervention. He reviewed Petitioner's medications and stated none required PPEC for administration. Most are prescribed on an as needed basis. The two medications requiring administration twice a day, he explained, could be given by the mother before she goes to work and when she returns home.

15. Petitioner's mother stated she does not have time to administer the medication in the morning. Respondent's physician consultant responded administration of the [REDACTED] should take no more than three minutes and he could not approve twelve hours of PPEC services per day for a three minute administration of medication.

16. Petitioner's mother stated she needs PPEC services but did not provide any explanation.

CONCLUSIONS OF LAW

17. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

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

19. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

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

21. Rule 59G-1.010 (166), Florida Administrative Code defines "medically necessary" or "medical necessity" as follows:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

22. Rule 59G-1.010 (164), Florida Administrative Code defines "medically complex" as a person who "has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention."

23. Rule 59G-1.010 (165), Florida Administrative Code defines "medically fragile" as:

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

24. Because Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

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

25. In reviewing the appeal for compliance with EPSDT requirements, PPEC services are part of Florida's Medicaid State Plan of services. The agency has administratively approved ongoing PPEC services pending the outcome of this appeal. Therefore, Respondent would need to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

26. The Florida Medicaid Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook- September 2013 (PPEC Handbook) is promulgated by Rule 59G-4.260, Florida Administrative Code, and provides the following purpose and definition of PPEC on page 1-1:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

27. On page 2-1, the PPEC Handbook provides the following requirements for those who can receive PPEC services:

To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:

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

28. On page 2-5, the PPEC Handbook provides a list of excluded services:

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.

- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, and child life.

29. Petitioner is requesting full day PPEC services (up to 12 hours per day). She provided no explanation for the need for the services.

30. Respondent's physician consultant reviewed the documentation submitted in support of the request for PPEC services. He explained there was no information indicating a need for skilled nursing intervention. The administration of medication needed twice a day could be done by the mother before she goes to work and when she returns home.

31. In reviewing the evidence and testimony, as well as the authorities cited above, Petitioner does not meet Medicaid's definition for being medically fragile or medically complex. Additionally, there is no documented need for skilled nursing intervention which is necessary for PPEC services to be medically necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

FINAL ORDER (Cont.)

16F-05778

PAGE - 9

DONE and ORDERED this 12 day of December , 2016,
in Tallahassee, Florida.



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

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

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

FILED

Nov 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05779
16F-05780

PETITIONER,

Vs.

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

And

MAGELLAN COMPLETE CARE,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 21, 2016 at 1:30 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent AHCA: No one appeared

STATEMENT OF ISSUE

At issue is whether the respondent Magellan's denial of the petitioner's request for dental services (fillings and antibiotic medication) was correct. The petitioner has the burden of proving his 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 Michelle Rigler, Compliance Officer, and Samantha Lorenzo, Appeals Manager, from Magellan Complete Care, which is the petitioner's managed health care plan. Magellan was included as an additional respondent in this proceeding since it is the petitioner's health plan. Also present as a witness for the respondent was Omeisha Smith, Complaints and Grievances Specialist, from DentaQuest, which reviews dental claims on behalf of Magellan.

The respondent, Magellan, submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Hearing Summary, Authorization Requests, Denial Notices, and Dental Policy/Plan Provisions.

FINDINGS OF FACT

1. The petitioner is a forty-five (45) 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 from Magellan, which utilizes DentaQuest for review of requests for dental services.
2. On or about July 15 and July 18, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Magellan to perform various dental services, including surgical tooth extractions, deep cleaning, dental fillings, and medication related to those services. On or about July 19

and July 20, 2016, Magellan partially denied this request. Magellan approved the deep cleaning and surgical extractions, but denied the other services (fillings and medication) as being non-covered services or benefits.

3. The petitioner stated he had not had any dental treatment in 10 years and needed various dental services. He stated Magellan approved the deep cleaning but denied the dental fillings and antibiotic medication (and associated irrigation). He believes the Magellan plan allows him a benefit of up to \$1500 to use for any required dental services.

4. Ms. Smith from DentaQuest stated that dental fillings and antibiotic medication/irrigation are not covered services under Magellan's dental plan provisions. She also stated the \$1,500 provision in the plan is for use only on covered services.

5. Dental services under the Medicaid State Plan in Florida are provided in accordance with the respondent AHCA's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

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. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

11. 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.

12. The petitioner's requests for the dental fillings and medication/irrigation were not denied due to any medical necessity considerations, but because those services are non-covered services or benefits according to the Magellan dental plan provisions.

13. The Florida Medicaid Program provides limited dental services for adults. The AHCA Dental Policy specifies that these services include periodic oral evaluations, radiographs, dentures, and some tooth extractions.

14. Managed care plans, such as Magellan, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Handbook.

15. After considering the evidence and testimony presented, the undersigned concludes that the petitioner has not demonstrated that the requested services should have been approved by Magellan. Dental fillings and medication/irrigation are non-covered services for adults under the Medicaid guidelines referenced above and under the Magellan dental plan provisions. Therefore, the hearing officer cannot make a determination that these services must be covered by the petitioner's plan. In addition, the provision in the Magellan plan concerning the \$1,500 benefit stipulates these funds must be expended on covered benefits 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.

DONE and ORDERED this 03 day of November, 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
MAGELLAN HEARINGS UNIT

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

FILED

Nov 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05846

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 [REDACTED]

CO-RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on September 27, 2016 at 9:01 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Mother

For the Respondent: Lisa Sanchez,
Medical/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny her request for dental procedure D7230-removal of impacted tooth-partially impacted (tooth extraction) for wisdom teeth 1, 16, 17, 32 and request for procedure D9223-deep sedation/general anesthesia for each tooth extraction. Because the issue under appeal involves a request for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Mindy Aikman, Grievance and Appeals Specialist, appeared as Respondent's witness from Petitioner's managed care plan Humana. Dr. Frank Manteiga, Dental Consultant, and Jackelyn Salcedo, Complaints and Grievance Specialist, appeared as Respondent's witnesses from DentaQuest.

Respondent's Exhibit 1 was entered into evidence.

FINDINGS OF FACTS

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

1. Petitioner is a sixteen year-old Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider.
2. Humana requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for procedure D7230-removal of impacted tooth-partially impacted (tooth extraction) for wisdom teeth 1, 16, 17 and 32 and requests for procedure D9223-deep sedation/general anesthesia for each tooth extraction. DentaQuest received the request on July 26, 2016.
4. DentaQuest made its determination on July 26, 2016, denying procedures D7230 and D9223. Notice was sent to Petitioner providing the denial reason for procedure D7230 for each wisdom tooth "there is no sign of infection or other medical reason for tooth removal." Because the extractions were not approved, the four sedation requests, procedure D9223, were also denied.
5. Petitioner filed a timely fair hearing request on August 1, 2016.

6. Petitioner is experiencing discomfort from two of her wisdom teeth. Petitioner's mother explained Petitioner's dentist recommended extraction because her wisdom teeth could lead to infection. Petitioner is currently taking ibuprofen to relieve her pain.

7. Respondent's dentist explained Petitioner's x-rays do not show any infection or pathology for any of her wisdom teeth. Therefore, there is no current medical need for them to be extracted.

CONCLUSIONS OF LAW

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

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

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

11. Sections 409.971 – 409.973, Florida Statutes, establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

12. Section 409.912, Florida Statutes, provides the Agency may mandate prior authorization for Medicaid services.

13. Fla. Admin. Code R. 59G-1.010 (226) defines “prior authorization” as follows:

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

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

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

....

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

15. The May 2016 Florida Medicaid Dental Services Coverage Policy (Policy) has been promulgated into rule by Fla. Admin. Code R. 59G-4.060, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593> .

16. Pages 4 and 5 of the Policy explains the Early and Periodic Screening, Diagnosis, and Treatment requirements:

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

17. Petitioner's dentist submitted a request to extract her wisdom teeth because they could lead to infection.

18. Respondent explained x-rays of Petitioner's wisdom teeth do not show any of them having infection or pathology that would support the medical necessity to have them extracted. Full weight is being given to the medical expert's analysis. The above authority makes clear Medicaid services must be consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.

19. Considering the totality of the documentary evidence and testimony, as well as the above cited definitions of medical necessity and EPSDT requirements, the

undersigned finds the Respondent correctly determined extraction of Petitioner's wisdom teeth is not medically necessary at this time.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 01 day of November , 2016,

in Tallahassee, Florida.



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

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

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

FILED

Nov 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05848

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]

CO-RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in this matter on September 28, 2016 at 8:43 a.m.

APPEARANCES

For the Petitioner: Pro se.

For the Respondent: Lisa Sanchez,
Medical/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through Molina Healthcare of Florida (Molina), to deny her request for blood work to be performed by an out-of-network provider. Because the issue under appeal involves a request for a service, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Appearing as witnesses for Respondent were Bonnie Blitz, Nurse Director; Anthony Perez, Manager for Healthcare Services; Elaine Calano, Healthcare Supervisor; Alice Quiros, Associate Vice-President for Government Contracts; and Carlos Galvez, Government Contracts Specialist, all from Petitioner's managed care plan, Molina.

Respondent's composite Exhibit 1 was entered into evidence. Petitioner's Exhibit 1 and 2 were entered into evidence.

In July 2016, Petitioner submitted three prior authorization requests to Molina for blood work to be performed by [REDACTED] Laboratory, an out-of-network laboratory. Molina has contracted with Quest Diagnostics to perform its laboratory services. Petitioner changed her managed care plan to Staywell effective August 1, 2016. Molina's Notice of Action was sent to the Petitioner on August 3, 2016 denying her request for the out-of-network laboratory.

If Petitioner's appeal is granted, she is requesting Molina cover the costs of blood work that she wants performed at [REDACTED] Laboratory due to Molina's delay in processing the prior authorization request. The matter at issue is Molina's denial of [REDACTED] Laboratory, an out-of-network provider, to perform the requested blood work.

Petitioner sent an email to the undersigned on October 5, 2016 with new information. This exparte communication was forwarded to the Respondents on October 7, 2016. Because the record was not held open for additional evidence, this information was not used in the final decision.

FINDINGS OF FACTS

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

1. Petitioner is a 25 year-old Medicaid recipient enrolled with Molina, a Florida Health Managed Care provider. She has been tentatively diagnosed with [REDACTED].

The diagnosis is based on her general symptoms: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED].

2. On July 26, 2016, Petitioner's primary care physician submitted a third prior authorization request for blood work procedures: 83516, 83520, 86332, 86352, 86353, 86356, 86359, 88112, 88184, 88185, 88230, and 88346. The prior authorization requested [REDACTED] provide the service. No explanation was submitted with the request to explain why a non-participating (out-of-network) laboratory was being requested.

3. Molina sent a Notice of Action to the Petitioner on August 3, 2016. In relevant part, Molina provided the following explanation for the denial:

The asked for non-participating facility is not approved. Using standard and accepted rules a Molina Healthcare doctor has looked at this request. There are participating facilities within the Molina Network that can treat your condition. Please call member services if you need the names of participating facilities in your area. Please talk to your provider about your healthcare options.

4. Petitioner filed a request for a fair hearing on August 2, 2016.

5. Petitioner expressed frustration with Molina's response to her follow-up queries on three prior authorizations submitted for blood work. She provided documentation of her faxes along with a chronology of her telephone calls to Molina. The undersigned advised dissatisfaction with Molina was not an issue to be addressed at the hearing but should be discussed among AHCA, Molina representatives, and herself at another time.

6. Petitioner insists only [REDACTED] Laboratory can perform the necessary blood work and tell her if she has [REDACTED]. To support her assertion, she provided a copy of a fibromyalgia test query she performed from Quest Diagnostics' website which showed no such test.

7. Petitioner retained her primary care physician (PCP) when she switched to Staywell managed care plan effective August 1, 2016. Since switching plans, she has not pursued the blood work services because she has been waiting for the results of the hearing. She expects her appeal to be granted. She wants Molina to pay for the blood work because of the delays she feels Molina took in processing her prior authorization requests.

8. Molina explained that there is no single test for [REDACTED] and that is why multiple blood work tests/analysis need to be done. Molina also explained that her PCP is responsible for interpreting the results of the blood work, not a laboratory. Molina asserted Quest Diagnostics does the blood work requested and that is the reason the request for an out-of-network provider was denied. Molina explained that delays in processing the prior authorization requests were due to lack of information submitted with the requests and Molina's attempts to get the missing information from Petitioner's PCP.

9. It was Petitioner's understanding the prior authorization requests were for the out-of-network provider. While the medical necessity for the blood work is not in dispute, the PCP failed to submit any documentation or justification for requesting a non-participating (out-of-network) laboratory.

CONCLUSIONS OF LAW

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

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

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

13. Florida Statutes 409.971 – 409.973 establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Laboratory services are one of the mandatory services that must be provided.

14. Section 409.912, Florida Statutes, also provides that the Agency may mandate prior authorization for Medicaid services.

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

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

of the delivery of the care, goods, or services.

16. Fla. Admin. Code R. 59G-1.010 (166) provides:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
-

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. The Florida Medicaid Laboratory Coverage Policy- June 2016 (Policy), incorporated by reference in Chapter 59G-4.190, Fla. Admin. Code, sets policies and standards for laboratory services and describes the program on page 1: “Florida Medicaid laboratory services provide clinical testing of bodily fluids, tissues, or other substances.”

18. On page 1, Section 1.1.2 of the Policy, it provides the following:

This Florida Medicaid policy provides the minimum service requirements for all providers of laboratory services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply

with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

19. The Florida Medicaid Provider General Handbook, July 2012, is promulgated in Rule 59G-5.020, Florida Administrative Code, and provides on page 3-10:

Managed Care Coverage

Medicaid reimbursement is restricted when a Medicaid recipient is enrolled in a managed care program. A provider must verify if the recipient is enrolled in a managed care program prior to delivering services.

For certain managed care plans such as HMOs and PSNs, the provider must receive authorization for the services that are included in the plan and bill the plan directly.

20. The medical necessity for the blood work to aid in diagnosing Petitioner is not in dispute.

21. Petitioner asserts Respondent's contracted laboratory, Quest Diagnostics, cannot do the blood work. Her assertion is not supported by any credible documentation. Moreover, Respondent rebutted that the blood work can be done at Quest Diagnostics.

22. On his prior authorization request, Petitioner's physician provided no documentation or justification for requesting an out-of-network laboratory.

23. After carefully reviewing the findings of fact and the cited authorities, the undersigned finds Petitioner has failed to prove by a preponderance of evidence that an in-net cannot provide the blood work services requested.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Agency for Health Care Administration acted correctly in denying Petitioner's request for an out-of-network laboratory to perform the requested blood work.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 01 day of November , 2016,

in Tallahassee, Florida.



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

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

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

FILED

Nov 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05850

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on September 28, 2016 at 10:05 a.m. and reconvened on October 26, 2016 at 10:41 a.m.

APPEARANCES

For the petitioner: [REDACTED],
Daughter

For the respondent: Lisa Sanchez,
Medical/Healthcare Program Analyst
Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is AHCA's action, through the Sunshine Health Long-Term Care plan, to deny petitioner's request for an additional 33 packets of wipes per month (33 packets x 48 wipes per packet = 1,584 wipes). Because the matter at issue involves a request for an increase in services, petitioner carries the burden of proof.

PRELIMINARY STATEMENT

Appearing as respondent's witnesses from petitioner's Long-Term Care (LTC) plan, Sunshine Health, on September 28, 2016 were: Dr. Heather Lutz, Medical Director; Joerosa David, Manager for Grievance and Appeals; Angie Milord, LTC Coordinator; Tammy Swan, Director for LTC; Missy Kimsey-Hickman, Case Manager Supervisor; Paula Daley, Appeals and Grievance Coordinator II; Kimberly Bouchette, Clinical Appeals Coordinator; and Jennifer Guy, Vice President for External Relations.

Appearing as respondent's witnesses from petitioner's LTC plan, Sunshine Health, on October 26, 2016 were: Dr. John Carter, LTC Medical Director; Joerosa Davis, Manager for Grievance and Appeals; Kizzy Alleyne, Paralegal; Shonda Salisbury, Supervisor for LTC; Angie Milord, LTC Coordinator; Tammy Swan, Director for LTC; Missy Kimsey-Hickman, Case Manager Supervisor; Paula Daley, Appeals and Grievance Coordinator II; and Kimberly Bouchette, Clinical Appeals Coordinator.

Respondent's Exhibits 1 and 2 were entered into evidence. Petitioner's Exhibit 1 was entered into evidence.

FINDINGS OF FACT

1. Petitioner is an 83 year-old recipient of the Medicaid program. She enrolled with Sunshine Health LTC plan effective September 1, 2015. Petitioner is also covered by Medicare.

2. Petitioner is diagnosed with [REDACTED] disease and [REDACTED]. She has been prescribed [REDACTED] three times daily as a means to rid her liver of toxins.

3. On May 25, 2016, Sunshine Health received petitioner's request for thirty-three (33) additional packages of wipes per month for a total of thirty-six (36) packages per month.

4. On May 31, 2016, Sunshine Health sent the petitioner a Notice of Action denying her request for the additional packages of wipes as not medically necessary. In relevant part, the notice explains: "The member currently receives 3 packs of Wipes per month (each case contains 12 packages of wipes with 48 individual wipes in each package), which is adequate to meet the member's present care needs."

5. Based on Sunshine's Notice of Action, petitioner was approved a total of 1,728 individual wipes ($3 \times 12 \times 48 = 1,728$). This amount of approved wipes was repeated in Sunshine Health's August 17, 2016 Medicaid Fair Hearing Summary.

6. Petitioner filed a timely request for a fair hearing on August 2, 2016.

7. Petitioner's daughter explained petitioner is receiving three (3) packets monthly containing forty-eight (48) wipes for a total of 144 (3×48) individual wipes. Petitioner's daughter could not understand why her mother was receiving 144 individual wipes, when the notices sent by Sunshine Health stated she was approved for 1,728. Her request for an additional 33 packages was submitted in order to receive the 1,728 wipes she understood were approved.

8. Petitioner's daughter explained her mother has up to four bowel movements daily. The daughter normally uses six (6) wipes per incident. For the biggest clean ups, she uses forty-eight (48) wipes.

9. Respondent explained that using different terms (packs, packages, packets, cases) to explain the number of wipes approved has contributed to confusion on the amount of wipes Sunshine Health has approved. Petitioner was approved for 144 wipes per month. This is what petitioner has been receiving.

10. Sunshine Health's medical director stated that his medical specialty is internal medicine and geriatric medical care. He has extensive experience with patients with urinary and bowel incontinence.

11. The medical director explained that wipes are a supplement to keep a patient clean. Wash clothes and toilet paper are the primary cleaning supplies.

12. The medical director noted that 144 wipes per month averages to 5 wipes per day. After re-reviewing the petitioner's needs, he approved 624 wipes per month, for an average daily use of 20 wipes. He opined this was more than an adequate supply of wipes.

13. Petitioner's daughter insisted she needs 1,728 wipes per month because the wipes are very thin and multiple wipes are needed for each cleaning.

CONCLUSIONS OF LAW

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

15. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code § 65-2.056.

16. 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).

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

18. Fla. Admin. Code 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

19. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook July 2010 (DME Handbook) is promulgated into Rule 59G-4.070, Florida Administrative Code.

20. On page 1-2 of the Handbook, the following definition of medical supplies is provided: “Medical supplies are defined as **medically-necessary** medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient’s home [emphasis added].”

21. The Florida Medicaid Home Health Services Coverage and Limitations Handbook October 2014 (HH Handbook) is promulgated into Rule 59G-4.130, Florida Administrative Code.

22. On Page 2-12 of the HH Handbook, it describes covered services for adults as follows: Medicaid reimburses the following services provided to eligible recipients age 21 and older: • Licensed nurse and home health aide visits, • Limited durable medical equipment and **supplies** [emphasis added], • Limited therapy evaluations.

23. The Florida Medicaid Provider General Handbook (Provider General) July 2012 is promulgated into Rule 59G-5.020, Florida Administrative Code. The Provider General 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.

24. Page 1-28 of the Provider General Handbook provides a list of HMO covered services. These services include medical supplies.

25. Petitioner's daughter asserts she needs 1,728 individual wipes each month to keep her mother clean. She states her mother has four (4) bowel movements (BM) each day. She usually uses six (6) wipes for each BM.

26. Respondent has determined that 634 individual wipes are medically necessary for the petitioner. With 31 days per month used, this allocation equates to 20 wipes per day. For petitioner's four BMs, this would equate to an average of 5 wipes allocated per incident. Because four (4) months have 30 days, this allows for 20 'allocated' wipes for each of these months, or a total of 80 'allocated' wipes, to be available for those incidents requiring more than five (5) wipes.

27. Respondent emphasized wipes are a supplement to cleaning the petitioner, after using a wash cloth, paper towels, and other cleaning aids. Full weight is being given to the medical expert's analysis. The above authority makes it clear Medicaid services cannot be in excess of the patient's needs and must be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.

28. After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer concludes the petitioner has not met her burden of proof. The 624 wipes per month approved by Molina appears sufficient, in addition to

the use of wash clothes, towels, to meet petitioner's needs. Petitioner's request for 1,728 wipes per month appears excessive and not medically necessary.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 07 day of November, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Nov 18, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05863

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 01 [REDACTED]
UNIT:

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 10, 2016 at 11:10 a.m. in Pensacola, Florida.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Carlos Galvez, Government Contract Specialist,
Molina HealthCare of Florida

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of July 15, 2016 denying the petitioner's request for a transcutaneous electrical nerve stimulation (tens) device. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

[REDACTED] husband of the petitioner, was present as a witness for the petitioner.

Marian Pulk, Provider Services Representative, Molina Healthcare, was present as custodian of the record. Present as witnesses for Molina Healthcare of Florida (Molina) were Alice Quiros, AVP of Government Contracts; Valerie Maguire, Medical Director; Bonnie Blitz, Director of Healthcare Services; Natalie Fernandez, Government Contract Specialist; and Elaine Calana, Supervisor of Healthcare Services.

Diane Soderlind, Registered Nurse Specialist, Agency for Health Care Administration, was present as an observer with no objections.

Molina submitted evidence prior to the hearing, which was entered as Respondent's Exhibit 1. Molina submitted additional evidence on the morning of the hearing. The additional evidence was supplied to the petitioner at the hearing. The additional evidence was entered as Respondent's Exhibit 2.

The original hearing request was due to denial of epidural injections. However, the respondent reversed the decision on epidural injections on October 4, 2016. The undersigned did not review the matter regarding epidural injections in the course of this hearing due to the reversed decision resolving the issue.

The record closed on October 10, 2016.

FINDINGS OF FACT

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

2. The petitioner began coverage with Molina on November 1, 2015.

3. The petitioner's physician requested a transcutaneous electrical nerve stimulation (tens) device July 11, 2016.
4. The respondent denied the request for the tens device on July 12, 2016.
5. The respondent issued a Notice of Action on July 15, 2016 informing the petitioner the tens device request was denied, as the requested service is not a covered benefit.
6. On July 27, 2016 the respondent received a verbal appeal from the petitioner for the denial of the tens device.
7. The petitioner explained her sciatic nerve causes her constant pain in her low back and radiating down both legs to the knee. She further explained she often loses feeling from her waist to the foot when the nerve pain is severe.
8. The petitioner believes she requires the tens device as the nerve needs constant stimulation so that she can retain feeling in her leg and foot.
9. The petitioner expressed she feels "drugged up" when the only treatment offered right now is pain medications. The pain medications do "take the edge off the pain" but do not resolve the problems.
10. The petitioner advised she has multiple emergency room visits each month due to the sciatic nerve flare-ups.
11. The petitioner and her husband advised this painful condition is causing them problems in their marriage, as well as the husband's ability to work.
12. The respondent reported a tens unit is not a covered benefit as it is not listed on the fee schedule for Medicaid covered services.

13. Dr. Maguire explained that the medical necessity of a service is not reviewed when the service, or in the instant case device, is not covered by Medicaid.

14. The respondent explained the fee schedule for covered services and benefits is developed by the Agency for Health Care Administration (AHCA).

CONCLUSIONS OF LAW

15. 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.

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

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

18. 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). The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

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

20. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

21. Fla. Admin. Code R. 59G-1.010 (226) defines Prior Authorization as “the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for

its affiliated providers to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.”

22. Fla. Admin. Code R. 59G-4.070 “Durable Medical Equipment” states:

(1) This rule applies to all durable medical equipment and supply providers enrolled in the Medicaid program.

(2) All durable medical equipment and medical supply providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook, July 2010, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent’s Web Portal at <http://my-medicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Paper copies of the handbooks may be obtained by calling the Provider Contact Center at 1(800) 289-7799 and selecting Option 7.

(3) Medicaid durable medical equipment and medical supply providers are required to use the following form, which is incorporated by reference: the Custom Wheelchair Evaluation form, AHCA-Med Serv Form, 015, July 2007, five pages. This form is available from the Medicaid fiscal agent’s Web Portal at <http://my-medicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Forms. The form may also be photocopied from Appendix A in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

23. The July 2010 Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (“DME Handbook”) is promulgated into law by Chapter 59G of the Florida Administrative Code.

24. Page 1-2 of the DME Handbook defines Durable Medical Equipment (DME) as “medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient’s home as determined by the Agency for Health Care Administration (AHCA).”

25. Fla. Admin. Code R. 59G-1.010 (116) provides:

(166) “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

(emphasis added)

26. The findings show the petitioner is requesting a tens device. The undersigned concludes as a tens device can be used multiple times and would serve a medical purpose, a tens device would be considered durable medical equipment.

27. The undersigned reviewed the Medicaid Durable Medical Equipment and Medical Supply Services Provider Fee Schedule for All Medicaid Recipients effective January 1, 2016. The undersigned could find no listing for a transcutaneous electrical nerve stimulation (tens) device included in the fee schedule. In accordance with the above controlling authority, the undersigned concludes that a tens device is not a covered item under DME.

28. The findings show the respondent’s report that when an item is not on the fee schedule, the question of medical necessity is not reviewed. The undersigned reviewed the controlling authority regarding medical necessity and concludes although the tens unit was prescribed by a physician, that alone does not mean the device is medically necessary. In addition, the prescribing of the unit alone also does not make a tens device a covered service. The undersigned concludes the respondent correctly denied the request.

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 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 November, 2016,

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
AHCA, Medicaid Fair Hearings Unit
Molina Hearings Unit

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

FILED

Nov 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05890

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 8, 2016 at 9:45 a.m.

APPEARANCES

For the petitioner: [REDACTED], pro se

For the respondent: Susan Martin, ACCESS Operations & Management
Consultant I

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any exhibits. The respondent submitted four exhibits, entered as Respondent's Exhibits "1" through "4". The record was held open

until close of business on September 15, 2016 for submission of additional evidence from the parties. On September 15, 2016, additional evidence was received from the petitioner, which was entered as Petitioner's Exhibit "1". No additional evidence was submitted by the respondent. The record closed on September 15, 2016. On October 3, 2016, additional documents were received from the petitioner. The undersigned reviewed the documents and determined these were relevant to the issue. Therefore, the undersigned reopened the record and entered this evidence as Petitioner's Exhibit "2". The record closed on October 3, 2016.

FINDINGS OF FACT

1. The petitioner (52) filed an application for Medicaid disability on May 25, 2016. The petitioner reported on her application that she was disabled. The petitioner is not age 65 or older and does not have any minor children.

2. The petitioner's disabling conditions include: [REDACTED]

[REDACTED]
[REDACTED] In 2007, the petitioner had surgery on her [REDACTED].

3. The petitioner received Social Security Disability Income (SSDI) through the Social Security Administration (SSA) in 2007. On or about 2008 through 2009, the petitioner's SSDI ended when she returned to work at her previous employer, [REDACTED] County Public Schools. The petitioner is now retired and currently receives a state retirement pension.

4. The petitioner applied for disability with SSA on February 2, 2015. The petitioner reported all of her disabling conditions to SSA. The petitioner was denied disability benefits through SSA on June 25, 2015 with a denial code N-42. Code N-42 means

“Non-pay-Capacity for substantial gainful activity-other work, [REDACTED]”. On July 28, 2015, the petitioner filed a reconsideration with SSA. On September 18, 2015, SSA denied the reconsideration for the same disabling conditions.

5. The Division of Disability Determination (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The petitioner’s application was referred to DDD on June 23, 2016.

6. DDD did not conduct an independent review; instead, it denied the petitioner’s disability claim by adopting the SSA denial decision (June 25, 2015). DDD has access to SSA information. The Disability Determination and Transmittal returned from DDD lists the petitioner’s primary diagnosis as [REDACTED] and her secondary diagnosis as [REDACTED]

7. On August 3, 2016, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application; due to not meeting the disability requirement.

8. The petitioner explained she was declared disabled by SSA back in 2007 for the same disabling conditions. Additionally, she needs to see a doctor as she doesn’t feel any sensation on her feet due to her [REDACTED].

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 42 C.F.R. § 435.541 addresses determinations of disability and states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations.

(1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) **An SSA disability determination is binding on an agency until the determination is changed by SSA.** [emphasis added]

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) **The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.** [emphasis added]

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

...

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

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

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

13. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid disability application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner reported all her disabling conditions to SSA. SSA denied the petitioner's disability claim on June 25, 2015 because it determined she was not disabled under its rules.

14. The petitioner argued back in 2007, she received SSA benefits due to her hand injury. She explained that she needs to see a doctor. On July 28, 2015, SSA reconsidered the petitioner's disability claim and determined the June 25, 2015 denial was correct. No further appeal was sought by the petitioner.

15. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from June 25, 2015 and denying the petitioner's Adult-Related (SSI) Medicaid application.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 01 day of November, 2016,

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

FILED

Nov 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

██████████
██████████
██████████

APPEAL NO. 16F-05962

PETITIONER,

Vs.

CASE NO. ██████████

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 ██████████
UNIT: ██████████

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 27, 2016 at 1:05 p.m. in ██████████, Florida.

APPEARANCES

For Petitioner: ██████████, pro se

For Respondent: Jonathan Daniels, 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 is correct. The burden of proof is assigned to the respondent by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner presented one witness who testified: [REDACTED], the petitioner's friend. Petitioner submitted one exhibit, which was accepted into evidence and marked as Petitioner's Exhibit "1".

Respondent was represented by Jonathan Daniels with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Mr. Daniels testified. Respondent submitted eight exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "8".

One continuance was granted for the petitioner.

FINDINGS OF FACT

1. Petitioner received SSI-Related Medicaid benefits from the respondent for the period of May 1, 2015 through August 31, 2016. The Department of Health Division of Disability Determination (hereafter "DDD") determined the petitioner disabled effective May 2015.
2. On September 8, 2015, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On November 3, 2015, SSA denied the petitioner's SSI application using the code N35. N35 means "Non-pay-Impairment is severe at the time of adjudication but not expected to last twelve months, no visual impairment". In March 2016, SSA denied the petitioner's request for reconsideration of his SSI denial. On May 4, 2016, the petitioner appealed the denial of his SSI application and that appeal is currently pending.

3. On June 27, 2016, the petitioner submitted a redetermination application for SSI-Related Medicaid benefits. The application listed the petitioner as claiming to be disabled; and applying for Social Security benefits on September 9, 2015.
4. On July 25, 2016, the respondent submitted both the Disability Determination and Transmittal form (Respondent's Exhibit 4) and a packet of medical information to DDD to re-determine if the petitioner met the criteria to be considered disabled.
5. On July 29, 2016, DDD determined the petitioner not disabled using the denial code N31. N31 means "Non-pay-Capacity for substantial gainful activity-customary past work, no visual impairment". The Disability Determination and Transmittal form had "Hankerson 3/16. Same allegations, hearing pending" handwritten on it. The document also listed the petitioner's age as 55 years old.
6. On July 29, 2016, the respondent terminated the petitioner's Medicaid benefits as DDD determined him not to be disabled.
7. On August 1, 2016, the respondent mailed the petitioner a Notice of Case Action indicating his Medicaid benefits would end effective August 31, 2016 as, "No household members are eligible for this program".
8. Petitioner did not agree with the respondent's determination that he was not eligible for full Medicaid benefits as he has a medical condition that require medications, physician visits, and various tests. Petitioner explained he cannot afford to pay for all of his medical expenses and requires Medicaid to pay for them.
9. Respondent determined the petitioner's SSI-Related Medicaid benefits had to be terminated because the respondent had to adopt the SSA's denial of his September 8, 2015 SSI application.

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. 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.

14. 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.

15. 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.

16. Petitioner applied for SSI on September 8, 2015. SSA denied the petitioner's SSI application on November 3, 2015 pursuant to code N35. SSA also denied the petitioner's reconsideration of his SSI denial in March 2016. On May 4, 2016, the petitioner appealed the SSI denial with SSA. Petitioner submitted a redetermination application for Medicaid benefits with the respondent on June 27, 2016.

17. Respondent had determined the petitioner disabled effective May 2015, but terminated his Medicaid benefits effective August 31, 2016 as it adopted SSA's denial of the petitioner's SSI application.

18. The Department's 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 denial 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."

19. Petitioner has a pending appeal with SSA and his SSI application was denied while he was receiving SSI-Related Medicaid benefits; therefore, the petitioner is eligible to receive continued Medicaid benefits pending the outcome of his SSA appeal.

20. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent did not meet its burden of proof to indicate the petitioner's SSI-Related Medicaid benefits were correctly terminated effective August 31, 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is GRANTED. Respondent is ORDERED to approve the petitioner's SSI-Related Medicaid benefits effective September 1, 2016 until a decision is made on the petitioner's appeal with the Social Security Administration.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of November, 2016,

in Tallahassee, Florida.

Mary Jane Stafford

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

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

FILED

Nov 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06007

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:47 p.m. on October 26, 2016.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on September 23, 2016. Petitioner did not appear at the September 23, 2016 hearing, as he thought that

someone would call him, instead of him calling into the hearing. The hearing was rescheduled and convened on October 26, 2016.

Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". Petitioner did not receive the respondent's exhibits prior to the hearing and elected to continue with the hearing without the respondent's exhibits. The record was closed on October 26, 2016.

FINDINGS OF FACT

1. On April 22, 2016, the petitioner (age 60) submitted a web application for Food Assistance and SSI-Related Medicaid Disability for himself. Medicaid is the only issue.
2. Petitioner defined his disabilities as: [REDACTED]
[REDACTED]
[REDACTED]
3. To be eligible for SSI-Related Medicaid, the petitioner must be age 65 or older and/or considered blind/disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD determines Medicaid Disability for the Department.
4. The petitioner applied for disability through the SSA on May 9, 2016. The SSA denied the petitioner disability on August 11, 2016. Petitioner is appealing the SSA denial through an attorney; an appeal date has not been scheduled.
5. Petitioner does not have new or worsening medical conditions that the SSA is not aware of.

6. On May 27, 2016, the Department electronically sent DDD the petitioner's documentation for review. DDD adopted the SSA disability denial decision and also denied the petitioner Medicaid Disability on August 11, 2016.

7. On August 16, 2016, the Department mailed the petitioner a Notice of Case Action, notifying he was denied Medicaid, due to not meeting the disability requirements.

CONCLUSIONS OF LAW

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

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

10. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations of Disability, in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the

determination, except In cases specified in paragraph (c) (4) of this section.

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

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

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

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility...

11. The above authority explains that the SSA determination is binding on the Department.

12. In accordance with the above authority, the Department adopted the SSA disability denial decision and also denied the petitioner Medicaid Disability.

13. In careful review of the cited authority and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the Department's action to deny the petitioner Medicaid Disability is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of November, 2016,

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

Nov 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06042

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically reconvened an administrative hearing in the above-referenced matter at 1:00 p.m. on September 29, 2016.

APPEARANCES

For the Petitioner: [REDACTED], Authorized Representative (AR)
[REDACTED], Business Office Manager

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner retroactive Institutional Care Program (ICP) Medicaid benefits for February 2016, March 2016 and April 2016 is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing originally convened at 10:48 a.m. on September 23, 2016. The parties agreed to reconvene on September 29, 2016. Petitioner is deceased and was represented by her AR. Appearing as witnesses for the petitioner were, [REDACTED] (CH), Medicaid Specialist [REDACTED], and [REDACTED], Social Worker, Hospice of [REDACTED] and the [REDACTED]. CH was only present at the September 23, 2016 hearing.

Petitioner's AR did not submit exhibits. Respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record remained open through end of business day on September 29, 2016, for the petitioner's AR to submit an exhibit. The exhibit was received timely and entered as Petitioner Exhibit "1". The record was closed on September 29, 2016.

FINDINGS OF FACT

1. The petitioner (age 91) was admitted to [REDACTED] on October 7, 2015. Petitioner remained at [REDACTED] until her death on [REDACTED], 2016.
2. On May 24, 2016, the petitioner's AR submitted an ICP Medicaid application for retroactive months, February 2016, March 2016 and April 2016. The application does not list income or assets.
3. The Department did not require a Department interview for the May 24, 2016 application. The Department Running Record Comments, dated May 24, 2016, indicate that the petitioner receives \$1,232.90 from Social Security.

4. On May 25, 2016, the Department mailed the petitioner's representative a Notice of Case Action (NOCA), requesting documents to determine eligibility. The NOCA states in part:

We need the following information by June 06, 2016.
Please complete and sign the Affidavit Designated Representative Form.
The following information is needed for review: Client has a pooled trust for the disabled and never has been determined disabled by Social Security or the State of Florida, we will need medical packet with disabling condition, physician diagnosis and recent hospital discharge summary if any. Also, we remind that proof that an application for SSA disability has been placed for the client before any benefits can be approved. And also we will need bank statements for the last 3 months to current date (with bank name on all pages) for all banks accounts.

5. The respondent's representative claims that the Department did not receive the requested "certificate of disability" for the petitioner. And on June 24, 2016, the Department mailed the petitioner a NOCA, notifying the May 24, 2016 application was denied; due to not receiving all the information requested to determine eligibility.

6. Respondent's representative contends that the petitioner has a pool trust for the disabled. And due to the petitioner being over the age of 65, the Department's policy (1640.0576.08) requires verification that the petitioner is disabled.

7. CH, the petitioner's witness, alleges that in accordance with the Department's policy (she was unable to provide the policy number), the petitioner is not required to be disabled due to being over the age of 65. The record remained open for CH to provide said policy.

8. Respondent's representative responded that the age requirement to be eligible for ICP benefits is different from the disability requirement when an individual has a pool trust for the disabled.

9. Petitioner's AR did not dispute that a "certificate of disability" was not provided for the petitioner. Petitioner's AR asserts that the petitioner was on Hospice and that she provided the Department a "Certificate of Terminal Illness". Petitioner's AR opined that a "Certificate of Terminal Illness" proves the petitioner was disabled. The record remained open for the petitioner's AR to submit said certificate.

10. Respondent's representative maintains that a "Certificate of Terminal Illness" cannot be accepted as verification of disability.

11. After the hearing, the petitioner's AR submitted the Department's policy for ICP eligibility, not pool trust for the disabled requirement.

12. Also after the hearing, the petitioner's AR submitted: 1) Initial Physician Certification of Terminal Illness, dated December 20, 2015, showing "Effective Date of Certification 12/20/15 – 03/18/16" and 2) Second 90-Day Physician Recertification of Terminal Illness, dated February 24, 2016, showing "Effective Date of Certification 2/24/16 – 05/23/16".

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. 42 U.S. Code § 1396p addresses trusts for the disabled and states in part:

(d)(4)(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter...

16. The above authority explains trusts for the disabled are established for the benefit of the individual who is disabled.

17. 42 U.S. Code § 1382c defines aged, blind and disabled:

(a)(1) For purposes of this subchapter, the term "aged, blind, or disabled individual" means an individual who—

(A) is 65 years of age or older, is blind (as determined under paragraph (2)), or is disabled (as determined under paragraph (3))...

(3)(A) Except as provided in subparagraph (C), an individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in 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 twelve months...

(C)(i) An individual under the age of 18 shall be considered disabled for the purposes of this subchapter...

18. The evidence submitted establishes that the Department requested verification that the petitioner has been determined disabled. The respondent's representative referred to the verification as a "certificate of disability".

19. The petitioner's AR did not dispute that a "certificate of disability" was not provided.

The petitioner's AR argued that she provided a "Certificate of Terminal Illness" from Hospice, which she believes proves the petitioner is disabled.

20. The respondent's representative argued that the "Certificate of Terminal Illness" does not replace a "certificate of disability" in accordance with the Department's policy 1640.0576.08.

21. The Department's Program Policy Manual, CFOP 165-22, passage 1640.0576.08, Exceptions for Trusts Set Up 10/1/93 or Later (MSSI, SFP) states in part:

Trusts for the disabled under 65: A trust containing the assets of a disabled individual under age 65, if:

1. it was established on or after 10/01/93; and
2. it was established for the benefit of the individual by a parent, grandparent, legal guardian or a court (cannot be established by the disabled individual himself, must be by parent, grandparent, legal guardian or court order); and
3. 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 behalf of the individual.

Pooled trusts for the disabled: A trust containing the assets of an individual who is disabled, if:

1. it was established on or after 10/01/93;
2. the trust is established and managed by a nonprofit association;
3. a separate account is maintained for the beneficiary of the trust but, for purposes of investment and management, the trust pools the accounts;
4. the trust is established solely for the disabled individual by a parent, grandparent, legal guardian, court or the individual himself; and
5. to the extent that amounts remaining in the trust upon the individual's death are not retained by the trust, the trust pays to the state an amount equal to the total amount of medical assistance paid on behalf of the individual.

Both of the above special trusts can only be set up to benefit individuals who meet SSI disability criteria. Trusts for the disabled under 65 can be established only for individuals who are under 65. Pooled trusts for the disabled can be established for individuals of any age.

Disability must be determined for both of the above special trusts via regular policy; that is, the person must receive Social Security disability or

SSI benefits or the Department must make an independent determination to show that the individual meets the disability requirement.

22. The Department's policy explains, "...the person must receive Social Security disability or SSI benefits or the Department must make an independent determination to show that the individual meets the disability requirement."

23. The findings indicate that the petitioner did not receive Social Security disability or SSI benefits.

24. The Department's Transmittal NO. P00-08-0105, dated August 9, 2000, addresses District Medical Review Teams (DMRT) and in part states:

District Medical Review Teams handle disability determinations that are necessary for the Institutional Care, Optional State Supplementation, and some Home and Community Based Services Medicaid Waiver programs...

The DMRT must be capable of interpreting medical information and rendering a decision based on Social Security's definition of disability. Federal regulation (42 CFR 435.541 (f)) requires that a team must review the medical report and other non-medical evidence and determine on behalf of the department whether the individual's condition meets the definition of disability...

25. Federal Regulation at 42 C.F.R. § 435.541, Determinations of disability, in part states:

(e) Medical and nonmedical evidence. The agency must obtain a medical report and other nonmedical evidence for individuals applying for Medicaid on the basis of disability. The medical report and nonmedical evidence must include diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the SSI program specified in 20 CFR part 416, subpart I.

(f) Disability review teams—(1) Function. A review team must review the medical report and other evidence required under paragraph (e) of this section and determine on behalf of the agency whether the individual's condition meets the definition of disability...

26. The respondent's representative argued that the Department denied the petitioner's May 24, 2016 ICP Medicaid application due to not providing a "certificate of disability".

27. In careful review of the cited authorities and evidence, the undersigned concludes that in accordance with the Department's own policy "the Department must make an independent determination to show that the individual meets the disability requirement".

28. The case is remanded to the Department for corrective action. IT IS HEREBY ORDERED that the respondent make a disability determination on the petitioner and mail the petitioner's AR a NOCA with the results. This order does NOT guarantee that the petitioner will be eligible for retroactive ICP Medicaid benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted in that it is remanded to the respondent in accordance with the above 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 02 day of November, 2016,

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

Nov 14, 2016

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. 16F-06093

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter October 6th, 2016, at 8:32 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 respondent's action to enroll her in the Medically Needy (MN) program as opposed to authorizing full Medicaid. The petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal. The child's Medicaid coverage is not under appeal.

PRELIMINARY STATEMENT

The record was left open until the close of business, October 11th, 2016, to allow the petitioner and the respondent time to submit additional evidence. Both parties submitted evidence timely and the record was closed.

Appearing as a witness for the petitioner at the proceeding was her husband,

██████████.

Petitioner's exhibits 1 through 6 were admitted into evidence.

Respondent's exhibits 1 through 14 were admitted into evidence.

By way of a Notice of Case Action dated August 11th, 2016, the respondent informed the petitioner that her application for MN dated June 29th, 2016 was approved and she was enrolled with an estimated Share of Cost (SOC) of \$2,695 for June 2016 and \$1,575 for July 2016 through ongoing. On August 17th, 2016, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner applied for Family Medicaid on June 29th, 2016. As part of application process, the respondent is required to explore and verify all factors of eligibility, which include but are not limited to all sources of income and allowable expenses.

2. The petitioner's household includes herself, aged 32; her husband, aged 33, and one mutual child, aged 4 months.

3. The petitioner is applying for Medicaid for herself and the baby only.

4. The petitioner was employed at Bank of America until she went on maternity leave in May 2016. The petitioner received her final two checks on June 3rd, 2016, in

the gross amount of \$1,011.42 and June 17th, 2016, in the gross amount of \$108. The petitioner asserts that she had to pay both amounts back to Bank of America because they were issued to her in error. It is the petitioner's position that neither check should be counted in her eligibility determination. The respondent considered both of these amounts when determining eligibility. Both the petitioner and respondent provided proof of this income.

5. The petitioner's husband is self-employed. He and the petitioner are the sole owners of [REDACTED]. The petitioner asserts there were no profits from February 2016 through June 2016. Therefore, the petitioner was unable to provide any verification of the last four weeks of income as requested by the respondent. The petitioner did provide one check stub during the eligibility determination process. The check stub was dated July 22nd, 2016, in the gross amount of \$550.52. The respondent reviewed the check stub, surmised it was received on a weekly basis, and used the one pay stub as "best available information." The respondent then compared the income against the State Wages Information Collection Agency (SWICA) (the electronic data source by which the respondent receives gross income amounts reported by employers for the previous quarter's wages) and considered the SWICA amount of \$2,061.67 as monthly income when determining eligibility.

6. The petitioner provided evidence after the hearing that included a Profit and Loss statement for [REDACTED]. Between January 2016 and June 2016 the gross income before deductions was \$5,273.25. After deductions the business is operating at a loss.

7. The respondent considered \$2,061.67 in self-employment income for the petitioner's husband's income and \$1,119.42 for the petitioner's income for June to derive a total of \$3,181.09. From \$3,181.09 the respondent deducted the Medically Needy Income Limit (MNIL) of \$486 for a household of three for a total of \$2,695.09 and rounded down to \$2,695. This is the amount the respondent enrolled as the estimated SOC for June 2016. The respondent considered \$2,061.67 for the petitioner's husband's self-employment income for July and ongoing. From \$2,061.67 the respondent deducted the MNIL of \$486 for a total of \$1,575.67 rounded down to \$1,575. This is the amount the respondent enrolled as the estimated SOC for July 2016 and ongoing.

8. The petitioner's husband also owns a rental property located at [REDACTED]. [REDACTED] The petitioner provided evidence of the rental property cash flow, which includes a monthly breakdown of rental income and expenses as follows: The income from the rental property from January 2016 through June 2016 totals \$22,903 and the expenses (mortgage, water/garbage, gas, electricity, and maintenance, management, miscellaneous) total \$16,863.15. \$22,903 in income minus \$16,863.15 in expenses equals \$6,039.85 divided by 6 to derive a monthly amount of \$1,006.64. The respondent did not consider any of this income when determining eligibility but did provide proof of the rental property cash flow in its additional evidence.

9. The petitioner's husband has concerns for his wife's health if she is not approved for Medicaid. The petitioner's husband is also worried about penalties on his upcoming tax return for failing to have health insurance.

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

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

12. The Family-Related Medicaid income criteria set forth in 42 C.F.R. Section 435.603 states:

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.

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.

13. Federal regulation 42 C.F.R. Section 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid. It states:

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

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

...

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with Section 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.

14. In accordance with the above-cited authorities, the Medicaid assistance group is the petitioner, her husband, and their mutual child. The Findings of Fact show that the respondent determined the petitioner's eligibility with a household size of three even though the petitioner and the child were the only members applying. The hearing officer affirms the respondent's action.

15. The Department's Policy Manual Chapter 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.

16. The Department's Policy Manual Chapter 1830.0122 Verification of Income (MFAM) states:

To determine eligibility for Medicaid, verification of income will be performed by data exchange when available. An applicant's or recipient's self-attestation of income is accepted if the amount stated on the application or renewal is reasonably compatible with information obtained by the Department through electronic sources. Reasonably compatible means both self-attestation and electronic sources are below the applicable income standard or when the difference between both amounts

is ten percent (10%) or less without regard to the income standard. If the difference is more than 10%, first ask for a reasonable explanation and, if necessary, paper documentation from the individual. When income cannot be verified by data exchange, such as for individuals with no SSN or who have self-employment income, income must be verified by other acceptable means such as pay stubs, CF- ES 2620, etc.

17. The Department's Policy Manual Chapter 1830.0300 Self-Employment

(MFAM) states:

An individual who owns a business or otherwise engages in a private enterprise is considered self-employed. Income derived from self-employment is considered earned income.

This includes but is not limited to:

1. childcare;
2. sales from a franchise company;
3. picking up and selling cans;
4. farming and fishing self-employment;
5. selling newspapers;
6. income from an S corporation (The income, losses deductions, or credits are based on a partnership agreement and passed on to shareholders based on a pro rata share.); or
7. income from rental property.

18. The Department's Policy Manual Chapter Costs of Self-Employment

Income (MFAM) states:

Net earned income from self-employment is the total gross income derived from all trades and businesses as computed under the Internal Revenue Code, less deductions allowable under the Code, attributable to such trades or businesses. It includes the individual's share of ordinary net income (or loss) from partnerships even though the partnership profits have not been distributed yet. The assistance group is required to keep a record of business expenses incurred. Allowable costs of producing self-employment income include, but are not limited to, the following expenses:

1. identifiable costs of labor (salaries, employer's share of Social Security, group medical insurance, employee reimbursements, etc.);
2. stock, raw materials, seed and fertilizer, and feed for livestock;

3. rent and cost of normal building maintenance;
4. business telephone costs and utility expenses;
5. costs of operating a motor vehicle when required in connection with the operation of the business;
6. interest paid on debts related to the business property;
7. insurance premiums related to the business;
8. depreciation costs for owned property used in business or held to produce income;
9. travel meals, lodging and entertainment expenses away from home;
10. legal and professional fees; or
11. pension plans.

19. The Department's Policy Manual Chapter 1830.0316 Rental Income (MFAM) states:

Rental income is any payment for using real estate or personal property less allowable expenses.

Examples of rental income include payments for the use of:

1. land;
2. buildings;
3. an apartment, room, or house; or
4. machinery or equipment.

Income received from the rental of real estate is considered earned income from self-employment.

20. As stated in the Findings of Fact, the respondent considered the petitioner's income from Bank of America and the petitioner's husband's self-employment income from [REDACTED]. However, as stated in the above-cited authorities, all self-employment income should be counted. This includes income from the rental property in Chicago.

21. The Department's Policy Manual Chapter 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).

22. The Department's Policy Manual Chapter 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.

23. The hearing officer utilized the self-employment figures as follows: In regards to [REDACTED] \$5,273.25 in gross income was used and all deductions were allowed except the deduction labeled "Uncategorized Expense" with a total amount of \$39. The income reviewed from [REDACTED] began

in January 2016 and continued through June 2016. The resulting total was a negative number, so after all allowable deductions \$0 was used in reviewing eligibility. In regards to the rental property in Chicago, the cash flow statement provided by both the petitioner and the respondent was utilized. The findings show that after deductions, the petitioner receives \$1,006.64 in monthly profit from the rental property. This is the amount the hearing officer considered when reviewing eligibility. The petitioner's two checks received in June 2016 from Bank of America were used in reviewing eligibility for that month only but not used for July 2016 and ongoing.

24. The hearing officer reviewed the petitioner's Medicaid eligibility using the guidelines set forth in the above-cited authorities. Step 1: The total income for June 2016 is \$0 [REDACTED], \$1,006.64 (rental property in Chicago), and \$1,119.42 (Bank of America) to derive a sum of \$2,126.06. The total income for July 2016 and ongoing is \$0 [REDACTED] and \$1,006.64 (rental property in Chicago) to derive a sum of \$1,006.64. Step 2: There were no deductions reported. Step 3: The MNIL of \$486 for a household of three which includes a standard deduction of \$183 is deducted from \$2,126.06 for a total of \$1,640.06 rounded down to \$1,640 for June 2016. The MNIL of \$486 is deducted from \$1,006.64 for a total of \$520.64 rounded down to \$520 for July 2016 and ongoing. Step 4: The total countable net income of \$1,640 for June 2016 and \$520 for July 2016 and ongoing is more than the income limit for an adult in a household of three which is \$303 as found in the Department's policy manual Appendix A-7 (see Respondent's Exhibit 5 page 35). Step 5: Applying the 5% Modified Adjusted Gross Income (MAGI) deduction does not make the petitioner Medicaid eligible. Therefore, the MAGI cannot be applied. The hearing

officer determined a SOC amount of \$1,640 for June 2016 and \$520 for July and ongoing is appropriate.

25. In review of the evidence presented and the applicable regulations and guidelines, the hearing officer does not affirm the SOC amount authorized by the respondent. Therefore, the appeal is hereby denied in that the hearing officer concludes that the petitioner is ineligible for full Medicaid benefits, but granted in that the hearing officer concludes that the petitioner is eligible for a lower share of cost than determined by the respondent.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is granted in part and denied in part.

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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 14 day of November, 2016,
in Tallahassee, Florida.



Kimberly Vargo

FINAL ORDER (Cont.)

16F-06093

PAGE-12

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

Nov 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06110

PETITIONER,

Vs.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 13, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

The petitioner submitted three sets of medical records as evidence for the hearing, which were marked Petitioner Exhibits 1, 2, and 3.

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

The respondent's witness referred to a set of documents (evidence packet) during the hearing, but a copy of these documents was never submitted to the Office of Appeal Hearings. This was addressed during the hearing and the respondent was given an opportunity to file these documents, but nothing was ever received.

Also present for the hearing was a Spanish language interpreter [REDACTED] Interpreter Number [REDACTED], from [REDACTED]

FINDINGS OF FACT

1. The petitioner is a thirty-six (36) year-old Medicaid recipient. She is an undocumented, non-citizen alien. She was pregnant earlier this year, and on April 7, 2016, her labor was induced and she gave birth shortly thereafter in a hospital.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for certain Medicaid services.
3. The Medicaid Program, through eQ Health, partially denied the petitioner's hospital stay related to her labor and subsequent birth of her child. The dates of April 9 and 10 were covered, but coverage was denied for the dates of April 7 and 8.

4. The petitioner stated her labor was induced and her delivery date was moved up because a sonogram showed her baby was underweight. The sonogram showed the baby's weight was at the 14th percentile one week before the delivery and her doctor felt it was necessary for her to deliver the baby soon after before the weight dropped any more. She also stated she has not received any hospital bills related to her stay, but she did receive a bill from the anesthesiologist.

5. The AHCA representative stated that the petitioner is only entitled to emergency Medicaid coverage for aliens. However, this was not the basis for the partial denial of the hospital stay.

6. The respondent's witness, Dr. Calhoun, stated the reason for the partial denial was that the medical criteria for the induction of labor was not met in this case. The criteria require that there be a fetal weight of less than the 10th percentile, and the petitioner's baby's weight was at the 14th percentile. For this reason, the hospital dates of April 9 and 10 were approved for vaginal delivery and normal post-partum care. The dates of April 7 and 8 were denied because this was the period related to the induction of labor.

7. Services under the Medicaid State Plan in Florida are provided in accordance with the respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012.

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 Section 120.80, Fla. Stat.

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 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.).
12. 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.
13. Page 3-32 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.

14. As stated in the Findings of Fact, this provision concerning Medicaid for aliens was not a basis for the partial denial of the petitioner’s hospital services since the

provision contains an exception for labor and delivery. The basis for the partial denial was medical necessity criteria.

15. 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.

16. After considering the evidence and testimony presented, the undersigned concludes that the respondent correctly denied the hospital stay for the dates of April 7 and April 8. The applicable medical criteria for induction of labor require that there be a fetal weight of less than the 10th percentile and the fetal weight in this case was at the 14th percentile. Since the criteria for induction of labor were not met, the respondent was not required to cover the dates of the hospital stay pertaining to the induction of

labor. The respondent did approve and cover the dates of April 9 and 10, which pertained to the delivery and post-partum care.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 01 day of November, 2016,

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

FINAL ORDER (Cont.)

16F-06110

PAGE - 7

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
AHCA HEARINGS UNIT

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

FILED

Nov 02, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06156
APPEAL NO. 16F-07857

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 19, 2016, at 10:06 a.m., and reconvened on October 4, 2016 at 3:07 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Roderika Mack, Operation Management Consultant 1

STATEMENT OF ISSUE

The petitioner is appealing the following issues:

- A. The reduction of Food Assistance (FA) benefits at recertification.
- B. The petitioner is seeking Medicare Savings Program (MSP) benefits for three months prior to application.

The petitioner carries the burden of proof by preponderance of evidence in both appeals.

PRELIMINARY STATEMENT

The respondent presented documents which were entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any exhibits at the first hearing. The record was held open until September 29, 2016, to allow the petitioner an opportunity to review the exhibits. After the petitioner reviewed the evidence, she submitted documents which were entered into evidence and marked as Petitioner's Composite Exhibit 1. The undersigned reviewed the petitioner's evidence and found it necessary to reconvene. The record was closed on October 5, 2016 after the hearing.

A continuance was granted to the petitioner for prior scheduled hearings.

FINDINGS OF FACT

1. The petitioner was receiving FA benefits from a prior application. She was authorized for FA benefits of \$194 until August 2017.
2. On March 15, 2016, the petitioner (age 66) submitted an application for the MSP to SSA through the Area Agency on Aging. The petitioner's household consists of herself only. She was receiving SS of \$883 monthly and paid for Medicare Part B of \$104.90. Her monthly shelter expense was \$600. She had expenses for utilities.
3. On April 13, 2016, the respondent sent the petitioner a Notice of Case Action informing her that it received her MSP application on April 12, 2016 and that her household will be considered for MSP benefits in the month she submitted her application to SSA, which was March 15, 2016.

4. On April 25, 2016, the petitioner submitted a second application to the respondent for MSP. She listed herself as the only household member. She reported that she receive SS benefits for \$883. The respondent processed the application and approved MSP and FA benefits. She was eligible for MSP effective April 2016 and her revised FA benefits began June 2016. The respondent provided a copy of its October's 2016 budgets and its calculation as follows.

October 2016

SS income retirement (gross)	\$883
Total household income	\$883
Standard deduction for a household of 2	(\$155.00)
Excess Medical Expenses	(\$0.00)
Adjusted income after deductions	\$728
Shelter costs	\$600
Standard utility Allowance	\$345
Total rent/utility cost	\$945
Shelter standard (50% adjusted income)	\$364
Excess shelter deduction	\$581
Adjusted income	\$728
Excess Shelter Deduction	\$581
Adjusted income after shelter deduction	\$147
Thrifty Food Plan for Household size 2	\$194
Benefit Reduction 30% of \$147	\$45
Monthly FAP allotment	\$149

5. The respondent used the same gross monthly income as above to determine eligibility in the MSP. A \$20 unearned disregard was subtracted from the gross monthly income resulting to \$863. This was compared to the income standard for an individual of \$981. The petitioner's income was under the income standard for Qualified Medicare

Beneficiary Medicaid (QMB), a MSP. She was eligible for the state to pay her Medicare premium.

6. On May 16, 2016, the petitioner was sent a Notice of Case Action stating that her application for FA benefits was approved and she was eligible to receive \$149. The same notice stated that she was eligible for QMB from April 2016 ongoing.

7. On March 4, 2016, the petitioner requested a hearing to challenge the amount of FA benefits approved and she is seeking three months of MSP prior to her application date.

8. The petitioner argued she applied for MSP on March 15, 2016, and checked that she wanted three months of benefits prior to her application. She argued that she was not required to report any additional income unless her income exceeded \$1,276, which it did not.

9. The respondent asserted the petitioner was not eligible for MSP for any months prior to her month of application although she checked the box requesting benefits three months prior to her application. The respondent explained the petitioner's FA benefits were reduced as it updated her income in order to determine eligibility for MSP.

CONCLUSIONS OF LAW

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

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

The FAP benefits issue will be addressed first

12 Federal Regulations at 7 C.F.R. §273.9 defines “Income” in the Food Assistance Program. The passage reads in relevant part:

(a) *Income eligibility standards.* Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet...

(b) *Definition of income...*

(2) Unearned income shall include, but not be limited to:

(ii) Annuities; pensions; retirement, veteran's, or disability benefits;

(d) Income deductions. Deductions shall be allowed only for the following household expenses:

(1) Standard deduction...

(6) Shelter costs...

(ii) Excess shelter deduction...

(iii) Standard utility allowances...

13. The above-cited regulation explains that participants in the FAP are required to meet income standards. The authority also states the petitioner’s Social Security retirement benefits are included in the eligibility determination. The above regulation also sets forth specific potential deductions in the FAP budget.

14. It further states at 7 C.F.R. §273.10 (e) Calculating net income and benefit levels:

(1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:

(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net losses from the self-employment income of a farmer shall be offset in accordance with §273.11(a)(2)(iii).

(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions.

(C) Subtract the standard deduction.

(D) If the household is entitled to an excess medical deduction as provided in Sec. 273.9(d)(3), determine if total medical expenses exceed \$35. If so, subtract that portion which exceeds \$35.

(E) Subtract allowable monthly dependent care expenses, if any, up to a maximum amount as specified under Sec. 273.9(d)(4) for each dependent.

(F) If the State agency has chosen to treat legally obligated child support payments as a deduction rather than an exclusion in accordance with §273.9(d)(5), subtract allowable monthly child support payments in accordance with §273.9(d)(5).

(G) Subtract the homeless shelter deduction, if any, up to the maximum of \$143.

(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.

(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.

(ii) In calculating net monthly income, the State agency shall use one of the following two procedures:

(A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or...

(ii)(A)...the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income...

15. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1, states that effective October 1, 2015, the 200% Federal Poverty level (FPL) for a household size of one was \$1,962. The 100% Federal Poverty level (FPL)/Net Income Limit was \$981. The standard deduction was \$155 and the Standard Utility Allowance was \$345. Effective October 2016, the 200% Federal Poverty level (FPL) for a household size of one is \$1,980. The 100% FPL/net income limit for a

household size of one is \$990, the standard deduction is \$157 and the Standard Utility Allowance is \$338.

16. The undersigned reviewed the petitioner's income, expenses and the respondent's calculations and did not find the petitioner eligible for any additional FA benefits.

The Medicare Saving Program will now be addressed

17. Income limits for Medicare savings plan benefits are set forth in the 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:

(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C...

(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. §1396a(r)(2)...

18. The Policy Manual at passage 0240.0113, Qualified Medicare Beneficiaries (MSSI) sets forth the criteria for QMB. It states:

This program entitles certain eligible individuals to receive Medicare cost savings benefits: payments of premiums, deductibles, and co-insurance. To be eligible for QMB an individual must meet all the following criteria:

1. Be enrolled or conditionally enrolled in Medicare Part A.
2. Meet all technical criteria, except being aged (65 or older requirement) or disabled.
3. Income Limit: 100% of Federal Poverty Level.
4. Asset Limit: Three times the SSI resource limit with annual increases based on the yearly Consumer Price Index. Refer to Appendix A-9.

19. The Policy Manual at passage 0640.0509 addresses Retroactive Medicaid and states, "This policy does not apply to QMB." The petitioner is seeking retroactive QMB; however, the above states that retroactive Medicaid does not apply to QMB.

20. The Department's Transmittal NO: P-10-03-0006, March 31, 2010, addresses Medicare Improvement for Patients and Providers Act (MIPPA) and states:

The provisions of MIPPA that affect the Department are:

States are required to accept an application for the Low-Income Subsidy (LIS) as an application for the Medicare Savings Program (MSP).

States are required to have an asset limit for MSP to be at least the same as the asset limit for the full Low-Income Subsidy.

Eligibility Policies and Procedures:

Effective January 1, 2010, the Social Security Administration (SSA) will begin transmitting data electronically from the Low Income Subsidy applications to Florida for use in determining eligibility for the MSP.

The date the LIS application was received by SSA is also the date of application for MSP. The date constitutes the application for MSP only and no other Medicaid program or other benefit programs such as SNAP.

21. The above states, the date the LIS application was received by SSA is the MSP application date. As SSA received the petitioner's application on March 15, 2016, she is eligible for benefits in March 2016.

22. The Policy Manual at Appendix 9-A, shows the Income standard for QMB for an individual as \$981, Effective July 2016, the income standard for QMB for an individual is \$990.

23. The Code of 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..."

24. The petitioner's income of \$883 minus \$20 disregard, equals income of \$863. The petitioner is eligible for the MSP under the QMB Program. The petitioner argued

she should receive retro MSP three months prior to her application dated March 15, 2016. The undersigned did not find any authority to substantiate her argument to receive three months MSP prior to her application.

25. After careful consideration, the undersigned concludes the petitioner submitted an application for MSP to SSA on March 15, 2016. The petitioner was sent a notice stating that it was the date her application for MSP was received by SSA. The petitioner is eligible for QMB in March 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal for the amount of FA benefits is denied. The respondent's action is affirmed.

The appeal regarding MSP is partially granted. The petitioner is found eligible for the month of March 2016 only based on her MSP application to SSA in March 2016. It is partially denied as there are no retroactive benefits for the QMB Program, so no other months prior to the application date could be authorized.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 02 day of November, 2016,
in Tallahassee, Florida.

FINAL ORDER (Cont.)
16F-06156, 07857
PAGE -10

Christiana Gopaul Narine

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

Nov 21, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

██████████
██████████
████████████████████

APPEAL NO. 16F-06232

PETITIONER,

Vs.

CASE NO. ██████████

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 ██████████
UNIT: ██████████

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 21, 2016 at 2:02 p.m.

APPEARANCES

For the Petitioner: ██████████ ██████████

For the Respondent: Nakisha Williams, operations management consultant I

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his June 2, 2016 application for disability-related Medicaid. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner informed the undersigned that he wanted his Food Assistance (FA) and Medicaid benefits reviewed. The respondent resolved the FA issue. The

petitioner was satisfied with the resolution; therefore, only the Medicaid issue is under appeal.

The respondent submitted documents which were entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not provide any exhibits at the hearing. The record was held open until September 30, 2016, for the petitioner to provide the conditions reviewed by the Social Security Administration (SSA) and for the respondent to provide the Notice of Case Action. On September 22, 2016, the respondent provided a Notice of Case Action for Food Assistance (FA) which were entered into evidence and marked as Respondent's Composite Exhibit 2. The petitioner did not provide any exhibits. The record was closed on September 30, 2016.

FINDINGS OF FACT

1. On February 24, 2016, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On May 20, 2016, SSA denied the petitioner's SSI application using the code reason code N35 which means, "NONPAY Impairment is severe at time of adjudication but not expected to last 12 months, no visual impairment." On June 8, 2016, the petitioner appealed the denial of his SSI application and that appeal is currently pending.
2. On June 2, 2016, the petitioner (age 31) submitted an application for SSI-Related Medicaid benefits to the respondent. The petitioner is the only household member. As he is not yet 65 years of age and has no minor children in his household, the petitioner must meet the disability-related criteria in order to be considered for Medicaid.
3. On June 3, 2016, the respondent adopted the SSA decision and denied the petitioner's SSI- Related Medicaid application. Neither the petitioner nor the

Department confirmed the conditions reviewed by SSA. The petitioner believed that SSA reviewed him for his eyes only, as he was sent to an eye surgeon and no other doctors.

4. The respondent did not forward the petitioner's disability package to the Division of Disability Determination (DDD) for review and eligibility determination; therefore, an independent review was not done.

5. Neither the respondent nor the petitioner provided a Notice of Case Action related to the SSI-Related Medicaid program. The respondent confirmed the SSI-Related Medicaid denial date was June 3, 2016.

6. On August 23, 2016, the petitioner requested a hearing to challenge the respondent's decision.

7. The petitioner alleged that he has new disabling conditions which are [REDACTED]

[REDACTED] These conditions allegedly began after May 20, 2016. He did not provide medical evidence to substantiate his claim of the new disabling conditions.

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

10. Federal Medicaid 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.

(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 recipient, whether or not the State has a section 1634 agreement with SSA, and

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

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

11. The Department's Program Policy Manual (The Policy Manual) CFOP 165-22 at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP)" states,

...Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.

12. According to the above authority the agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility.

13. The petitioner is appealing his SSI denial with SSA; therefore, SSA is reconsidering its denial of the petitioner's SSI application through its appeal process.

Furthermore the petitioner has not provided evidence of any new disabling conditions; therefore, the SSA determination remains binding.

14. In accordance with the above controlling authority, the undersigned concludes that the respondent correctly adopted the SSA disability decision as opposed to making an independent decision on the petitioner's disability request. The petitioner has not met his burden to show he has new disabling condition.

15. The hearing officer concludes that the petitioner must complete the appeal process with SSA, and that the respondent is bound by SSA's decision unless an exception as described above is met. The petitioner met no exception.

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.

FINAL ORDER (Cont.)
16F-06232
PAGE -7

DONE and ORDERED this 21 day of November, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06316

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on November 3, 2016 at 11:17 a.m.

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Deanne Fields, Esq., Assistant Suncoast Regional Counsel

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's application for SSI-Related Medicaid benefits is correct. The burden of proof is assigned to the petitioner by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified; however, he was represented by

[REDACTED]. Petitioner submitted three exhibits, which were entered and

marked as Petitioner's Exhibits "1" through "3". Respondent was represented by Deanne Fields, Esq. with the Department of Children and Families (hereafter "DCF", "Respondent", or "Agency"). Respondent presented one witness who testified: Nicole Nurridin, Economic Self Sufficiency Specialist II with DCF. Respondent submitted two exhibits, which were entered and marked as Respondent's Exhibits "1" through "2".

One continuance was granted to both parties.

The record was left open until November 10, 2016 to allow both parties to submit proposed Final Orders. Neither party submitted the proposed Final Orders. However, on November 11, 2016 and after the record was closed, the petitioner submitted additional evidence, which was accepted into evidence and marked as Petitioner's Exhibit "4". The record closed on November 11, 2016.

FINDINGS OF FACT

1. On April 27, 2016, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On September 27, 2016, SSA denied the petitioner's SSI application using the code N31. On October 12, 2016, the petitioner appealed the denial of his SSI application and that appeal is currently pending.
2. On June 9, 2016, the petitioner submitted an application for Temporary Cash Assistance (TCA), Food Assistance (FA), and SSI-Related Medicaid benefits. TCA and FA benefits are not issues under appeal. On the application, the petitioner claimed to be disabled; and not to have health conditions that had changed since the SSI denial.

3. On June 14, 2016, the respondent mailed the petitioner a Notice of Case Action indicating his Medicaid application dated June 9, 2016 was denied as, "No household members are eligible for this program".
4. On September 8, 2016, the respondent determined the petitioner's June 9, 2016 application for SSI-Related Medicaid benefits was denied incorrectly because the petitioner's SSI application was pending with the SSA at that time.
5. On September 15, 2016, the respondent submitted both the Disability Determination and Transmittal form (Respondent's Exhibit 2) and a packet of medical information to the Department of Health Division of Disability Determination (hereafter "DDD") to determine if the petitioner met the criteria to be considered disabled.
6. On September 29, 2016, DDD determined the petitioner was not disabled using the denial code N31. The Disability Determination and Transmittal form had "Hankerson Denial (9/23/16)" handwritten on it. The document also listed the petitioner's age as 52 years old; his primary diagnosis as [REDACTED]; and his secondary diagnosis as [REDACTED]
7. Respondent denied the petitioner's SSI-Related Medicaid benefits as DDD determined the petitioner was not disabled.
8. Petitioner suffers from incontinence of the bowel; severe headaches that can last up to several weeks at a time; and unspecific body pain. Petitioner explained that SSA did not consider his incontinence, which may be due to his diabetes, in the denial of his SSI application. He also explained his headaches are getting worse and are lasting longer.

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-1.705(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...

12. 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.

13. 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.

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

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—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility. . .

16. Petitioner applied for SSI benefits on April 27, 2016 and was denied SSI benefits on September 27, 2016 pursuant to code N31. On June 9, 2016, the petitioner applied for Medicaid benefits with the respondent. On October 12, 2016, the petitioner appealed his SSI denial with SSA. On September 29, 2016, DDD determined the petitioner was not disabled by adopting the September 2016 SSI denial. Respondent denied the petitioner's application for SSI-Related Medicaid benefits as DDD adopted the SSA denial decision.

17. Petitioner is appealing his SSI denial with SSA; therefore, SSA is reconsidering its denial of the petitioner's SSI application through its appeal process. Although, the petitioner claims [REDACTED] as a new condition and claims his [REDACTED] are a worsening medical condition, these medical conditions are related to the medical conditions considered by SSA when making its determination. Therefore, the petitioner is encouraged to report the two aforementioned medical conditions to SSA during his

appeal process. Under these circumstances, the controlling authorities preclude the respondent from rendering an independent disability determination. Accordingly, the SSA federal determination remains binding on the respondent.

18. Therefore, the respondent was correct to adopt SSA's denial decision as the petitioner is appealing his SSI denial and petitioner's new or worsening medical conditions are related to the conditions considered by SSA in its determination.

19. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner has not met his burden of proof to indicate the respondent incorrectly denied his June 9, 2016 application for SSI-Related Medicaid benefits.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 16 day of December, 2016,

in Tallahassee, Florida.

Mary Jane Stafford

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

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
Deanne Fields, Esq.
Shane Deboard, Esq.

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

FILED

Nov 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06409

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 19, 2016 at 8:42 a.m. The hearing was reconvened on the same day at 2:31 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Mary Triplett, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the Department's action on August 26, 2016, denying her application for Medicaid benefits as she 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 3.

The petitioner did not present any documents at the hearing. The record was held open until October 29, 2016, for the petitioner to provide her denial letter from Social Security Administration (SSA). The letter was received on October 28, 2016, entered into evidence and marked as Petitioner's Exhibit 1.

The record was closed on October 29, 2016.

FINDINGS OF FACT

1. The petitioner filed a disability application with the Social Security Administration (SSA) on January 21, 2015. SSA denied the petitioner's disability claim on May 27, 2015. On June 11, 2015, the petitioner appealed the SSA denial. That appeal is currently pending.
2. On August 9, 2016, the petitioner submitted an application for SSI-Related Medicaid benefits to the respondent. She has no minor children. At the time of the application, the petitioner was 51 years old. Her date of birth is May 9, 1965. As she 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 she was disabled.
3. On August 22, 2016, a disability determination packet was sent to the Division of Disability Determinations (DDD), for them to complete a determination of disability.
4. DDD did not conduct an independent review but instead, denied the petitioner's disability claim by adopting the SSA denial decision of May 27, 2015.

5. The Explanation of Determination show the conditions considered by SSA were

[REDACTED]

6. On August 25, 2016, DDD informed the respondent of its decision by way of the Disability Determination and Transmittal form, which stated that the petitioner was not disabled, as they had adopted the SSA denial decision with reason code N32 which means, "Non-pay—Capacity for substantial gainful activity – other work, no visual impairment". The form also noted that the primary diagnosis was "12 Affective d/o and that the secondary diagnosis was 01 [REDACTED] d/o". In the remarks section of the transmittal was "Hankerson 5/16 same /related allegations, hearing pending."

7. On August 26, 2016, the respondent notified the petitioner that her Medicaid application dated August 9, 2016 was denied. The reason for the denial was that she did not meet the disability requirement.

8. On August 27, 2015, the petitioner requested a hearing to challenge the respondent's decision.

9. At the hearing on October 19, 2016, the petitioner alleged a new disabling condition, [REDACTED] caused by [REDACTED]. She asserted that the SSA denial was prior to her [REDACTED]. She provided medical reports which were completed in August 2016, to substantiate her claim of new disabling condition (Respondent's Composite Exhibit 3).

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. 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...

13. 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 Policy Manual at 1440.1205 addresses Exceptions to State Determination of Disability (MSSI, SFP) as follows:

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

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. [emphasis added]

17. 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 this criteria. The petitioner has a pending appeal with the SSA. The petitioner reported that she has a new condition which was not considered by SSA; however, the disability report from SSA shows that the petitioner was reviewed for neck and back problems which she claimed as her new condition. Therefore, the petitioner's [REDACTED] problem is not a new condition but a worsening condition. The petitioner has not met her burden to show she has a new disabling condition. The above authority states if there is no new disabling condition the state agency does not make a disability determination.

18. After considering the evidence, testimony and the appropriate authorities, the undersigned concludes the petitioner must complete the appeal process with SSA and the respondent is bound by SSA's decision unless an exception described above is met. The petitioner met no exception; therefore, the Department correctly adopted the SSA disability decision to denied 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.

DONE and ORDERED this 28 day of November, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Nov 03, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06424

PETITIONER,

Vs.

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

And

UNITED HEALTHCARE,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 3, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Jerome Hill, Fair Hearing Supervisor
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for dental services (partial upper dentures) was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

A telephonic hearing in this matter was originally scheduled for September 26, 2016. The petitioner and the AHCA representative appeared for the hearing on September 26. However, no one from United Healthcare called in for the hearing. The hearing was rescheduled for October 3, 2016 and the petitioner and the AHCA representative both called in again, but United Healthcare failed to appear again. United Healthcare was included as an additional respondent in this proceeding since it is the petitioner's health care plan.

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

Following the conclusion of the hearing on October 3, United Healthcare submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibit 1: Statement of Matters, Authorization Request, and Denial Notice.

FINDINGS OF FACT

1. The petitioner is an adult 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 July 18, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from United Healthcare for partial upper metal-based dentures. United Healthcare denied this request on July 20, 2016.
3. United Healthcare's denial notice to the petitioner advised him of the following reason for the denial of his request for the upper dentures:

The request for a cast metal framework partial denture is denied. The submitted x-rays show presence of periodontally involved teeth. A resin based partial denture may be considered a more appropriate restoration for the member's current underlying condition.

4. The petitioner stated he previously needed a deep cleaning, but this was also denied by United Healthcare and he developed an abscess and infection. He stated United Healthcare then denied his request for the dentures due to the infection or gum disease. He also stated he now needs a root canal as well.

5. Although no representative from United Healthcare appeared for the hearing, the denial notice confirms the petitioner's statement that the request for dentures was denied due to the condition of his gums or teeth. The denial notice also states a resin based denture would be more appropriate than metal dentures.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the respondent AHCA's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

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

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

10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), 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.).

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA. The Medicaid Handbooks are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. 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.”

13. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. The Florida Medicaid Program provides limited dental services for adults. Partial dentures are included in the covered services. The AHCA Dental Policy specifies that covered services include periodic oral evaluations, radiographs, dentures, and some tooth extractions.

15. Managed care plans, such as United Healthcare, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Policy.

16. After considering the evidence and testimony presented, the undersigned concludes the respondent correctly denied the petitioner's request for the upper partial metal dentures. Due to the condition of his teeth or gums, resin based partial dentures would be a more appropriate treatment option for the petitioner and he should explore this option with his provider.

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

FINAL ORDER (Cont.)

16F-06424

PAGE - 6

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 03 day of November, 2016,

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
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

Dec 05, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06440

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 18 [REDACTED]
UNIT: AHCA

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 31, 2016 at approximately 10:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's mother

For the Respondent: Lisa Sanchez
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's action reducing Petitioner's personal care services ("PCS") was correct. The burden of proof is assigned to Respondent.

- [REDACTED]
- [REDACTED]

3. Petitioner requires total assistance for bathing, personal hygiene, toileting, feeding himself, and selecting clothes.

4. Petitioner's mother is his primary caregiver. She has a history of [REDACTED] and muscle detachment. Her own medical needs limit her ability to care for Petitioner.

5. Petitioner attends school from 8:00 a.m. - 2:00 p.m., Monday through Friday. He was pull-up diapers at school and at home due to his incontinence.

6. Petitioner's mother works outside the home. She testified she is supposed to leave by 9:30 a.m. and returns home between 6:00 p.m. and 7:00 p.m., Monday through Friday. In addition, she works 12 hours per day on Saturdays and Sundays, from approximately 8:00 a.m. – 8:00 p.m.

7. On June 9, 2016, Petitioner was approved by South Florida Community Care Network for eight (8) hours per day of PCS from Monday – Friday and 12 hours per day on Saturday and Sunday (Pet. Exh. 3). The authorization period began June 15, 2016, and ended August 13, 2016. The Authorization Provider Notification lists Petitioner's Medicaid ID number, therefore the service was authorized through Medicaid.

8. On June 24, 2016, a request was made for PCS for eight (8) hours per day Mon.-Fri. and 12 hours per day Sat. and Sun. for the period of June 1, 2016 through November 30, 2016. This request overlaps the previous approval made by South Florida Community Care Network.

9. eQHealth Solutions, Inc. (“eQHealth”) is the Quality Improvement Organization (“QIO”) contracted by the Respondent to perform prior authorization reviews for home health services. PCS is a home health service.

10. A physician at eQHealth reviewed the request. On August 9, 2016, eQHealth issued a Notice of Outcome. (Resp. Exh. 4). The Notice approved four (4) hours per day of PCS, seven (7) days per week.

11. The principal reasons given for the denial were listed as: “The service is denied because it is for the convenience of the recipient, recipient’s caregiver or the provider; and, Submitted information does not support the medical necessity for requested frequency and/or duration.”

12. The clinical rationale given for the decision was:

The patient is a 9 year old male with [REDACTED]. The patient does not have a G-tube or a tracheostomy. The patient is on a regular diet and cannot feed himself. The patient is not on any medications. The patient is ambulatory, non-verbal and [REDACTED]. The patient requires assistance with activities of daily living. The mother is the sole caregiver and does not have any physical limitations. The mother works Monday to Friday from 8:00 am to 6:00 pm and Saturday and Sunday from 8:00 am to 8:00 pm. 4 hours of personal care services each day to assist with activities of daily living is adequate for the patient’s condition. The request for any additional personal care services is excessive. Caregivers are expected to provide care to the fullest extent possible. Constant supervision and monitoring are not covered benefits.

13. A reconsideration of the decision was requested on August 15, 2016. (Resp. Exh. 5). On August 17, 2016, eQHealth issued a Notice of Reconsideration Determination upholding its original decision, stating:

The medical basis for the reconsideration is as follows:

PR Recon Determination: 9 yo with autism. The patient is ambulatory and on a regular diet but is incontinent and requires assistance with ADLs. The

mother works M-F 8a-6p, Sa/Su 8a-8p and has medical issues/physical limitations.

Uphold previous review. All submitted documentation was reviewed. Sufficient hours have been approved to provide assistance with ADL care. The remaining hours, for monitoring and supervision, could be provided by non HHA personnel – supervision is not a covered service.

14. Dr. Mittal said he could increase the approved hours of PCS to six (6) hours per day on Sat. and Sun., two (2) each for the morning, afternoon, and evening.

15. Petitioner's mother testified that he soils himself approximately every half-hour. She said if he defecates he will play with his feces unless he is changed. He is bathed two (2) or three (3) times per day due to his [REDACTED]. He also receives other services at home during the day, including behavior therapy and occupational therapy, however, those providers cannot change his diaper.

16. Petitioner's PCS Plan of Care indicates he needs assistance with bathing and grooming, oral hygiene, and toileting and elimination. (Resp. Exh. 6).

17. Petitioner's mother said her son is physically 9-years-old but functions at the level of a 2-year-old. She said he needs hands-on care when she is unavailable, not mere supervision.

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

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

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

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

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

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home...

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. ...

(c) The agency may not pay for home health services unless the services are medically necessary ...

23. 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.

24. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services ("EPDST") requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children include:

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

25. Under the above statute, the Agency offers personal care services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

26. The United States Court of Appeals for the Eleventh Circuit clarified the states' obligation for the provision of EPSDT services to Medicaid-eligible children in *Moore*

v. Reese, 637 F.3d 1220, 1255 (11th Cir. 2011). The Court provided the following guiding principles in its opinion, which involved a dispute over private duty nursing:

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, **when such services are medically necessary to correct or ameliorate [his or her] illness and condition.**

(2) A state Medicaid plan must include “reasonable standards ... for determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphases added).

27. 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.

28. The October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook (Handbook) has been promulgated into rule by Chapter 59G, Florida Administrative Code¹. The Handbook describes services covered under the Florida Medicaid Home Health Services Program. PCS is an included service for individuals under the age of 21.

29. Page 1-2 of the Handbook states “Personal care services provide medically necessary assistance with activities of daily living (ADL)...that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability.”

30. Page 1-2 lists the types of ADLs for which a PCS provider can assist:

- Eating (oral feedings and fluid intake);
- Bathing;
- Dressing;
- Toileting;
- Transferring; and
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).

31. Pages 2-12 and 2-13 of the Handbook address excluded services which are not reimbursed by Medicaid. This list includes, in part:

- Mental health and psychiatric services;
- Respite care;
- Baby-sitting;
- Escort services;
- Day care or after school care; and
- Companion sitting or leisure activities

¹ The Handbook has since been replaced by the Personal Care Services Coverage Policy, effective November 2016. However, since the Handbook was in effect at the time the action was taken, it will be applied in this case.

32. Page 1-3 of the Handbook defines "babysitting" as: "The act of providing custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient."

33. In the instant case, the requested hours do not appear to be primarily for supervision, but for assistance with ADLs. Petitioner requires more than just supervision while his mother is away. He requires diaper changes and possible bathing due his [REDACTED].

34. In regard to parental responsibility, page 2-25 of the Handbook states:

Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider 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. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

35. The above paragraph establishes the Home Health Services Program is designed to supplement, but not replace, the care provided by the parents.

36. Petitioner's mother is in the home until he goes to school on weekdays. He gets out of school at 2:00 p.m. His mother returns home between 6:00 p.m. and 7:00 p.m., which is four (4) to five (5) hours later. On weekends, Petitioner's mother is away at work for 12 hours each day.

37. Petitioner does not require a PCS provider prior to school. His mother is required to provide assistance to the fullest extent possible. The Agency approved four (4) hours per day of PCS on weekdays. Because Petitioner's mother can be away as late as 7:00 p.m., the undersigned concludes an additional hour per day of

PCS on weekdays must be approved for his health and safety, not as a convenience to his mother. However, eight (8) hours would be in excess of his needs.

38. Petitioner's mother is away for 12 hours per day on weekends. The undersigned concludes he requires 12 hours per day of PCS on weekends. As stated above, Petitioner requires more than mere supervision. It is inevitable that he will require hands-on care during that period of time, and it cannot be determined exactly when he will need the care.

39. The undersigned has reviewed EPSDT and medical necessity requirements and applied such to the totality of the evidence. The additional hours are medically necessary and would serve to ameliorate his condition.

DECISION

Based upon the foregoing, Petitioner's appeal is PARTIALLY GRANTED and PARTIALLY DENIED. The Agency is directed to provide Petitioner with five (5) hours of personal care services, Monday through Friday, and 12 hours per day of personal care services on Saturday and Sunday.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)

16F-06440

PAGE - 12

DONE and ORDERED this 05 day of December, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06448

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]

CO-RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above referenced matter on October 19, 2016 at 10:06 a.m. and reconvened on November 9, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Daughter

For the Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is whether Respondent's denial of Petitioner's requests for an evaluation of physical therapy at home and an evaluation of nurse services at home is correct. Petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for Respondent from Better Health (a/k/a Simply Healthcare) were Dr. Francisco Hernandez, Medical Director, and Deborah Zamora, Grievance and Appeals Team Lead. Better Health is Petitioner's managed care plan. Respondent Exhibit 1 was entered into evidence.

The hearing was reconvened on November 9, 2016 for Respondent to provide the authority used in the plan's decision. Petitioner did not appear and Respondent requested additional time to submit a copy of the relevant authority. The record was held open to November 30, 2016. On November 14, 2016, Respondent provided a copy of the authority, Better Health's contract with AHCA, used in the decision. The document was entered as Respondent Exhibit 2.

FINDINGS OF FACT

1. Petitioner is an 89-year-old recipient of the Medicaid program. She is an enrollee with the Better Health managed care plan (MMA) and an enrollee in the Sunshine Health Long-Term (LTC) care plan.

2. Petitioner's treating physician submitted a prior authorization request to Better Health for approval of a physical therapy evaluation at home and a nurse evaluation at home.

3. Better Health sent Petitioner a Notice of Action on August 4, 2016 which denied the requests as not medically necessary. It provided the following explanation for the denial:

The facts that we used to make our decision are: Your request for physical therapy evaluation at home and nurse evaluation at home was not

approved. Our records indicate that you have been previously approved to receive therapy services with your contracted provider Cora Rehabilitation Services. Please coordinate all needed care with our primary care physician's office. Our records also show that you have a long term care plan and mixed services such as physical therapy and home care are covered under your long term care plan.

4. Petitioner filed a timely request for a fair hearing on August 22, 2016.

5. Petitioner's daughter stated her mother needs physical therapy and nursing services in the home.

6. Respondent explained Petitioner has both a managed care plan and a long-term care plan. Petitioner's requested services are covered by her long-term care plan and not her managed care plan, Better Health.

7. Petitioner's daughter acknowledged she has not requested Petitioner's long-term care plan provide the services.

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 Chapter 120.80 Florida Statutes.

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

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

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

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

13. Section 409.964, Florida Statutes established Florida Medicaid's Managed Care program, stating in relevant part" [t]he Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services."

14. On page 21 of the contract between AHCA and Better Health, "mixed services" is defined as "medicaid services that include the following services: assistive care services, home health and nursing care (intermittent and skilled nursing), hospice services, medical equipment and supplies (including durable medical equipment), therapy services (physical, occupational, respiratory and speech) and non-emergency transportation services."

15. Petitioner's requested physical therapy and nursing service are included in the definition of a "mixed service".

16. On page 93 of the contract between AHCA and Better Health, it provides a description of how mixed services are to be managed when a member has both a managed care plan and a long-term care plan. It states:

The Managed Care Plan shall provide case management and care coordination with other Managed Care Plans for enrollees with both MMA benefits and LTC benefits to ensure mixed services are not duplicative but rather support the enrollee in an efficient and effective manner. When a recipient is enrolled in both the LTC and MMA programs, the LTC case manager is primarily responsible for care coordination and case management to enrollees. **LTC Managed Care Plans shall provide mixed services to enrollees with LTC benefits, regardless of an**

enrollee's enrollment in an MMA Managed Care Plan. [Emphasis added.]

17. Petitioner is requesting her managed care plan, Better Health, approve an evaluation for physical therapy in the home and an evaluation for nursing services in the home

18. Respondent denied the requested evaluations because the services are covered by Petitioner's long-term care plan.

19. After considering the evidence, the Fla. Admin. Code Rule, and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that Respondent has appropriately denied the requested evaluations for physical therapy in the home and nursing care in the home. Petitioner should have her provider submit the prior authorization requests for the evaluations to her long-term care provider.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 23 day of December, 2016, in
Tallahassee, Florida.



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

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

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

FILED

Nov 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06459

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 27, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for medication associated with dental services was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as a witness for the respondent was Mindy Aikman, Grievance Specialist, from Humana, which is the petitioner's managed health care plan. Humana was included as an additional respondent in this proceeding since it is the petitioner's health plan. Also present as a witness for the respondent was Jackeline Salcedo, Complaints and Grievances Specialist, from DentaQuest, which reviews dental claims on behalf of Humana.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Case Summary, Claim Form, Authorization Determination, and Plan Provisions/Covered Benefits.

FINDINGS OF FACT

1. The petitioner is a sixty-four (64) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review of requests for dental services.
2. The petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Humana for approval of a tooth extraction, with associated anesthesia and medication. DentaQuest and/or Humana initially denied this request due to lack of a referral. However, on September 14, 2016,

DentaQuest approved the tooth extraction and anesthesia. The request for medication was denied as not being a covered service or benefit.

3. The petitioner stated she was not aware of the subsequent approval of the tooth extraction and anesthesia. She also mentioned she had a request for an x-ray which was also denied.

4. Ms. Salcedo from DentaQuest stated that medication related to the tooth extraction is not a covered service under Humana's dental plan provisions.

5. Dental 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

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

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. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

11. 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.

12. The petitioner’s request for the medication was not denied due to any medical necessity considerations, but because that service is a non-covered service or benefit according to the Humana dental plan provisions.

13. The Florida Medicaid Program provides limited dental services for adults. The AHCA Dental Policy specifies that these services include periodic oral evaluations, radiographs, dentures, and some tooth extractions.

14. Managed care plans, such as Humana, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Policy.

15. After considering the evidence and testimony presented, the undersigned concludes that the petitioner has not demonstrated that the requested service (medication) should have been approved by Humana. Medication for dental services is a non-covered benefit for adults under the Medicaid guidelines referenced above and under the Humana dental plan provisions. Therefore, the hearing officer cannot make a determination that this service must be covered by the petitioner's plan.

16. With regard to the petitioner's statement concerning a denial of a request for an x-ray, that denial was not an issue addressed in this proceeding. The petitioner may have a right to request a separate hearing on that issue if appropriate.

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.)

16F-06459

PAGE - 6

the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 16 day of November , 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

FILED

Dec 19, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

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

APPEAL NO. 16F-06460

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on November 14, 2016 at approximately 3:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's mother

For the Respondent: Lisa Sanchez
Medical/Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether or not Respondent's action denying Petitioner's request for personal care services ("PCS") was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner’s mother represented her. She gave oral testimony but did not move any exhibits into evidence. Lisa Sanchez, Medical/Health Care Program Analyst represented Respondent, the Agency for Health Care Administration (“AHCA” or the “Agency”). Respondent presented one (1) witness, Dr. Darlene Calhoun, Physician Reviewer with eQHealth Solutions (“eQHealth”). Respondent’s Exhibits 1 – 7 were entered into evidence. Administrative notice was taken of the following of the October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook. A Spanish language interpreter was present.

FINDINGS OF FACT

1. The Petitioner is a 6-year-old female. Petitioner’s medical history includes:

- [REDACTED]

2. Petitioner attends school during the day. She currently receives PPEC services until 5:00 p.m. after school. PPEC is authorized through March of 2017.

3. Petitioner’s single mother is her primary caregiver. Her mother does not return home until 7:00 p.m. A friend watches Petitioner after PPEC until her mother gets home.

Petitioner receives her medications and flushing of her [REDACTED] while at PPEC. Her mother’s friend prepares meals and bathes Petitioner.

4. Petitioner's mother also works on weekends. She pays out of pocket for supervision on weekends. She said her employment situation is becoming unstable because she has to leave work to administer medications and [REDACTED].

5. A request for PCS, from August 1, 2016 through September 3, 2016, was submitted. eQHealth is the Quality Improvement Organization ("QIO") contracted by the Respondent to perform prior authorization reviews for home health services. PCS is a home health service.

6. A physician at eQHealth reviewed the request. On August 8, 2016, eQHealth issued a Notice of Outcome. (Resp. Exh. 5). The Notice denied the request in full.

7. The principal reasons given for the denial were listed as: "The service is denied because it is for the convenience of the recipient, recipient's caregiver or the provider; and, Submitted information does not support the medical necessity for requested services."

8. The clinical rationale given for the decision was:

The patient is a 5 year old female with [REDACTED] status post [REDACTED], [REDACTED] [REDACTED] status post decompression. In 2013, [REDACTED], [REDACTED]. The patient *does not have a G-tube* or a tracheostomy. The patient is on a regular diet and can feed [herself]. The patient's only medication is [REDACTED]. The patient is verbal. The patient is ambulatory and can jump, skip, and run. The patient attends PPEC. The mother is the caregiver and does not have any physical limitations. The mother works full-time and is self-employed. The clinical information provided does not support the medical necessity for any personal care services. Constant supervision and monitoring are not covered benefits. (emphasis added).

9. Dr. Calhoun said it was an error for the reviewer to [REDACTED]. Petitioner's mother said she is not self-employed in the traditional sense. She said she is paid as a subcontractor, but the two (2) companies she works for dictate her schedule.

10. Dr. Calhoun said Petitioner would require skilled nursing visits for medication administration and tube flushing, not PCS. PCS is to help an individual to perform their activities of daily living (“ADLs”). She said the wrong service was requested. She also said that PCS is unnecessary because Petitioner’s mother is able to care for her before and after work and that any PCS hours would only be for supervision.

CONCLUSIONS OF LAW

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

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

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

14. 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.).

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

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

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home...

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. ...

(c) The agency may not pay for home health services unless the services are medically necessary ...

16. The definition of medically necessary is found in Fla. Admin. Code R. 59G-1.010

which states:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

17. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and

Treatment Services (“EPDST”) requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children include:

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

18. Under the above statute, the Agency offers PCS as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

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

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include “reasonable standards ... for determining eligibility for and the extent of medical assistance” ... and such standards must be “consistent with the objectives of” the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician’s discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, “a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both

the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. The state is not required to provide medically unnecessary, albeit desirable, EPSDT services. However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)).

20. 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.

21. The October 2014 Florida Medicaid Home Health Services Coverage and Limitations Handbook (Handbook) has been promulgated into rule by Chapter 59G, Florida Administrative Code¹. The Handbook describes services covered under the Florida Medicaid Home Health Services Program. PCS is an included service for individuals under the age of 21.

22. Page 1-2 of the Handbook states “Personal care services provide medically necessary assistance with activities of daily living (ADL)...that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability.”

¹ The Handbook has since been replaced by the Personal Care Services Coverage Policy, effective November 2016. However, since the Handbook was in effect at the time the action was taken, it will be applied in this case.

23. Page 1-2 lists the types of ADLs for which a PCS provider can assist:

- Eating (oral feedings and fluid intake);
- Bathing;
- Dressing;
- Toileting;
- Transferring; and
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).

24. Pages 2-12 and 2-13 of the Handbook address excluded services which are not reimbursed by Medicaid. This list includes, in part:

- Mental health and psychiatric services;
- Respite care;
- Baby-sitting;
- Escort services;
- Day care or after school care; and
- Companion sitting or leisure activities

25. Page 1-3 of the Handbook defines "babysitting" as: "The act of providing custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient."

26. In the instant-matter, the requested hours appear to be primarily for supervision, not for assistance with ADLs. Further, the assistance Petitioner requires are skilled nursing services, not PCS.

27. In regard to parental responsibility, page 2-25 of the Handbook states:

Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider 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. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

28. The above paragraph establishes the Home Health Services Program is designed to supplement, but not replace, the care provided by the parents.

29. Petitioner is a 6-year-old female. All 6-year-old children require adult supervision. PCS can only be provided for performance of ADLs, not for babysitting.

30. The undersigned has reviewed EPSDT and medical necessity requirements and applied such to the totality of the evidence. Petitioner has not met her burden of proof to show the PCS should be approved.

31. Petitioner's mother said she has to leave work in order to take care of administering her daughter's medications and [REDACTED]. She is encouraged to work with the Agency regarding requesting nursing services to perform this task.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and the Agency's action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)

16F-06460

PAGE - 10

DONE and ORDERED this 19 day of December, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Dec 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06461

PETITIONER,

Vs.

AMERIGROUP,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 [REDACTED]
UNIT: AHCA

AMERIGROUPS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on November 16, 2016 at approximately 1:30 p.m.

APPEARANCES

For Petitioner:

[REDACTED]
Petitioner's Mother

For Amerigroup:

Debra Greene
Grievance & Appeals Coordinator

STATEMENT OF ISSUE

At issue is Amerigroup's denial of Petitioner's request for comprehensive orthodontic treatment and 12 periodic orthodontic treatment visits. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Petitioner's mother represented her. She gave oral testimony, but did submit any exhibits. Suzanne Chillari, Medical/Health Care Program Analyst with the Agency for Health Care Administration ("AHCA" or "Agency") observed the hearing. In addition to Ms. Greene, the following individuals were present as witnesses for Amerigroup:

- Jackelyn Salcedo – Complaints & Grievances Specialist – DentaQuest
- Dr. Daniel Dorrego – Dental Consultant – DentaQuest

Amerigroup moved Exhibits 1 – 13 into evidence.

FINDINGS OF FACT

1. Petitioner is a 9-year-old female. She is enrolled with Amerigroup as her managed care plan. DentaQuest is Amerigroup's dental vendor.
2. On September 18, 2015, Petitioner's treating orthodontist wrote a treatment plan which, in part, included eliminating a posterior crossbite. A Medicaid Orthodontic Initial Assessment Form ("IAF") was submitted. The IAF had a result of 15 points. (Resp. Exh. 3). Dr. Dorrego said a score of 26 or higher is required for approval of braces.
3. The IAF, at condition # 3, lists a possible crossbite of the anterior teeth. Dr. Dorrego said crossbites of anterior teeth are automatically approved for braces, regardless of score, but that crossbites of posterior teeth are not.
4. On October 23, 2015, Amerigroup issued a letter to Petitioner stating they were approving "braces." (Resp. Exh. 8). Petitioner's mother said the approval was through a medical exemption. She called DentaQuest to confirm and was given an

authorization number. She was told the authorization was good until October 23, 2018 and that the braces were covered 100%.

5. Ms. Salcedo said Petitioner's orthodontist requested that the authorization be voided because they wanted to resubmit the request under a different code. The code approved, D8060, which is for palette expansion, does not require IAF scoring.

6. Petitioner began her orthodontic treatment on December 3, 2015. The treatment included posterior crossbite correction, not just palette expansion. Dr. Dorrego said that the crossbite correction is considered comprehensive treatment.

7. On April 19, 2016, DentaQuest received a request from Petitioner's orthodontist for comprehensive orthodontic treatment, code D8070, and 12 periodic orthodontic treatment visits, code D8670. DentaQuest scored an IAF form on its own, and came up with a result of 11 points. (Resp. Exh. 5). On April 21, 2016, they denied the request in full, stating that Petitioner did not meet the 26 point requirement on the IAF. (Resp. Exh. 6). Amerigroup issued a Notice of Action the same day.

8. An internal appeal was requested. On July 25, 2016, DentaQuest upheld the denial, again stating that Petitioner did not meet the 26 point requirement. (Resp. Exh. 9).

9. On July 26, 2016, Amerigroup had an additional review performed by another company, MCMC. (Resp. Exh. 11). The reviewer for MCMC concluded Petitioner's score on the IAF is 16 and said the request should be denied for failure to meet the 26 point score requirement. On July 29, 2016, Amerigroup issued a letter informing Petitioner that the denial was upheld. Petitioner requested a hearing on August 24, 2016.

10. Petitioner's mother said the crossbite has been corrected, but the treatment has left her daughter with four (4) gaps in her front teeth. Petitioner's mother also said the last time she visited the orthodontist was in May of 2016 because the orthodontist said they will not continue to treat her unless they are paid, either through Medicaid or directly from her. The continued treatment would close the gaps in the teeth. They said the options are to remove the braces now and leave the gaps, or to continue the treatment, which requires continued payment.

11. Petitioner's mother said her daughter complains of jaw cramps and has to put ice on it to alleviate the pain.

12. Dr. Dorrego testified that Petitioner would benefit from orthodontic treatment, but that she does not pass the IAF requirements.

CONCLUSIONS OF LAW

13. By agreement between the Agency for Healthcare Administration ("AHCA" or "Agency") 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.

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

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

16. 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.).

17. Legal authority governing the Florida Medicaid Program is found in Fla. Stat. Chapter 409, and in Chapter 59G of the Florida Administrative Code. AHCA is the single state agency that administers the Medicaid Program.

18. The Florida Medicaid Dental Services Covered and Limitations Handbook, November 2011 (“Dental Handbook”), was previously promulgated into law by Fla. Admin. Code R.59G-4.060. The Dental Handbook was replaced by the Florida Medicaid Dental Services Coverage Policy (“Dental Policy”), effective May 3, 2016, pursuant to R.59G-4.060.

19. The undersigned reviews the action at the time it was taken. There is a quirk in this case due to the timeline of events. On April 21, 2016, when the initial denial was made and the Notice of Action was issued, the Dental Handbook was in effect. However, on July 25, 2016, when DentaQuest upheld the denial, and on July 26, 2016, when MCMC upheld the denial, the Dental Handbook had been replaced by the Dental Policy.

20. Page 2-18 of the Dental Handbook states a total score of 26 or more on the IAF may qualify a recipient for orthodontic treatment. A score of less than 26 indicates the recipient may not qualify for orthodontic treatment because the patient’s condition is not severe enough, even if they have some degree of malocclusion. An exception is possible for borderline cases. Therefore Dr. Dorrego, DentaQuest, and MCMC were correct to consider the IAF requirement of 26 points as part of the decision-making process.

21. The Dental Policy, which is only six (6) pages long, does not contain any 26 point requirement on the IAF. In Section 7.2, the Dental Policy says the provider must

include an "Orthodontic initial assessment." However, it does not state that any particular form must be used. The Dental Handbook, at Appendix A, contained the IAF. The IAF itself did not mention a 26 point requirement, rather, that requirement was listed on page 2-18, as mentioned above.

22. The undersigned concludes that the change in the law, which repealed the Dental Handbook and replaced it with the Dental Policy, eliminates the requirement of a score of 26 on the IAF. The information contained in the form is still probative regarding the need for orthodontic treatment, but it is no longer definitive. The only absolute requirement is that the treatment be medically necessary.

23. 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.

24. Since the Petitioner is under 21 years of age, a broader definition of medical necessity applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Section 409.905, Fla. Stat., Mandatory Medicaid services, provides that Medicaid services for children include:

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

25. Under the above statute, the Agency offers dental services as an EPSDT service to Medicaid-eligible recipients less than 21 years of age.

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

(1) [A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and

a treating physician is “required to operate within such reasonable limitations as the state may impose.”

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.” Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state’s provision of a required EPSDT benefit, such as private duty nursing services, “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”

(6) A state “may place appropriate limits on a service based on such criteria as medical necessity.” In so doing, a state “can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis” and may present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

27. 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.

28. In the instant-matter, there are multiple reasons why the comprehensive orthodontic treatment and periodic visits are medically necessary. First and foremost, the treatment has already begun, based upon an approval for “braces” that Petitioner’s mother verified. Second, she now has uncorrected gaps in her teeth due to the current stage of the treatment. Third, Petitioner complains of pain in her jaw and has to use ice to soothe the pain. Further, Dr. Dorrego testified that Petitioner could benefit from braces even though she did not score 26 points on the IAF. As stated above, the IAF and 26 point requirement are not listed in the Dental Policy.

29. It is clear that continued treatment would help correct and ameliorate Petitioner's condition. She is in pain and she needs to finish what has already been started in order to fix the gaps in her teeth. To the extent there was any confusion about authorization between Amerigroup, DentaQuest, and the orthodontist, that issue can be resolved amongst themselves, outside of the hearing process. In the meantime, Petitioner needs to complete her medically necessary orthodontic treatment.

DECISION

Based upon the foregoing, Petitioner's appeal is GRANTED. Amerigroup is directed to provide Petitioner with the comprehensive orthodontic treatment and 12 periodic visits, consistent with her request.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)
16F-06461
PAGE - 10

DONE and ORDERED this 07 day of December, 2016,
in Tallahassee, Florida.



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

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

Nov 21, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-06465

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 11, 2016 at 11:30 a.m.

APPEARANCES

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

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

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny licensed practical nurse (LPN) service hours that were requested for the petitioner for the certification period July 1, 2016 through August 25, 2016, was correct. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as a witness for the respondent was Rakesh Mittal, M.D., Physician-Consultant with eQ Health Solutions. The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Statement of Matters, Clinical Notes, Denial Notices, and Supporting Documentation, such as medical records

FINDINGS OF FACT

1. The petitioner's home health agency, CR and RA Investments (hereafter referred to as "the provider"), requested the following LPN service hours for the certification period at issue: 8 hours per day, 7 days per week.

2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for home health services. The provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner's medical conditions; her functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the petitioner, her family, or her physicians, other than a home health assessment conducted with her mother and telephone calls to the mother from the care coordinator. All pertinent information was submitted by the provider directly to eQ.

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

- 16 months old

█ [REDACTED]

5. The petitioner attends a Prescribed Pediatric Extended Care Facility (PPEC) from approximately 8:30 a.m. to 2:30 p.m., Monday to Friday.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by a LPN. The duties include, in part:

- Observe [REDACTED] precautions and monitor [REDACTED] activity

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information, and denied the requested nursing hours. This physician-reviewer wrote in part:

The submitted documentation does not support the medical necessity for the requested PDN services. There are no consistently documented skilled nursing interventions. Monitoring for potential [REDACTED] alone is not supportive of the need for skilled nursing services. Recommend denial of the requested PDN services.

A notice of this determination was sent to all parties on July 15, 2016.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the request for reconsideration. A reconsideration review was requested in this case on August 15, 2016, but it was rejected by eQHealth as an untimely request.

9. The petitioner thereafter requested a fair hearing and this proceeding followed.

10. The respondent's witness, Dr. Mittal, stated the request for nursing hours was appropriately denied since no skilled interventions are needed. He stated nurses are not to be used to monitor for [REDACTED] since [REDACTED] are considered an episodic illness which can occur at any time. He also stated the petitioner is on two [REDACTED] medications

but there was no current information submitted concerning the frequency of [REDACTED] activity.

11. The petitioner's mother stated she is requesting the nursing hours for [REDACTED] precautions. She is requesting the services from 3:00 p.m. to 11:00 p.m. daily. She also stated her daughter has difficulty with feeding.

12. Home health care for minors, including nursing care, is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Home Health Services Coverage and Limitations Handbook (effective October, 2014).

CONCLUSIONS OF LAW

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

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

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

16. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since this was an initial request and the petitioner had not been previously approved for any home nursing services. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

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

18. The petitioner has requested LPN nursing 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.

19. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

20. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.-- Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21...

5110. Basic Requirements

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you¹ must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for

¹ "You" in this manual context refers to the state Medicaid agency.

medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

21. The service the petitioner has requested (LPN nursing 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.

22. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

5110. Basic Requirements...

...Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

5122. EPSDT Service Requirements

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

5124. Diagnosis and Treatment

B. Treatment.--

1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

23. Once a service has been identified as requested under EPSDT, 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.

24. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested nursing services.

25. In the petitioner's case, the respondent has determined that nursing services at home are not medically necessary.

26. 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.

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

28. The Home Health Services Handbook on page 2-19 sets forth the requirements for private duty nursing services, as follows:

Private duty nursing services must be:

- *Ordered by the attending physician.*
- *Documented as medically necessary.*
- *Provided by a registered nurse or a licensed practical nurse.*
- *Consistent with the physician approved POC.*
- *Prior authorized before services are provided.*

29. The Home Health Services Handbook on page 1-5 defines private duty nursing as follows:

Private duty nursing services are medically necessary skilled nursing services that can be provided to recipients under the age of 21 in their home or other authorized settings to support the care required by their complex medical condition.

Private duty nursing is furnished for the purposes of performing skilled interventions or monitoring the effects of prescribed treatment.

30. The petitioner's physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

31. The respondent's witness stated the petitioner does not meet the criteria for nursing services at home since no skilled interventions are needed and nursing services are not to be used for monitoring for [REDACTED] activity.

32. The petitioner's mother is requesting the nursing services to provide [REDACTED] precautions from 3:00 p.m. to 11:00 p.m. daily.

33. After considering the documentary evidence and testimony presented, the undersigned concludes the petitioner has not demonstrated that the respondent should have approved the requested nursing service hours. No current information was submitted concerning the frequency of [REDACTED] activity and the evidence presented establishes that nursing services should not be used for monitoring for [REDACTED] activity.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 21 day of November, 2016,

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

FINAL ORDER (Cont.)

16F-06465

PAGE - 11

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

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

FILED

Nov 18, 2016

Office of Appeal Hearings
Dept. of Children and Families

██████████
██████████
████████████████████

APPEAL NO. 16F-06470

PETITIONER,

Vs.

CASE NO. ██████████

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 ████████
UNIT: ████████

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on November 3, 2016 at approximately 1:42 p.m. CDT.

APPEARANCES

For the Petitioner: ██████████, *pro se*, ██████████, sister

For the Respondent: Kenesha Hanley, operation and management consultant I

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of September 9, 2016 denying her May 12, 2016 application for Medicaid. The petitioner objected to the lack of timely communication and timely action on her Medicaid determination. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Lauren Coe, Division of Disability Determinations program operations administrator, appeared as a witness for the respondent.

This hearing was continued from October 6, 2016 to November 3, 2016 because of office closings caused by hurricane Matthew.

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "9".

FINDINGS OF FACT

1. On May 10, 2016, the petitioner applied to the respondent for Food Assistance Program (FAP) and Medicaid benefits. At issue is Medicaid and not FAP (Respondent's Exhibit 2).
2. On May 10, 2016, a medical interview was completed as part of the Division of Disability Determination's (DDD) eligibility determination process. The packet of DDD information was completed and sent by the respondent to DDD the same day (Respondent's Exhibit 7).
3. On June 2, 2016, the DDD packet was returned to the respondent without a decision as the disclosure information form was not included in the packet. Without it, DDD is unable to obtain the medical records needed to make a determination of disability.
4. According to respondent testimony, the completed disclosure form was indexed into the respondent's document imaging system on May 10, 2016.
5. The DDD packet, containing the disclosure form, was again sent to DDD on July 26, 2016.

6. On August 26, 2016, the petitioner requested an administrative fair hearing citing the lack of a decision on a May 10, 2016 application as the primary reason for the request.

7. The NOCA's sent to client during the period of concern are

April 11, 2016	How to use the MyACCESS Account
April 13, 2016	FAP denial
May 10, 2016	How to use the MyACCESS Account
May 11, 2016	FAP approval
September 1, 2016	Pended for information about a change for FAP and Medicaid
September 9, 2016	Medicaid denial

Not until September 1, 2016 did the respondent provide a NOCA concerning the May 10, 2016 Medicaid application.

8. In the time between the hearing request and the convening of the hearing, DDD reached a decision. On September 7, 2016, DDD determined that the petitioner did not meet the Social Security Administration's standard to be considered disabled; therefore, the respondent denied the Medicaid application September 8, 2016. The reason cited by DDD for the denial was N32 along with the remark, "client is able to do other light work (Respondent's Exhibit 8)."

9. A NOCA was mailed to the petitioner informing her of the denial and reason on September 9, 2016. The reason stated, "no household members are eligible for this program (Respondent's Exhibit 1)."

10. The petitioner's sister (CB) and spokesperson, is concerned about her sister's health, citing long-term [REDACTED]. CB represents her sister because her sister is not mentally capable of managing her own affairs. CB is concerned that

her sister's physical ailments could be fatal and is focused on her physical rather than mental health.

11. The DDD determination considered only physical allegations. [REDACTED] and a [REDACTED] were the focus of the DDD determination.

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.

13. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

15. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he 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...

16. The findings show petitioner is 48 years old. In this case, before Medicaid eligibility can be determined, petitioner must meet the federal definition of disabled.

17. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1440.1204, Blindness/Disability Determinations (MSSI, SFP), states in part:

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs. State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year. If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

18. The above authority explains that a disability application must be sent to the DDD to be reviewed for applicants who are under the age of 65, who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs. DDD concluded the petitioner is not a disabled individual.

19. The DDD determination was based on allegations of physical conditions only. The undersigned has heard trustworthy testimony as to the deteriorated mental condition of the petitioner and concludes that mental capacity and mental health should have been considered in DDD's determination process.

20. The undersigned also concludes that the respondent was remiss in notifying the petitioner of actions taken in reference to the Medicaid application but sees no action to be taken to rectify the omission at this time. Written notification of case action is

required whether or not it is “automatically” generated by the computer system used by the respondent to make eligibility determination.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The case is granted and remanded to the respondent who is ordered to amend the DDD packet to include information about the petitioner’s mental condition and again send the packet to DDD for reconsideration. If a favorable determination is reached, the respondent is ordered to consider the original Medicaid application date of May 10, 2016 as the corresponding date of application. Once a new determination is made, the respondent will issue a new notice that includes 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.

FINAL ORDER (Cont.)
16F-06470
PAGE -7

DONE and ORDERED this 18 day of November, 2016,
in Tallahassee, Florida.



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

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

FILED

Nov 21, 2016

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. 16F-06480

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 24, 2016 at 2:05 p.m. in Tallahassee, Florida.

APPEARANCES

For the Petitioner: [REDACTED], husband

For the Respondent: Christine Frier, Senior Human Services
Program Specialist, ACCESS Program Office

Amy Sumner, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of June 14, 2016 approving his wife for Institutional Care Program (ICP) Medicaid with a patient responsibility of \$370.88. The petitioner believes the patient responsibility should be lower due to his expenses. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted evidence on October 13, 2016, which was entered as Petitioner's Exhibit 1. The Department submitted evidence on October 18, 2016, which was entered as Respondent's Exhibit 1.

The record was held open for additional information from the Department through October 28, 2016. The Department submitted the additional information on October 24, 2016. This was entered as Respondent's Exhibit 2.

The record closed on October 28, 2016.

FINDINGS OF FACT

1. The petitioner applied for Institutional Care Program (ICP) Medicaid on March 4, 2016.
2. The petitioner or institutionalized spouse (IS) resided in the nursing facility from March 2016 until her death in September 29, 2016.
3. The petitioner's spouse resides in the community independently. He is 78 years old.
4. The petitioner's income consisted of her Social Security Income of \$780 and her retirement from City of Tallahassee of \$1,160.61. Her total gross income is \$1,940.61 ($\$780 + \$1,160.61 = \$1,940.61$).
5. The personal needs allowance for institutionalized individuals effective July 1, 2015 is \$105.
6. The Department explained the petitioner's total income of \$1,940.61 less the \$105 personal needs allowance leaves countable income of \$1,835.61.

7. The community spouse (CS) has income consisting of his Social Security Income of \$948 and his retirement from City of Tallahassee of \$600.46. His total gross income is \$1,548.46.

8. The Department issued a Notice of Case Action on April 4, 2016 establishing the patient responsibility of \$370.88 and spousal diversion amount of \$1,063.31 beginning April 2015.

9. The Department recorded in case notes the petitioner's request for a hearing on April 14, 2016. His request for hearing was to determine if he could retain more of his wife's income for household expenses.

10. The hearing request in April 2016 was not forwarded to the Office of Appeal Hearings; therefore, the undersigned is reviewing the case from April 2016.

11. The Department issued a Notice of Case Action on June 14, 2016, which decreased the patient responsibility to \$363.88, and increased the community spousal diversion amount to \$1,071.31.

12. The Department reviewed the case again on July 19, 2016 by completing a supervisory review. The review was completed as the CS is requesting the patient responsibility again be decreased and community spousal diversion amount increased so that he can afford to pay his bills.

13. The CS reported on July 19, 2016 a burial contract expense, which was not previously reported.

14. The Department spoke with the CS again on August 30, 2016 regarding the patient responsibility. The CS again requested the patient responsibility be

decreased and community spousal diversion amount increased so that he can afford his bills.

15. The appeal request was entered into the system on August 30, 2016.

16. The petitioner is deceased as of September 29, 2016. Only the months of April 2016 through September 2016 are in question.

17. The petitioner pays a monthly health insurance premium of \$400.42.

18. The CS has a mortgage obligation of \$797.77 and a home insurance obligation of \$75. The CS total shelter expenses are \$872.77.

19. The CS incurs utility expenses. The Department allows \$345 for utility expenses.

20. The Department totaled the petitioner's shelter expenses of \$872.77 and the utility allowance of \$345 to reach a total shelter expense of \$1,217.77.

21. The Department explained the calculation of the spousal diversion amount for April 2016 through June 2016 as follows: The CS income totaled \$1,548.46. The Shelter costs of \$1,217.77 were compared to 30 percent of the minimum monthly maintenance income allowance (MMMIA) of \$597 to reach an excess shelter cost of \$620.77 ($\$1,217.77 - \$597 = \620.77). The Department added the MMMIA of \$1,991 to the excess shelter costs of \$620.77 to reach a subtotal of the community spouse allowance of \$2,611.77. The Department subtracted the CS income amount \$1,548.46 from the community spouse allowance \$2,611.77 to reach a community spouse diversion amount of \$1,063.31 ($\$2,611.77 - \$1,548.46 = \$1,063.31$).

22. For April 2016 through June 2016, the patient responsibility was calculated as follows: The IS income totaled equals \$1,940.61. The IS income of

\$1,940.61 less the personal needs allowance of \$105 and the community spouse allowance of \$1,063.31 leaves a subtotal of \$771.30. The CS insurance premium of \$400.42 was subtracted from the subtotal of \$771.30 to reach a patient responsibility of \$370.88 ($\$771.30 - \$400.42 = \370.88).

23. The Department explained the calculation of the spousal diversion amount beginning July 1, 2016 as follows: The CS income totaled \$1,548.46. The Shelter costs of \$1,217.77 were compared to 30 percent of the minimum monthly maintenance income allowance (MMMIA) of \$601 to reach an excess shelter cost of \$616.77 ($\$1,217.77 - \$601 = \616.77). The Department added the MMMIA of \$2,003 to the excess shelter costs of \$616.77 to reach a subtotal of the community spouse allowance of \$2,619.77. The Department subtracted the CS income amount \$1,548.46 from the community spouse allowance \$2,619.77 to reach a community spouse diversion amount of \$1,071.31 ($\$2,619.77 - \$1,548.46 = \$1,071.31$).

24. Beginning July 1, 2016, the patient responsibility was calculated as follows: The IS income totaled equals \$1,940.61. The IS income of \$1,940.61 less personal needs allowance of \$105 and the community spouse allowance of \$1,071.31 leaves a subtotal of \$764.30. The CS insurance premium of \$400.42 was subtracted from the subtotal of \$764.30 to reach a patient responsibility of \$363.88 ($\$771.30 - \$400.42 = \363.88).

25. The CS does not report an exceptional circumstance, temporary or long term, which causes the diversion amount to be inadequate. He reports the diversion amount currently does not allow him enough income to pay all of his bills and be able to visit his wife in the facility.

26. The CS reported he did not have any additional resources to use in paying the patient responsibility while his wife was living.

CONCLUSIONS OF LAW

27. 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.

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

29. Fla. Admin. Code R. 65A-1.713 "SSI-Related Medicaid Income Eligibility Criteria" states in relevant part:

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. § 1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. § 1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference). When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.

...

(b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:

1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month.
2. If the individual's monthly income does not exceed the institutional care income standard in any month the department will prorate the income over the period it is intended to cover to compute patient responsibility, provided that it does not result in undue hardship to the client. If it causes undue hardship it will be counted for the anticipated month of receipt.

30. The Department's ACCESS Program Policy Manual, CFOP 165-22, section 1840.0101 "Earned and Unearned Income (MSSI, SFP)" states in relevant part:

Income is classified into two categories for budgeting purposes: earned income and unearned income. All non-exempt income must be verified at application and review unless otherwise specified.

Exempt income is income (earned or unearned) that is excluded from consideration when determining eligibility or patient responsibility. Accept the individual's statement for amount and type of exempt income, unless information is questionable or verification is required.

...

Unearned income is income for which there is no performance of work or services. Unearned income may include:

1. retirement, disability payments, unemployment/workers' compensation, etc.;
2. annuities, pensions, and other regular payments;
3. alimony and support payments;
4. dividends, interest, and royalties;
5. proceeds of life insurance policies;
6. prizes and awards;
7. gifts and inheritances; and
8. SSA, SSD, and SSI.

31. The Department's Policy Manual section 1840.0102 "Deductions from Gross Income (MSSI, SFP)" states in relevant part:

Some deductions withheld from gross income must be included as income. Examples of these deductions include:

1. premiums for Supplemental Medical Insurance (SMI/Medicare) from a Title II (Social Security) benefit,
2. premiums for health insurance or hospitalization,
3. premiums for life insurance,
4. federal and state income taxes,
5. Social Security taxes,
6. optional deductions,
7. a garnished or seized payment,
8. guardianship fees, and
9. child support if not redirected irrevocably from the source.

32. In accordance with the above controlling authorities, the undersigned concludes the Department correctly included the gross income from each source for both the IS and CS to determine ICP eligibility.

33. Fla. Admin. Code R. 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria" states in relevant part:

(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.

(b) At the time of application only those countable resources which exceed the community spouse's resource allowance are considered available to the institutionalized spouse.

(c) The community spouse resource allowance is equal to the maximum resource allocation standard allowed under 42 U.S.C. § 1396r-5 or any court-ordered support, whichever is larger.

(d) After the institutionalized spouse is determined eligible, the Department allows deductions from the eligible spouse's income for the community spouse and other family members according to 42 U.S.C. § 1396r-5 and paragraph 65A-1.716(5)(c), F.A.C.

(e) If either spouse can verify that the community spouse resource allowance provides income that does not raise the community spouse's income to the state's minimum monthly maintenance income allowance (MMMIA), the resource allowance may be revised through the fair hearing process to an amount adequate to provide such additional income as determined by the hearing officer. Effective November 1, 2007 the hearing officers must consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. The hearing officers will base the revised community spouse resource allowance on the amount necessary to purchase a single premium lifetime annuity that would generate a monthly payment that would bring the spouse's income up to the MMMIA (adjusted to include any excess shelter costs). The community spouse does not have to actually purchase the annuity. The community spouse will have the

opportunity to present convincing evidence to the hearing officer that a single premium lifetime annuity is not a viable method of protecting the necessary resources for the community spouse's income to be raised to the state's MMMIA. If the community spouse requests that the revised allowance not be based on the earnings of a single premium lifetime annuity, the community spouse must offer an alternative method for the hearing officer's consideration that will provide for protecting the minimum amount of assets required to raise the community spouse's income to the state's MMMIA during their lifetime.

(f) Either spouse may appeal the post-eligibility amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist. Exceptional circumstances that result in extreme financial duress include circumstances other than those taken into account in establishing maintenance standards for spouses. An example is when a community spouse incurs unavoidable expenses for medical, remedial and other support services which impact the community spouse's ability to maintain themselves in the community and in amounts that they could not be expected to be paid from amounts already recognized for maintenance and/or amounts held in resources. Effective November 1, 2007, the hearing officers must consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. If the expense causing exceptional circumstances is a temporary expense, the increased income allowance must be adjusted to remove the expenses when no longer needed.

(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.

(emphasis added)

34. The above controlling authority sets forth a provision for couples when one member is in a nursing facility and the other remains in the community to appeal the ICP income allowances determined by the Department. The hearing officer may adjust the allowances if proof is provided to show that exceptional circumstances have resulted in significant inadequacy of the community spouse's income allowance to meet her needs.

35. The findings show that \$1,063.31 of the IS's income is diverted to the CS, causing the patient responsibility to be \$370.88 beginning April 2016. The findings show these amounts were updated effective July 1, 2016 for a patient responsibility of \$363.88 and a Spousal diversion amount of \$1,071.31. The above controlling authority explains in a situation where proof is provided to show that an exceptional circumstance has caused a significant inadequacy, the diversion amount to the CS can be increased, resulting in a lower patient responsibility amount and a greater amount paid by Medicaid (ICP) to the nursing facility.

36. A couple must present proof that an exceptional circumstance has caused unavoidable extreme financial duress for the CS. The CS has presented proof that the total income and expenses are nearly the same. The CS has not presented the undersigned with an exceptional circumstance, either temporary or long term, causing a significant financial inadequacy for the CS. Therefore, in accordance with the above controlling authority, the undersigned concludes the petitioner does not meet the requirements for an increase in the spousal diversion amount. Petitioner has not met her burden of proof.

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 21 day of November, 2016,

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

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

FILED

Dec 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06484
16F-06485

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 24, 2016, at 1:30 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED].

For the Respondent: Sylvia Stokes, Operations & Management Consultant.

STATEMENT OF ISSUE

The petitioner is appealing the termination of her Food Assistance Program benefits and the requirement to complete an application for recertification to receive continued Food Assistance Program benefits. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On August 25, 2016, the petitioner filed an appeal requesting continued benefits for the FAP and Medicaid benefits. The appeal was continued from prior scheduled hearing due to office closure.

At the start of the hearing, the petitioner informed the undersigned that the Medicaid issue has been resolved and that she no longer needs a decision on it. Therefore, the Medicaid Appeal 16F-06485 will be dismissed as moot.

During the hearing, the petitioner did not submit any exhibits for consideration. The respondent presented eight exhibits which were accepted into evidence and marked as Respondent Exhibits "1" through "8" respectively. The record was left open through October 26, 2016 for the respondent to provide additional information. The information was timely received and marked as Respondent's Exhibit 9. The record was left open extended through November 19, 2016, per respondent's request for more time to locate the petitioner and assist her in the application process. The respondent did not provide any additional information, nor did he/she contact the hearing officer for additional time. The record was closed on November 19, 2016.

FINDINGS OF FACT

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

1. Prior to the action under appeal, the petitioner had been receiving FAP and Medicaid benefits for her and her son. The son was receiving Supplemental Security Income (SSI) and the household used to be certified for a one-year period.

2. On February 9, 2016, the petitioner submitted an application requesting Temporary Cash Assistance (TCA), FAP and Medicaid benefits for her household. On that application, the petitioner reported her mailing address as [REDACTED]. She also reported that her son was no longer receiving SSI, See Respondent's Exhibit 1. The respondent approved FAP and Medicaid benefits. The petitioner was given a six month certification ending August 31, 2016. The petitioner was notified via a Notice of Case Action generated on February 12, 2016. The notice was sent to the mailing address reported by the petitioner, See Respondent's Exhibit 9.

3. On July 18, 2016, the respondent sent the petitioner a Notice of Eligibility Review. The Notice was sent to [REDACTED]. It informed the petitioner that August 2016 was the last month she would receive benefits and that she or her authorized representative must reapply by the 15th day of August 2016 to keep her receiving benefits without a break, See Respondent's Exhibit 2. The above notices were not returned to the respondent.

4. On August 2016, the respondent was made aware that the petitioner's FAP benefits for that month were not available on her electronic benefits transfer (EBT) card. On August 24, 2016, the respondent contacted the petitioner informing her that her FAP benefits were authorized and would be available the next day. During the conversation, the petitioner was reminded to submit an application as soon as possible in order to guarantee any future FAP benefits, See Respondent's Exhibit 6. The petitioner was issued FAP benefits for September 2016 after review, See Respondent's Exhibit 8.

5. The respondent explained that the petitioner was only certified for six months because her son's SSI has stopped, resulting in the household no longer being eligible

for a year certification period. She explained that the petitioner has been advised over and over about the need for an application to continue her FAP benefits, but has refused to comply. During the hearing, it was discovered that the address provided by the petitioner on her February 9, 2016 application, to which all the notices were sent, was incorrect. The petitioner explained that someone completed the application for her and that she was not aware of the mistake.

6. The petitioner did not dispute the facts presented by the respondent. She acknowledged her conversations with the respondent, but argued that she did not complete an application because she usually gets certified for a year; therefore, did not know why she is required to reapply so soon to continue receiving her FAP benefits. As of the date of the hearing, the petitioner has not reapplied. During the hearing, the petitioner has agreed to provide her location for the respondent to assist her with the application. The record was left open through November 19, 2016 for the respondent to provide a status update to the undersigned, but none was received.

CONCLUSIONS OF LAW

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

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

9. The Code of Federal Regulations at 7 C.F.R. § 273.14 set forth the requirements for recertification.

(a) General. No household may participate beyond the expiration of the certification period assigned in accordance with Sec. 273.10(f) without a determination of eligibility for a new period. The State agency must establish procedures for notifying households of expiration dates, providing application forms, scheduling interviews, and recertifying eligible households prior to the expiration of certification periods. Households must apply for recertification and comply with interview and verification requirements.

(b) *Recertification process*—(1) *Notice of expiration*. (i) The State agency shall provide households certified for one month or certified in the second month of a two-month certification period a notice of expiration (NOE) at the time of certification. The State agency shall provide other households the NOE before the first day of the last month of the certification period, but not before the first day of the next-to-the-last month. Jointly processed PA and GA households need not receive a separate food stamp notice if they are recertified for food stamps at the same time as their PA or GA redetermination.

(ii) Each State agency shall develop a NOE. The NOE must contain the following:

(A) The date the certification period expires;

(B) The date by which a household must submit an application for recertification in order to receive uninterrupted benefits;

(C) The consequences of failure to apply for recertification in a timely manner;

10. The above regulation provide that no household may participate beyond the expiration of the certification period assigned by the respondent. The respondent assigned the petitioner a six-month certification from March 1, 2016 through August 31, 2016 and notified her via a Notice of Case Action generated on February 12, 2016. A Notice of Eligibility Review was then sent on July 18, 2016, reminding the petitioner to submit an application and the consequences if she fails to do so. As the Notice of

Eligibility Review was sent to the petitioner to the address given by her, it is concluded that the respondent made a diligent attempt to send notification to the petitioner that her Food Assistance Program certification would end August 31, 2016.

11. Additionally, the petitioner was verbally informed on several occasions of the requirement to reapply, but she declined. The petitioner contends she should have been certified for a year. The petitioner finally agreed to cooperate with the respondent to initiate an application process; however, no verification was received from the respondent to confirm that cooperation.

12. After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that the respondent's action to terminate Food Assistance Program benefits effective October 2016 was within the regulations of the Program. The petitioner is required to reapply and complete the necessary application to guarantee her eligibility to receive continued Food Assistance Program benefits. The petitioner has failed to meet her burden that she is eligible for any FAP benefits beyond the certification period assigned to her by the respondent.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 06 day of December, 2016,

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
[REDACTED]

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

FILED

Dec 09, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06505

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:45 a.m. on October 31, 2016.

APPEARANCES

For the Petitioner: [REDACTED], Authorized Representative (AR)
Aging Solutions

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Institutional Care Program (ICP) Medicaid from July 2015 through December 2015, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on September 26, 2016 and did not convene due to the petitioner's AR not providing the required AR form to represent the petitioner. The AR subsequently provided the required AR form to represent the petitioner. The hearing was rescheduled and convened on October 31, 2016.

The petitioner was not present. [REDACTED], [REDACTED] (Facility) Business Office Manager, appeared as a witness for the petitioner. Petitioner did not submit exhibits. The respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The petitioner did not receive the respondent's exhibits and elected to proceed with the hearing without the respondent's evidence. The record was closed on October 31, 2016.

FINDINGS OF FACT

1. Petitioner was admitted to the Facility in June 2015. The petitioner is incapacitated and did not have a guardian when she was admitted. The petitioner's AR became the petitioner's court appointed guardian on May 9, 2016.
2. On April 7, 2016, an ICP application was submitted for the petitioner. On June 23, 2016, another ICP application was submitted for the petitioner. No other ICP applications were received for the petitioner.
3. Petitioner's AR agreed that ICP applications for the petitioner were not submitted prior to April 7, 2016.
4. On July 12, 2016, the Department mailed the Facility a Notice of Case Action (NOCA) approving the petitioner ICP benefits for March 2016, April 2016, May 2016, June 2016 and July 2016.

5. On July 26, 2016, the Department mailed the Facility another NOCA approving the petitioner ICP benefits for January 2016, February 2016, March 2016 and April 2016.
6. The Department's policy only allows three months retroactive coverage from the date of the application. Therefore, the Department approved the petitioner ICP benefits from January 2016 using the April 7, 2016 application.
7. Petitioner's AR contends that an ICP application could not be submitted for the petitioner prior to April 7, 2016 because they were waiting on guardianship.
8. Petitioner's AR stated that the petitioner was over the asset limit, which is another reason the Facility was unable to submit a prior ICP application until a guardian was appointed. And once a guardian was appointed, the guardian closed the petitioner's accounts that made her over the asset limit.

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. The Fla. Admin. Code R. 65A-1.702, Medicaid 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)...

12. In accordance with the above authority, Medicaid eligibility “includes three months” prior to the month of application.

13. The evidence submitted establishes that ICP applications were submitted on behalf of the petitioner on April 7, 2016 and June 23, 2016. And the Department approved the petitioner ICP benefits effective January 2016, three months prior to the April 7, 2016 application.

14. Petitioner’s AR agrees that ICP applications were not submitted for the petitioner prior to the April 7, 2016 applications; although they are requesting retroactive ICP benefits from July 2015 through December 2015.

15. Petitioner’s AR argued that ICP applications could not be submitted for the petitioner prior to April 7, 2016, because the petitioner did not have an appointed guardian.

16. In careful review of the cited authority, evidence and testimony, the undersigned concludes that the petitioner’s AR did not meet the burden of proof. The undersigned concludes that the Department’s action to deny the petitioner ICP benefits from July 2015 through December 2015 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 December, 2016,

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]
Office of Economic Self Sufficiency

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

FILED

Nov 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06510

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:18 a.m. on September 30, 2016

APPEARANCES

For the Petitioner: [REDACTED], Authorized Representative (AR)
[REDACTED]
Business Office Manager

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Institutional Care Program (ICP) Medicaid benefits for June 2016 is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner is deceased and was represented by her AR. [REDACTED], Senior Medicaid Solutions, Filing Specialist, appeared as a witness for the petitioner.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on September 30, 2016.

FINDINGS OF FACT

1. Petitioner was admitted to [REDACTED] on June 6, 2016. Petitioner was transferred to the hospital on June 15, 2016 and passed away on June 18, 2016.
2. On June 17, 2016, an ICP Medicaid application was submitted on behalf of the petitioner. The application lists \$575 Supplemental Security Income (SSI) and no assets.
3. On June 21, 2016, the Department mailed the petitioner's witness a Notice of Case Action (NOCA). The notice states in part:

We need the following information by July 1, 2016.
Please complete and sign the Affidavit for Designated Representative Form. The following information is needed to complete this application: bank statements beginning 3/2016, verification of all income other than Social Security and all assets, including life insurance face/cash value, prepaid burial contracts, homestead, etc... [Petitioner] was admitted on 6/6 and elected hospice on 6/8. There are 2 days of uncovered ICP as [petitioner] does not have Medicare. Need the complete medical packet to be sent to cares for those 2 days...

4. Petitioner's AR alleges that the petitioner did not have assets and the only income she had was from SSI, which was deposited into a Direct Express account. Petitioner's

known family is a daughter, who does not want to have anything to do with the petitioner.

5. Respondent's representative contends that Direct Express is a bank; therefore, the Department requires the petitioner's bank statements to verify the balance.
6. Petitioner's witness claims that Direct Express is a government bank that will not release the petitioner's bank statement(s).
7. Website (usdirectexpress.com) identifies Direct Express as a Debit MasterCard, issued by Comerica Bank.
8. On July 19, 2016, the Department mailed the petitioner's witness a NOCA, notifying the petitioner's ICP Medicaid application was denied; due to not receiving the requested information to determine eligibility.
9. Petitioner's AR believes that the petitioner should be approved ICP, due to hardship, since they are unable to get a bank statement.

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-1.303, Assets, states in part:
 - (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.

13. The above authority explains that assets are countable if the asset is available to the individual.

14. The findings established that the petitioner had a Direct Express account and the money (asset) in the Direct Express account was available to her. Website, usdirectexpress.com, identifies Direct Express as a Debit MasterCard, issued by Comerica Bank. The Social Security Administration electronically deposited the petitioner's monthly SSI into her Direct Express account.

15. Fla. Admin. 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, 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...

16. In accordance with the above authority, the respondent mailed the petitioner's witness a NOCA on June 21, 2016, requesting the petitioner's bank statement(s) (among other documents) to determine the petitioner's ICP Medicaid eligibility.

17. Petitioner's witness testified that Direct Express is a government bank that will not provide the petitioner's bank statement(s).

18. Also in accordance with the above authority (#15), the Department denied the petitioner's June 17, 2016 ICP Medicaid application; due to not providing the required information to determine ICP Medicaid eligibility.

19. In careful review of the cited authorities, evidence and testimony, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the Department's action to deny the petitioner ICP Medicaid benefits 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 01 day of November, 2016,

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

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

Nov 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06514

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 [REDACTED]
UNIT: [REDACTED]

D - DDD - Disability

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on October 13, 2016 at approximately 10:00 a.m. CDT. The hearing was reconvened on October 24, 2013 at 8:30 a.m. CDT.

APPEARANCES

October 13, 2016 & October 21, 2016

For the Petitioner: [REDACTED] *pro se*, [REDACTED], his wife

For the Respondent: Lynda J. Burrows, economic self-sufficiency specialist supervisor.

The same parties were in attendance at both hearings.

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of October 13, 2016 denying Medicaid eligibility for petitioner's wife (BD). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was continued due to receipt of a response from the Division of Disability Determination that was so recent that a notice of case action (NOCA) had not been mailed out yet. The record was left open for the respondent to submit additional documentation. This information was received November 2, 2016.

After the receipt of the additional documentation, the hearing officer realized that the previously submitted information had not been admitted into evidence. An interim order was sent identifying the exhibits and allowing each party 10 days to register objections to admitting them as proposed in the interim order. Neither party responded to the interim order. The information received from the respondent was entered into evidence and marked as Respondent's Exhibits "1" through "10". The information received from the petitioner was entered into evidence and marked as Petitioner's Exhibits "1" through "6".

The record was closed November 21, at least 10 days after the mailing of the interim order.

Margaret Poplin, of the Office of Appeal Hearings, observed the first proceeding without objection.

FINDINGS OF FACT

1. On June 27, 2016, the petitioner submitted an application to the respondent requesting SSI-Related Medicaid, Food Assistance Program benefits, and Medicaid Savings Program (MSP) benefits. The request for Food Assistance and MSP were processed and approved; however, the request for SSI-Related Medicaid was overlooked (Respondent's Exhibit 2).
2. The Medicaid application was reconsidered upon receipt of a hearing request. A Division of Disability Determination (DDD) packet was prepared and sent to their Tallahassee office (Respondent's Exhibit 1) seeking a disability determination for the petitioner's wife based on the June 27, 2016 request for SSI-Related Medicaid.
3. A Disability Determination and Transmittal (CF-ES 2909) was received from DDD by the respondent October 11, 2016. The petitioner's wife was determined NOT to be disabled. The primary diagnosis considered was [REDACTED] (03) and the secondary diagnosis considered was [REDACTED] (12). The basis code used for the decision was N43. The remarks section states, "Hankerson 3/15 same/related allegations, hearing pending" (Respondent's Exhibit 5).
4. Supplemental Security Income (SSI) benefits were applied for October 22, 2014. The application was denied, determining the applicant was not disabled on January 7, 2015 with denial code N32. The decision was appealed April 4, 2015 and is still under appeal (Respondent's Exhibit 9, and Petitioner's Exhibit 3).
5. The petitioner has been issued a Disabled Persons Parking Identification Permit from the Florida Department of Highway Safety and Motor Vehicles (Petitioner's Exhibit 5).

6. Upon inquiry, it was agreed that there were no new disabling conditions that have not been brought to the attention of the Social Security Administration (SSA).

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.

8. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

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

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

11. 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.

12. The Department's Program Policy Manual, CPOF 165-22, passage 1440.1205

Exceptions to State Determination of Disability (MSSI, SFP) states:

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

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

13. 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.

14. In this case, the petitioner is under 65 and has several medical conditions such as [REDACTED]. The findings show that these medical conditions were reviewed in the SSA disability determination. The

findings show the petitioner applied for SSI-Related Medicaid more than 12 months; however, the petitioner has applied for and been denied SSA disability benefits with the alleged medical conditions and the SSA denial is also currently under appeal.

Therefore, the undersigned concludes that the petitioner did not meet the burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to adopt the decision currently under appeal made by SSA. Until the 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, 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.)
16F-06514
PAGE -7

DONE and ORDERED this 29 day of November, 2016,
in Tallahassee, Florida.



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

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

FILED

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

Dec 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06525

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:15 a.m. on November 4, 2016.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Sylma Dekony, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the respondent's (or the Department) action to approve the petitioner Medically Needy (MN) Medicaid with a \$724 Share of Cost (SOC) instead of full Medicaid. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on September 30, 2016. Both parties appeared on September 30, 2016. The petitioner requested that the hearing be rescheduled. Petitioner's request was granted and the hearing was rescheduled and convened on November 4, 2016.

██████████, the petitioner's friend, appeared as a witness for the petitioner. Petitioner did not submit exhibits. Respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record was closed on November 4, 2016.

FINDINGS OF FACT

1. On July 25, 2016, the petitioner (age 82) submitted an application for Food Assistance and SSI-Related Medicaid for herself. The application lists \$1,011 income from Social Security (SS) and \$165.35 income from a pension. Expenses listed include \$251.96 monthly medical insurance. Medicaid is the only issue.
2. The income limit for full SSI-Related Medicaid for an individual is \$872. Petitioner's income exceeds the \$872 SSI-Related Medicaid income standard. The next available Medicaid program is the MN with a SOC.
3. The following is the Department's calculation of the petitioner's SOC:

\$1,011.00	SS
+\$ 165.35	Macy's pension
<hr/>	
\$1,176.35	total household income
-\$ 20.00	unearned income disregard
-\$ 180.00	MN income level (MNIL) for a household size of one
-\$ 251.96	medical insurance
<hr/>	
\$ 724.00	SOC (cents dropped)

4. On August 23, 2016, the Department mailed the petitioner a Notice of Case Action notifying her July 25, 2016 application was approved for MN with a \$724 SOC.
5. Petitioner did not dispute the Department's calculation of her SOC. Petitioner believes since she is on a fixed income and has monthly expenses she should be eligible for full SSI-Related Medicaid.

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 Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income

Eligibility Criteria states in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level...

(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...

9. 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.

10. The Department's Program Policy Manual, CFOP 165-22, appendix A-9 (July 2016), identifies \$872 as 88 percent of the FPL for an individual.

11. The evidence submitted establishes that the petitioner receives \$1,176.35 monthly income, which exceeds the \$872 income limit for full SSI-Related Medicaid.

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

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

14. Federal Regulations at 42 C.F.R. § 436.831 explains medical deductions and in part states, "(e) Determination of deductible incurred expenses (1) Expenses for Medicare and other health insurance premiums..."

15. In accordance with the cited authorities, the Department deducted \$20 unearned income, \$180 MNIL and \$251.95 petitioner's medical insurance from the petitioner's \$1,176.35 household income, to arrive at a \$724 SOC.

16. In carefully review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes the respondent's action to approve the petitioner MN Medicaid with a \$724 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 13 day of December, 2016,

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

Dec 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06535
APPEAL NO. 16F-08266

PETITIONER,

Vs.

CASE NO [REDACTED]

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 4, 2016 at 1:35 p.m.

APPEARANCES

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

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

ISSUE

The issue under appeal is the respondent's action on August 30, 2016 to terminate the petitioner's spouse's enrollment in the Medically Needy (MN) program due to her failure to complete a telephone interview.

Also at issue is the respondent's action on November 7, 2016 to terminate the petitioner's coverage under the Qualifying Individual 1 (QI1) program as his income exceeded the income eligibility standard.

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

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on October 26, 2016 at 9:00 a.m. However, the petitioner did not wish to proceed as he did not receive the Department's evidence. The hearing was rescheduled to convene on November 4, 2016 at 1:30 p.m.

The hearing convened as scheduled.

Appearing as a witness for the petitioner was his wife, [REDACTED].

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

The record was held open until 5:00 p.m. on November 18, 2016 to allow the respondent and the petitioner to submit additional evidence. Evidence was received and entered as the Respondent's Exhibit.

The record was closed as of 5:00 p.m. on November 18, 2016.

Correspondence was received from the petitioner on November 23, 2016. However, the correspondence received was not considered in this appeal, as the record was closed as of November 18, 2016.

FINDINGS OF FACT

1. On July 28, 2016, the petitioner, age 55, completed an application to recertify for the Medicare Savings Program (MSP) and SSI-Related Medicaid for himself and his

wife, age 60. The petitioner listed on the application the household's telephone number as [REDACTED]

2. The petitioner's wife was previously enrolled in the MN program from October 2015 through September 30, 2016 and the petitioner was previously receiving coverage under the Q11 program.

3. The MSP consists of three Medicaid programs which include the Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB), and Qualified Individual 1 (QI1). These are limited coverage Medicaid Programs which pays the Medicare Part B premium.

4. The Respondent's Exhibit 2 includes the Notice of Case Action dated August 3, 2016 requesting the following verifications due by August 15, 2016: ..."1.You will receive a call at [REDACTED] for your Medicaid Disability Interview which is scheduled for (8/9/2016) between the hours of (11-Noon)..."

5. The Respondent's Exhibit 2 also includes the Running Records Comments (CLRC) dated August 9, 2016, which states: "DDD int attempted at 11:01 to [REDACTED]...Reschedule for 8/15 @ 11AM..." The CLRC notes dated August 15, 2016 states: "DDD int attempted with CP at [REDACTED]-Left message on VM..." CLRC notes dated August 16, 2016 states: "RCVD VM from C to call her back at [REDACTED] called clt back, left message on vm..."

6. The Department terminated the petitioner's spouse's MN coverage on August 29, 2016 due to not completing the disability interview.

7. The Department included in its calculations for the QI1 program, the petitioner's gross monthly income from Social Security in the amount of \$1548. He pays a Medicare Part B premium in the amount of \$104.90. The total income included in the budget was \$1548. The standard \$20 unearned income disregard was subtracted from the total gross income which resulted in a countable income of \$1528.

8. The Department determined that the petitioner was ineligible for the QI1 Medicaid program as the income exceeded the QI1 income standard for an individual in the amount of \$1337. The Respondent's Exhibit 3 includes the Notice of Case Action dated November 7, 2016 which indicates that the petitioner is ineligible for the QI1 program beginning August 1, 2016.

9. The petitioner does not dispute the income included in the Department's calculations. The petitioner argues that he provided to the Department all of the requested verifications. The petitioner argues that his wife attempted to complete the phone interview and left a message. The petitioner points out that the Department's evidence includes a return call to a phone number with the area code of [REDACTED]" (Respondent's Exhibit 2, page 19). The petitioner argues that he and his wife do not have a phone number with area code [REDACTED]" and that he does not know to whom the number belongs. The petitioner argues that his wife has a [REDACTED]" telephone number and has had the same number for at least 10 years. The petitioner argues that his wife contacted the Department twice and requested a call back for the interview but no one returned her call. The petitioner contends that he does not recall receiving a letter

requesting for a disability interview. The petitioner reports that he rarely has issues with his mail.

10. The petitioner argues that his wife was receiving Supplemental Security Income (SSI) before they were married; she is disabled and has extensive medical problems. The petitioner contends that his wife was receiving SSI until August 2015 and was terminated because they were married in July 2015.

11. The petitioner's wife had [REDACTED] surgery in November 2015 and a major medical surgery this year. The petitioner argues that his wife was enrolled in the MN program with a share of cost (SOC) in the amount of \$1100 each month. The petitioner argues that his wife needs Medicaid to receive her medical care. The petitioner contends that his wife has not reapplied for SSI. The petitioner's wife lists her medical conditions as [REDACTED] issues, [REDACTED].

12. The petitioner believes the Department is changing its policy at will because he has been receiving coverage under the Q11 program for years. The petitioner argues that he is married and should be recognized as a couple. The petitioner argues that his Social Security income will be reduced due to the termination of the Q11 program.

13. The Department is unsure how the petitioner's wife was previously enrolled in the MN program. The Department contends that the ex-parte process was completed. The Department contends that there was no other contact made to the petitioner's wife in an attempt to conduct the disability interview after August 29, 2016. The Department contends that the case worker makes the first attempt for the disability

interview and will send a letter requesting the interview if unsuccessful. The Department reports that there has been no returned mail in the petitioner's case.

14. The Department contends that an error was made in the petitioner's case and he was approved for the Q11 in error. The Department explained that its policy was clarified and it was determined that the petitioner was not eligible for the Q11 program.

CONCLUSIONS OF LAW

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

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

The termination of the spouse's MN coverage will be addressed first:

17. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria, sets forth the rules to be eligible under the SSI-Related Medicaid groups. The findings show that the petitioner's spouse is under age 65 and has no minor children in her home. The undersigned concludes the Department correctly began to review the petitioner's spouse for potential eligibility under the SSI-Related Medicaid Program rules.

18. Fla. Admin. Code R. 65A-1.205 addresses the eligibility determination process and states in relevant part:

(1) (a) The Department must determine an applicant's eligibility initially at application...It is the applicant's responsibility to keep appointments with

the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification..., the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview; whichever is later. For all programs, verifications are due ten calendar days from the date of written request or interview, or 60 days from the date of application, whichever is later...If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension...

(3) The Department conducts phone or face-to-face interviews with applicants/recipients or their authorized/designated representatives when required for the application or complete eligibility review process. The Department conducts face-to-face interviews upon request in the ACCESS Florida office, the applicant's/recipient's home, or other agreed upon location. The applicant/recipient or their authorized/designated representative must keep the interview appointment or reschedule the missed appointment...

(4) If an applicant or recipient does not keep an appointment without arranging another time with the eligibility specialist; or does not sign and date the applications described in subsection (1); or does not submit required documentation or verification the Department will deny benefits as it cannot establish eligibility.

19. The findings show that the Department terminated the petitioner's spouse's enrollment in the MN program as she failed to complete the interview. The findings show that the Department mailed a letter with the instructions that a caseworker would contact the petitioner's spouse on August 9, 2016 between 11:00 a.m. and noon to conduct the disability interview. The findings show that

the petitioner's spouse returned the Department's phone call on or around August 16, 2016 in an attempt to conduct the disability interview. The findings show that the petitioner's phone number is [REDACTED]. The findings also show that the case worker returned the petitioner's spouse's phone call on August 16, 2016 at the incorrect phone number.

20. Based on the above findings of fact and conclusions of law, the undersigned concludes that the respondent terminated the petitioner's spouse's MN coverage in error, as the petitioner's spouse attempted to conduct the disability interview before the termination of her coverage under the MN program. Therefore, the Department is remanded with instructions to conduct the disability interview and complete a disability determination in the petitioner's spouse's case. The Department is to issue notice with appeal rights upon completion of its determination.

The termination of the coverage under the QI1 program will now be addressed:

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

...

(12) Limits of Coverage

(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium...

...

(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 time limits for those programs.)

22. Fla. Admin. Code R. 65A-1.713(1) further addresses the SSI-

Related Medicaid Income Eligibility Criteria as follows:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

...

(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.

...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

23. The Department's Program Policy Manual at Appendix A-9, effective July 2016, sets forth that the income limit for QMB benefits for an individual as \$990 and QMB couple as \$1335; SLMB benefits for an individual is \$1,188 and SLMB Couple as \$1,602; and QI1 benefits for an individual as \$1337 and QI1 couple as \$1803.

24. 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..."

25. The Court held in Winick v. Dep't of Children and Family Services, 161 So.3d 464 (Fla. 2d DCA June 2014), where an individual who receives Medicare Part A and is applying for the Medicare Buy-In Program and lives with his/her spouse, the Department must determine eligibility using the family size of two.

26. The findings show that the petitioner is married and living with his wife. He is the only one in the household receiving Medicare, and he is requesting assistance with the payment of his Medicare Part B premium. Therefore, the undersigned applies the Winick decision to this appeal. It is concluded that the respondent erred in applying the individual income standard to petitioner. The Department's Program Policy Manual at Appendix A-9 shows the Income Limit for a QMB Couple as \$1,335, SLMB Couple as \$1,602, and QI1 Couple as \$1,803. The petitioner's income of \$1,548 minus \$20 disregard, equals income of \$1,528. It is concluded that the petitioner is eligible for the Medicare cost saving benefits under the SLMB Program. The respondent's termination of Medicare cost savings benefits is reversed. The petitioner is eligible for SLMB Program benefits from the onset of the determination of ineligibility for the QI1 program beginning August 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, both appeals are granted.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of December, 2016,
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

Nov 21, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NOs. 16F-06555
16F-06715

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION

CIRCUIT: 13 [REDACTED]

UNIT: [REDACTED]

RESPONDENT.

_____ /

FINAL ORDER OF DISMISSAL

On November 7, 2016, the hearing officer entered a Preliminary Order of Dismissal in this matter explaining a review of the information supplied by both parties indicates the petitioner has not received a formal denial from Amerigroup regarding the services for which he is requesting reimbursement as evidenced by the lack of a Notice of Action in the documents provided by both parties. The Preliminary Order of Dismissal also explained Appeal No. 16F-06715 appears to be duplicative of the earlier appeal and, therefore, unnecessary.

The Preliminary Order of Dismissal explained that the Office of Appeal Hearings has limited jurisdiction which is conferred to it by statute or rule and that, in order for an action to be reviewed by a hearing officer, the respondent must have denied a claim for services or there must have been a termination, suspension, or reduction in services.

The Order requested the parties submit a Notice of Action documenting a denial by the respondent, thereby affirming the petitioner's right to request an administrative

hearing at this time. It instructed the parties to supply this information to the Office of Appeal Hearings as soon as practicably possible but, in any event no later than 10 days from the date of the Order. It further advised that this action would be dismissed if the information requested was not produced.

As of the date of this Final Order of Dismissal, neither party has provided a Notice of Action or any other information substantiating the petitioner's right to request a hearing at this time. Accordingly, these appeals are hereby DISMISSED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 21 day of November, 2016,
in Tallahassee, Florida.



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

Copies Furnished To: , Petitioner
AHCA, Medicaid Fair Hearings Unit
Amerigroup Hearings Unit

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

FILED

Nov 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06557

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION

CIRCUIT: 05 [REDACTED]

UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia Antonucci convened an administrative hearing in the above-referenced matter on October 12, 2016 at approximately 3:24 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner

For the Respondent, AHCA: Sheila Broderick, RN Specialist,
Agency for Health Care Administration

For the Respondent, United Healthcare: Christian Laos, Senior Compliance Officer

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or "the Agency"), through its contracted health plan, United Healthcare Community Plan (United), to deny Petitioner's request for the prescription medication [REDACTED] (200 mg via 2 shots, taken subcutaneously, once per month). Petitioner bears

the burden of providing, by a preponderance of the evidence, that Respondent's denial is improper.

PRELIMINARY STATEMENT

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program. Following transition to a managed care system, AHCA now oversees provision of services through designated managed care organizations (MCOs)/Health Maintenance Organizations (HMOs). United is the MCO to which Petitioner belongs.

As of July 1, 2016, AHCA representatives are attending Medicaid hearings in a solely observational capacity. While AHCA remains a Respondent/party to the appeal, the MCO is tasked with presenting its case and providing support for its decision(s).

This matter convened for telephonic hearing on October 12, 2016. Petitioner appeared as her own representative. Respondent, United, was represented by Christian Laos, Senior Compliance Officer, who presented two, additional United witnesses: Sloan Karver, MD, Medical Director; and Debra Smith, PharmD, Director of Pharmacy. Petitioner's Exhibits 1 through 8, inclusive, and Respondent's Exhibits 1 through 5, inclusive, were accepted into evidence. Sheila Broderick, RN Specialist with AHCA, observed the proceedings.

Administrative notice was taken of all pertinent legal authority; however, as noted on the record of hearing, on October 12, 2016, AHCA's website was not displaying the promulgated Preferred Drug List (PDL) or relevant Drug Criteria/Limitations. On that date, the AHCA website instead displayed a notice that these documents were undergoing updates, and were thus temporarily unavailable. United's witnesses

testified that they expected these links to become functional, and the updates to be available for viewing, by the end of the month.

In preparation of this Final Order, and based upon *de novo* review of United's action, the undersigned has utilized the PDL and Drug Criteria/Limitations, updated October 13 and October 30, 2016, respectively. Links to these documents are provided within this Final Order, so that Petitioner may access same.

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 a Medicaid-eligible adult, over the age of 21, who is diagnosed with [REDACTED]
2. At all times relevant to this proceeding, Petitioner has been receiving Medicaid through a Managed Care model, via United Healthcare.
3. On or about June 15, 2016, Petitioner's physician/provider submitted to United a request for injectable [REDACTED], 200mg per month. Said request included a "Specialty Medication Prior Authorization Cover Sheet," an [REDACTED] Prior Authorization Request Form," and a prescription.
4. Review of the Specialty Medication Prior Authorization Cover Sheet reflects that the medication is requested to treat [REDACTED]. Although this request appears to indicate that Petitioner was previously taking [REDACTED], Petitioner indicated at hearing that she used to take [REDACTED] while seen at a community clinic, but has never had it

approved by United Healthcare. As such, the request was reviewed as one for a new medication as opposed to continuation of a previously authorized prescription drug.

5. Review of the [REDACTED] Prior Authorization Request Form ([REDACTED] Form”) shows some inconsistent responses from Petitioner’s provider, which make it difficult to evaluate Petitioner’s medical and drug history. In completing the form, the provider first noted that Petitioner has NOT experienced a contraindication to treatment with two or more listed medications, then circled “Yes” to indicate that Petitioner had received treatment with other medications; however, the names of these medications were not circled or otherwise specified.

6. In the section of the [REDACTED] Form which asks “Did previous treatment with at least one immunosuppressive agent result in treatment failure, an intolerance/adverse reactions, or does the patient have a documented contraindication to treatment with at least one immunosuppressive agent?” (emphasis original), the provider did not list a medication name, but indicated dates of treatment from 2013 to February of 2016. The provider wrote in “none” on the blanks provided to indicate adverse reactions, intolerance, or contraindication.

7. On the portion of the [REDACTED] Form that asks “Did previous treatment with immunosuppressive agents and oral corticosteroids result in treatment failure, an intolerance/adverse reactions, or does the patient have a documented contraindication to treatment with both immunosuppressive agents and oral corticosteroids?” (emphasis original) the provider wrote only “Had intolerance to [REDACTED].” Further down on the form, the provider added, “Had surgery for [REDACTED] & had allergy to [REDACTED] & now taking [REDACTED] since 2013.”

8. Via Notice of Action dated June 16, 2016, United informed Petitioner of its decision to deny this request, noting, in pertinent part:

⊗ We determined that your requested services are **not medically necessary** because the services do not meet the reason below: (*See Rule 59G-1.010*)

⊗ 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.

The request does not meet the health plan's reason(s) for an exception to the Medicaid Preferred Drug List (PDL), also sometimes known as the formulary. Other medications are available on the Preferred Drug List that may work for you.

...

The requested medication is used for people who have tried another medicine. The facts given to us do not show that you have tried another medication. This decision was made per the UnitedHealthcare Community Plan Florida [REDACTED] Guideline.

9. Petitioner timely requested a hearing to challenge this denial.

10. At hearing, Petitioner testified that she had surgery in 2013, began [REDACTED], and had an allergic reaction to same. As a result, she was administered [REDACTED] while in recovery. The Petitioner did not recall using any medications other than [REDACTED] temporary steroids, and later [REDACTED] through the community clinic. She noted that since stopping [REDACTED] in 2016, she has experienced frequent bowel movements which prevent her from leaving the house. She visited the prescribing provider in June of 2016, but is interested in seeing a different gastroenterologist for follow-up care.

11. Dr. Smith testified that in reviewing Petitioner's request, she considered United's criteria for authorization of [REDACTED], which mirror those published by AHCA. Specifically, since Petitioner is being treated for [REDACTED], these criteria include:

- Patient is > 18 years of age
- Patient has a documented diagnosis of moderate to severe [REDACTED]

- A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- Patient has inadequate responses, intolerance, or has contraindications to conventional therapy (clinical documentation must be submitted demonstrating response to previous therapies):
 - Budesonide, mesalamine, or corticosteroids (i.e. prednisone, methylprednisolone) OR
 - Non-biologic DMARDs (e.g. azathioprine, methotrexate, mercaptopurine) AND
 - Patient has an inadequate response, intolerance, or has contraindications to ██████████[®]

12. Per Dr. Smith, the first two criteria are fulfilled, in that Petitioner is over the age of 18 and has a confirmed diagnosis of ██████████. However, because Petitioner's provider did not submit a negative TB test, nor any documentation to establish a failed response to ██████████, United denied the request for ██████████.

13. Dr. Smith explained that United had attempted to contact Petitioner's provider to determine whether ██████████ would be appropriate, but did not receive a response.

14. United agreed to provide case management services to Petitioner, to both assist her in finding a new physician, if she so desires, and/or to facilitate the provision of an appropriate medication to meet Petitioner's needs. Specifically, United testified that it would contact Petitioner on or before October 14, 2016 to discuss her options for working with a provider to either request a medication from the PDL or to obtain the required documentation for a non-PDL drug.

CONCLUSIONS OF LAW

15. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

Section 120.80, Florida Statutes. The Office of Appeal Hearings provided the parties with adequate notice of the administrative hearing.

16. Florida Medicaid is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The program is administered by the Agency for Health Care Administration, now through a Managed Care model.

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

18. As this matter involves a request for a prescription approval, the burden of proof is assigned to the Petitioner, pursuant to Florida Administrative Code R. 65-2.060(1).

19. The standard of proof in an administrative hearing is preponderance of the evidence, as provided by Florida Administrative Code R. 65-2.060(1).

20. Section 409.912, Florida Statutes provides that AHCA shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.

21. The Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook (July 2014) ("the Handbook") is promulgated into law by Florida Administrative Code R. 59G-4.250. Page 1-4 of the Handbook lists requirements for Health Maintenance Organizations (HMOs), as follows:

Prescribed Drug Services

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.

A Medicaid HMO is required to cover any product that is required to be covered under the fee-for-service Medicaid program as specified in section 1927 of Title XIX of the Social Security Act. If a product meets the definition of a covered service under that section there must be a provision to make it available through the HMO and through fee-for-service. (emphasis added)

22. Page 2-2 of the Handbook notes:

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.

23. At page 2-11, the Medicaid Handbook explains that:

In order to be reimbursed by Medicaid, providers must obtain prior authorization before dispensing certain drugs.

Prior authorization from Medicaid is required prior to reimbursement in the following situations:

1. The drug is not on the Preferred Drug List.
2. Clinical Prior Authorization is required for specific drugs a) For an indication not approved in labeling; b) To comply with certain clinical guidelines; or c) If the product has the potential for overuse, misuse, or abuse. The Agency may require the prescribing professional to provide information about the rationale and supporting medical evidence for the use of a drug. A current list of drugs for which clinical prior authorization is required, and clinical prior authorization forms, may be found on the webpage at www.ahca.myflorida.com/Medicaid/Prescribed_Drug.¹
3. If a prescriber hand writes “brand medically necessary” on the face of a prescription when a generic is available with a state or federal pricing limit. (emphasis added)

¹ As the cited link is not functional, for the parties’ convenience, a better direct link for preferred drug list and prior authorization information is: http://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml see “Preferred Drug List” and “Summary of Drug Limitations”).

24. As [REDACTED] is not on the preferred drug list, it requires prior authorization, and must also meet both the criteria listed on page 9 of AHCA's Summary of Drug Limitations (updated October 30, 2016)² as well as AHCA's [REDACTED] Prior Authorization Drug Criteria (updated August 8, 2016).³

25. As noted, above, the [REDACTED] Prior Authorization criteria published by AHCA require that:

- Patient is > 18 years of age
- Patient has a documented diagnosis of moderate to severe [REDACTED]
- A negative tuberculin test (TB) prior to initiating therapy and results have been provided
- Patient has inadequate responses, intolerance, or has contraindications to conventional therapy (clinical documentation must be submitted demonstrating response to previous therapies):
 - Budesonide, mesalamine, or corticosteroids (i.e. prednisone, methylprednisolone) OR
 - Non-biologic DMARDs (e.g. azathioprine, methotrexate, mercaptopurine) AND
 - Patient has an inadequate response, intolerance, or has contraindications to [REDACTED]

26. The totality of the evidence demonstrates that Petitioner is over the age of 18, and is diagnosed with [REDACTED]; however, there is no evidence to show that a negative TB test has been furnished along with the request for [REDACTED], nor that [REDACTED] (the formulary/PDL drug for treatment of [REDACTED]) has been tried and determined ineffective.

² Available at:

http://ahca.myflorida.com/medicaid/Prescribed_Drug/pdf/Summary_of_Drug_Limitations_10-31-2016_v36.pdf

³ Found at: [http://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria_pdf/\[REDACTED\]_Criteria.pdf](http://ahca.myflorida.com/Medicaid/Prescribed_Drug/drug_criteria_pdf/[REDACTED]_Criteria.pdf)

27. In order for any medication not on the PDL to be authorized, the MCO reviewer must determine that said medication is “medically necessary.” Per Florida Administrative Code R. 59G-1.010(166):

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. ...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

(emphasis added)

28. Respondent contends that because the Petitioner has yet to attempt a medication from the PDL, authorization of [REDACTED] would be premature and in excess of her needs. Absent documented trial and failure of a PDL medicine, OR a clear, documented explanation as to why attempting a PDL medication would be inappropriate, Petitioner is unable to establish that United’s denial was improper.

29. Petitioner is encouraged to continue working with United to obtain the services and medications that best meet her medical needs. Should Petitioner wish to file a new request for [REDACTED], or for any other item or service, she may do

so at any time. If her request is denied, she will retain the right to challenge that/those particular issue(s).

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 28 day of November , 2016,

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
United Health Care Hearings Unit

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

FILED

Nov 17, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06560

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 [REDACTED]

CO-RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 12, 2016 at 8:43 a.m. and re-convened on November 2, 2016 at 11:42 a.m.

APPEARANCES

For the petitioner: Pro se.

For the respondent: Lisa Sanchez, Medical/Healthcare Program Analyst,
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is AHCA's action, through Sunshine Healthcare, in denying prescription coverage for [REDACTED]. Because the matter at issue is an initial request, the burden of proof is assigned to the petitioner.

PRELIMINARY STATEMENT

Appearing as witnesses for the respondent from Sunshine Healthcare on October 12, 2016 were: Kizzy Alleyne, Paralegal; Richard Plymel, Pharmacy Director; Paula Daley, Appeals and Grievance Coordinator II; and Kimberly Bouchette, Clinical Appeals Coordinator.

Appearing as witnesses for the respondent from Sunshine Healthcare on November 2, 2016 were: Joerosa Davis, Manager for Appeals and Grievances; Sabrina Leigester, Supervisor of Case Management Services; and Dr. David Gilcrist, Medical Director.

Respondent's Exhibits 1 and 2 were entered into evidence. Petitioner's Exhibits 1 through 8 were entered into evidence.

Petitioner requested continuation of [REDACTED] pending the outcome of his appeal. Respondent advised the petitioner's prescription for [REDACTED] expired prior to his prior authorization request for a prescription renewal and he, therefore, was not eligible for continuation of his medication.

Petitioner submitted a request to Sunshine Healthcare for reimbursement of his out-of-pocket expenditures for [REDACTED]. Petitioner was informed the respondent needed time to respond to his request. If the petitioner does not agree with the respondent's action on his reimbursement request, he can then file a request for a fair hearing.

FINDINGS OF FACT

1. The petitioner is a 61 year-old Medicaid recipient who enrolled with the managed medical care provider Sunshine Health effective December 1, 2015, and is a current active member.

2. The petitioner is diagnosed with [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

3. On July 21, 2016, the petitioner's pain management doctor, [REDACTED], submitted a medication prior authorization request for [REDACTED]

4. On July 22, 2016, the respondent sent a Notice of Action to the petitioner denying the petitioner's request for oxymorphone. The notice included the following explanation:

Unable to approve [REDACTED] Tablet 10mg ER. The guideline for this drug must be met to be covered. (Sunshine Health Miscellaneous Drug Prior Authorization Criteria). You are required to try drugs from the preferred drug list before this drug can be approved. Please use Preferred Drug List (PDL) medication: [REDACTED]. Your doctor will have to send information you have tried these drugs and they did not improve your health condition. If you are unable to take these drugs your doctor will have to provide the reason. Your doctor has been contacted.

5. The petitioner filed a timely request for a fair hearing on August 4, 2016.

6. The petitioner stated he has been on [REDACTED] for more than four years. He asserted he was on five medications before going on [REDACTED] but had severe reactions to them. He provided medical records from Dr. [REDACTED] and Dr. [REDACTED]

██████████ who both have prescribed ██████████ for the petitioner. The records provide documentation of the treatments he has received, along with prescribed medications, but do not document a past trial period for ██████████.

7. Prior to ██████████ the petitioner stated ██████████ was his pain management doctor, for almost four years. He was on ██████████ at that time.

8. Petitioner's previous managed care plan, Humana, approved a prior authorization request for ██████████ on May 21, 2015. The approval was for 12 months. The approval was "based on [petitioner's] current prescription drug benefits. Future benefits are subject to change with notice." (See Petitioner Exhibit 2, page 24.) No testimony or documentation was provided on what requirements, if any, were in effect for ██████████ at the time of Humana's approval.

9. On April 8, 2016, Sunshine Health, through its pharmacy provider, approved petitioner's request for ██████████. The approval was for 90 days, ending the prescription approval effective July 7, 2016. This was Sunshine Health's first review and approval of ██████████ for the petitioner since he became a member in December 2015.

10. Respondent's pharmacy director explained review of the prior authorization for ██████████ requires assessing medical necessity and the appropriate dosage level for the petitioner's condition. Without the petitioner's medical records, the pharmacist cannot accurately and appropriately assess the medical necessity and appropriateness of the dosage level of the ██████████ for the petitioner.

11. Respondent's medical director advised Sunshine Health's April 2016 approval of [REDACTED] was in error because proof of trial and failure of PDL alternative medications, [REDACTED], is required.

12. [REDACTED] is not on the Preferred Drug List (PDL) but alternative medications [REDACTED] are on the PDL. As a result, the respondent's medical director explained Sunshine Health needs petitioner's clinical records that document his trial use and failure of [REDACTED].

13. The medical director noted the petitioner was a patient of [REDACTED] who remains a participating provider with Sunshine Health. If the petitioner were to accept [REDACTED] as his pain management doctor again, Sunshine Health would be able to obtain the petitioner's past medical records from [REDACTED]. Documentation needed to approve [REDACTED] for the petitioner may be contained in those records. Petitioner was very happy with [REDACTED] in the past and was agreeable to having him provide his pain management care again.

CONCLUSIONS OF LAW

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

15. This is a final order pursuant to § 120.569 and § 120.57, Florida Statutes. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

16. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence.

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

18. Fla. Admin. Code R. 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...

19. AHCA's Prescribed Drug Coverage, Limitations, and Reimbursement Handbook (Handbook), dated July 2014, is incorporated in Florida Administrative Rule 59G-4.250.

Page 1-4 states the following for Health Maintenance Organizations (HMO):

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.

A Medicaid HMO is required to cover any product that is required to be covered under the fee-for-service Medicaid program as specified in section 1927 of Title XIX of the Social Security Act. If a product meets the definition of a covered service under that section there must be a provision to make it available through the HMO and through fee-for-service.

20. Page 2-4 of the Handbook provides requirements for the Preferred Drug List and states in relevant part:

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 in selected therapeutic classes will be presented to the P & T Committee with their relevant clinical efficacy and relative net cost positions. The P & T Committee will recommend the most cost effective drugs in each therapeutic category to AHCA for consideration for inclusion on the PDL. A minimum of two products per therapeutic class, if available, will be recommended. **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 [emphasis added].** Please see the following section of this handbook for explanation of the prior authorization process for non-PDL products.

Non-PDL drugs may be approved for reimbursement upon prior authorization. A step-therapy process that requires initial use of PDL products before authorization of non-PDL products will then permit prior authorization (PA) for non-listed drugs. Oral contraceptives and HIV/AIDS-related anti-retroviral products are covered, and are exempt from PDL requirements. Mental health drugs are not exempt from PDL requirements. Nursing home residents and waiver program participants are not exempt from PDL requirements.

....

AHCA will publish and disseminate the additions and deletions to the PDL in a timely manner as they are adopted. The PDL and updates will be posted on the Agency website at [www.ahca.myflorida.com/Medicaid/Prescribed Drug/pharm_thera/](http://www.ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/).

21. Page 2-12 of the Handbook, "How Non-PDL Requests are Processed" states:

Medications on the Preferred Drug List must have been tried within the twelve months prior to the request for a non-PDL alternative product. Certain step-therapy prior authorization protocols require the prescriber to use medications in a similar drug class or for a similar medical indication unless contraindicated in the federal Food and Drug Administration labeling. Reimbursement for a drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides written medical or clinical documentation that the product is medically necessary because:

- There is not an acceptable clinical alternative on the PDL to treat the disease or medical condition; or
- The PDL alternatives have been ineffective in the treatment of the recipient; or
- The number of doses has been ineffective, or based on historic evidence and known characteristics of the patient the PDL drug is likely to be ineffective.

██████████ is currently not on the PDL list. ██████████ are on the PDL list. As noted in the Handbook, the PDL list is periodically updated. Therefore, the criteria for approval of a medication, such as ██████████ can change. Past approval or denial of a medication does not necessarily mean it will be approved or denied in the future, because the criteria for approval can change.

23. The petitioner argues he has been on ██████████ for years and does not understand why it is being denied now. He has provided medical records from two of his doctors, but the records do not contain documentation of trial and failure of ██████████ or ██████████

24. Before a prescription for ██████████ can be approved, the respondent explained Sunshine Health needs past clinical records that document the petitioner has tried ██████████ and ██████████ which are on the PDL, and failed to provide the pain relief he needs or has resulted in adverse reaction(s).

25. After considering the evidence and all of the appropriate authorities set forth in the findings above, the undersigned finds the petitioner's evidence, including documentation from his doctor, insufficient to support approval of [REDACTED]. Petitioner does not meet the above cited criteria established by Florida Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 17 day of November, 2016,
in Tallahassee, Florida.



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

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

FILED

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

Dec 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06582

PETITIONER,

Vs.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 14, 2016 at 11:30 a.m.

APPEARANCES

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

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's action to partially deny the petitioner's request for Speech Therapy (ST) service hours for the certification period July 28, 2016 through January 20, 2017, was correct. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as witnesses for the petitioner were [REDACTED], speech therapy assistant, and [REDACTED], speech therapist, from [REDACTED] Therapy, which is the petitioner's speech therapy provider. The petitioner did not submit any documents as evidence for the hearing.

Appearing as a witness for the respondent was Rakesh Mittal, M.D., Physician-Consultant with eQHealth Solutions, Inc. The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Statement of Matters, Outpatient Review History, Denial Notices, and Speech Therapy reports.

FINDINGS OF FACT

1. The petitioner's ST service provider [REDACTED] Therapy (hereafter referred to as "the provider"), requested the following ST service hours for the certification period at issue: 14 units (3.5 hours) weekly. Each unit is the equivalent of fifteen (15) minutes.
2. eQHealth Solutions, Inc. is the Quality Improvement organization (QIO) contracted by the respondent to perform prior authorization reviews for therapy services. The provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner's medical conditions, his functional limitations, and other pertinent information related to the household.

3. eQHealth Solutions' personnel had no direct contact with the petitioner, his family, or his physicians. All pertinent information was submitted by the provider directly to eQHealth Solutions.

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

- 18 years old
- Diagnosis includes [REDACTED] (MRELD)

5. The petitioner was previously approved to receive 14 units weekly of ST services in the prior certification period. He attends school but receives no speech therapy services at his school.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the ST provider.

The therapy goals include the following:

- Improving verbal expressive language skills
- Improving receptive language skills
- Improving literacy skills
- Improving social/behavioral communication

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested ST services, approving 8 units (2 hours) weekly rather than the requested 14 units (3.5 hours) weekly. A notice of this determination was sent to all parties on August 1, 2016. The notice stated the following rationale for the partial denial:

The patient is an 18 year old with [REDACTED] who may benefit from continued speech therapy addressing understanding nouns and answering questions.

The request is excessive based on the severity of the delay, goals submitted and the progress made over many years of therapy. Four units two times per week is sufficient therapy at this developmental age.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the request for reconsideration. A reconsideration review was requested by the provider. A reconsideration review was conducted by eQHealth and a notice of reconsideration determination was sent on August 15, 2016 which upheld the initial decision to approve 2 hours weekly of services.

9. The petitioner thereafter requested a fair hearing and this proceeding followed.

10. The respondent's witness, Dr. Mittal, testified that the reduction of the petitioner's speech therapy service to 2 hours weekly was appropriate because he has made great progress in meeting his therapy goals. He stated the petitioner met 21 of 25 goals at 100% mastery and the other 4 goals at a level of 70-85%. He also stated the services can be increased again in the future if necessary.

11. The petitioner's mother believes the speech therapy should be continued at the level of 3.5 hours weekly so that her son can gain the skills necessary to obtain a job in the future. She also mentioned the Medicaid program previously attempted to reduce services because her son was not meeting enough therapy goals.

12. The petitioner's speech therapist stated the petitioner met his goals based on the criteria listed in each goal, but was not at 100% mastery. His new therapy goals are to

achieve 100% mastery. She also stated the petitioner is not at the level of a normal 18 year old and may not progress in his therapy if the services are reduced at this time.

13. ST service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

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

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

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 since the petitioner had been previously approved for 14 units (3.5 hours) weekly of speech therapy service and the Respondent is seeking to reduce this service to 8 units (2 hours) weekly. 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. 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.

19. The petitioner has requested ST 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.

20. 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.

21. 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.

¹ "You" in this manual context refers to the state Medicaid agency.

22. The service the petitioner has requested (ST services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

Any service under this section shall be provided only when medically necessary ...

23. 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.

24. 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.

25. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested ST services.

26. In the petitioner's case, the respondent has determined that 8 units (2 hours) weekly of ST service is medically necessary, rather than the 14 units (3.5 hours) weekly requested by the petitioner. The petitioner was previously approved for 14 units of speech therapy weekly.

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

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

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

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

28. 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.

29. ST services, also referred to as speech-language pathology services, are described on page 1-4 of the Therapy Handbook as follows:

Speech-language pathology services involve the evaluation and treatment of speech-language disorders.

Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and

enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

30. The Therapy Handbook on page 2-2 sets forth the requirements for ST services, as follows:

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

31. The petitioner's physician ordered a ST service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

32. The respondent's witness, Dr. Mittal, stated he believes the services should be reduced at this time since the petitioner has been making great progress in therapy and has met almost all his therapy goals.

33. The petitioner's witnesses stated he still needs to improve his skills and he only met his goals based on the criteria listed for each goal and did not demonstrate 100% mastery. For example, a goal may specify he is to achieve a certain skill with 75% accuracy and the fact he met this goal means he achieved 75% accuracy in that skill rather than 100% mastery.

34. 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 reducing the requested speech therapy services for the certification period at issue. Although the petitioner has made good progress in his

therapy and has met most of his goals, the testimony of his mother and speech therapist support the continuation of therapy at the current level to allow him to continue improving his skills and attempt to reach 100% mastery of those skills.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, and the petitioner shall continue receiving 14 units (3.5 hours) of speech therapy services weekly for the current certification period.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of 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 28 day of December, 2016,

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

FINAL ORDER (Cont.)

16F-06582

PAGE - 12

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

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

FILED

Nov 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06592

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 28, 2016, at 9:30 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Stacy Ann Mills, supervisor.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny full Medicaid benefits for her 19 year-old daughter and enrolling her in the Medically Needy Program with an estimated share of cost (SOC). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On September 8, 2016, the petitioner requested an appeal challenging the Department's action of denying full Medicaid benefits for her daughter and enrolling her in the Medically Needy Program with an estimated SOC of \$1,248.

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The respondent submitted nine (9) exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 9.

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 was self-employed only and the daughter was receiving full Medicaid. She last received full Medicaid in August 2016.
2. The petitioner has applied for disability for her daughter with the Social Security Administration (SSA). On August 31, 2016, the petitioner received a notice informing her that the daughter was not disabled. The petitioner is appealing the SSA decision.
3. On August 4, 2016, the petitioner submitted an application requesting Family-Related Medicaid benefits for her 18 year-old daughter only (DOB [REDACTED]). The daughter turned 19 on [REDACTED]. On that application, the petitioner did not report that her daughter was disabled or pregnant. The respondent sent a pending notice requesting income information from the petitioner.
4. The verification was received and the case was processed and approved. On August 12, 2016, the respondent sent the petitioner a Notice of Case Action informing

her that her daughter was approved for the Medically Needy Medicaid with a \$1,248 share of cost effective September 2016, See Respondent's Exhibit 1.

5. On September 8, 2016, the petitioner requested a hearing challenging the respondent's action. The petitioner was seeking full Medicaid for her daughter only. She is challenging her daughter's enrollment in the Medically Needy Program.

6. The petitioner is gainfully employed and is responsible for health insurance premiums on herself only. She is a tax filer and her daughter is her tax dependent. She provided the respondent with a completed income verification form, See Respondent's Exhibit 5. The document indicates she received \$910.26 on 7/22/16 and \$859.95 on 8/5/16. The respondent considered both amounts representatives of petitioner's earnings and used them to determine eligibility for Medicaid for the daughter. Petitioner's biweekly income was converted to a monthly amount by multiplying the average biweekly income by 2 to equal \$1,770.22. This amount is called modified adjusted gross income (MAGI). As the daughter was not eligible for AFDC-Related Medicaid due to her age, the respondent enrolled her in the Medically Needy Program. The Medically Needy Income Level (MNIL) of \$387 for a standard filing unit size of two was subtracted from the MAGI, resulting to the petitioner estimated SOC of \$1,383. It was further reduced by \$135 total recurring medical insurance premiums, resulting in the final SOC being \$1,248, See Respondent's Exhibit 7

7. The respondent's representative explained that the 19-year old was no longer eligible for full Medicaid due excess income. The respondent explained that the daughter's disability conditions were not known to the Department.

8. During the hearing, the petitioner did not dispute any facts presented by the respondent. She acknowledged her income and confirmed that the income verification she provided to the respondent. During the hearing, petitioner argued that her daughter is severely disabled and needs full Medicaid to get proper care. Petitioner reported that her daughter has [REDACTED] and is [REDACTED]. Additionally, she is [REDACTED] with [REDACTED]. The respondent explained how the Medically Needy Program works and advised the petitioner to submit medical bills earlier in the month for tracking. The petitioner's has already provided the respondent with medical bills for her daughter for September 2016, which have since been tracked.

9. As of the date of this hearing, the petitioner's appeal with Social Security Administration is pending before an administrative law judge (ALJ).

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 petitioner did not report the daughter being disabled; therefore, the respondent only considered her eligibility under the Family-Related Medicaid coverage group

13. The Family-Related Medicaid income criteria is set forth in 42 C.F.R 435.603. It states:

(a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

14. Federal regulation 42 C.F.R. § 435.603(f) Application of modified gross income (MAGI) defines a Household for Medicaid. It states:

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

...

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought,

the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

15. The Department's Policy Manual, CFOP 165-22 (The Policy Manual) at passage 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

16. In accordance with the above controlling authorities, when the daughter is being tested, the Medicaid household group is the daughter and the petitioner (two members). The findings show the Department determined the daughter's eligibility with a household size of two to determine Medicaid eligibility for the 19-year old daughter. The undersigned concludes the Department correctly determined the petitioner's household size as two for Medicaid eligibility purposes. A more favorable outcome come not be found.

17. Federal regulations at 42 C.F.R. § 435.603(d) Application of modified gross income (MAGI) defines Household Income. It states:

(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax

return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

18. 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.

19. 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.

20. 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 petitioner's household income was correctly converted.

21. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. The undersigned concludes the child is ineligible for 1931 Medicaid group due to her age. The respondent proceeded to explore the Medically Needy Program. The undersigned recognizes the petitioner's concerns about her daughter and her various medical needs. However, the controlling legal authorities do not allow for any more favorable outcome.

22. 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".

23. 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.

24. 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.

25. In accordance with the above controlling authorities, the respondent determined the petitioner's daughter SFU as a household of two based on her tax filing status.

26. 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 two is \$387.

27. The daughter's SOC was estimated to be \$1,248. The hearing officer reviewed the respondent's SOC calculation and found no errors. The hearing officer found that no exception to this calculation. It is concluded that a no more favorable share of cost could be determined.

28. 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 daughter full Medicaid under the 1931 Medicaid coverage group and her enrollment in the Medically Needy Program is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. 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 29 day of November, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06609

PETITIONER,

Vs.

CASE NO. [REDACTED] 8

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on October 18, 2016 at 8:30 a.m.

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: Brian Meola, Esq., Assistant General Counsel, DCF Office
of the General Counsel

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner's application for Institutional Care Program (ICP) Medicaid benefits on July 18, 2016 is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present, but was represented by legal counsel.

Appearing as witnesses for the respondent were Stan Jones, ACCESS Economic Self-Sufficiency Specialist II and Kane Lamberty, Senior Human Services Program Specialist with Program Office Policy.

Petitioner submitted one exhibit, entered as Petitioner's Exhibit "1". Respondent submitted two exhibits, entered as Respondent's Exhibits "1" and "2". The record remained open until close of business on November 14, 2016 for the parties to submit additional information. On October 18, 2016, additional information was received from the petitioner and entered as Petitioner's Exhibit "2". On October 18, 2016, additional information was received from the respondent. However, the information submitted was already included in the respondent's first exhibit. Therefore, the Hearing Officer did not enter it again. The Hearing Officer requested that the parties submit Proposed Orders by November 14, 2016. Neither party submitted Proposed Orders by the required November 14, 2016 due date. The record was closed on November 14, 2016. No other evidence was considered or reviewed.

FINDINGS OF FACT

1. The petitioner (92) was admitted to [REDACTED] on March 11, 2016. On [REDACTED], the petitioner's wife (83) passed away.
2. On June 15, 2016, the petitioner's authorized representative submitted an application for ICP Medicaid benefits, including coverage for the following retroactive months: March 2016, April 2016 and May 2016. The application listed two bank accounts; a [REDACTED]
[REDACTED].

3. On June 17, 2016, the respondent mailed the petitioner's representative a Notice of Case Action (NOCA), requesting additional documents to determine eligibility and due no later than June 27, 2016. The NOCA states in part:

Dear [REDACTED]

The following is information about your eligibility.

Once you receive your case number you can go to www.myflorida.com/accessflorida to activate your My ACCESS Account. You will be able to get case status information. You will also be able to print a temporary Medicaid card if you are eligible for Medicaid.

We need the following information by June 27, 2016.

Proof of income and assets for each month you are requesting retroactive Medicaid
Other - please see comments below

4. On June 20, 2016, the petitioner's legal counsel submitted the petitioner's pooled trust which states in part:

12. Distribution of Remainder Upon Termination of Beneficiary's IBA

a. Termination after the Death of a Beneficiary. Upon the death of a Trust Beneficiary, verified by a copy of the deceased Beneficiary's death certificate, any amounts that will remain in a deceased Beneficiary's separate IBA shall be distributed under one of the following options:

- One hundred percent (100%) of such assets shall be deemed surplus Trust property and shall be retained by the Trust pursuant to all of the relevant and applicable provisions of 42 U.S. C. §1396p.

This repayment to the states shall be given all priority over any other expenses to the degree enumerated in the statutes and government rules. In the absence of federal regulations directing the Trust as to priority in the case of multiple state claims, the claims of multiple states shall be prorated and paid to the extent funds are retained as surplus Trust property. The Trustee is authorized to rely on statements of claims provided by the Beneficiary Advocate that have been received from the applicable state Medicaid agency. The Payback Amount shall only be for medical assistance paid on behalf of the Trust Beneficiary during the aforesaid Payback time period. Notwithstanding anything to the contrary herein, if the government reimbursement claims equal or exceed the IBA Remainder Amount, the IBA Remainder Amount in its entirety shall be deemed surplus Trust property and shall be retained by the Trust.

5. On July 18, 2016, the respondent mailed the petitioner a NOCA notifying his June 15, 2016 Medicaid application was denied for not receiving proof of the value of assets.
6. The respondent's witness explained the petitioner had a pooled trust of \$20,000.00 and his deceased spouse also had her own pooled trust of \$20,000.00; both were set up on April 22, 2016 and funded on May 16, 2016. The petitioner was the sole beneficiary of his wife's pooled trust prior to her passing. No documentation was provided by the petitioner or his representative to explain what happened to the deceased spouse's pooled trust of \$20,000.00 when she passed away.
7. The respondent's witness further explained the pooled trust executed for the petitioner was not clear on the options to select; "retained by trust" or "pay back to the state". The pooled trust shows 10% shall be retained as surplus trust property and names [REDACTED] (petitioner's daughter) as 100% beneficiary of any assets not retained as surplus.
8. The petitioner's counsel is requesting ICP Medicaid benefits for the petitioner from May 1, 2016.
9. Since the petitioner was the sole beneficiary for his wife's pooled trust, the respondent needed verification of what happened to those funds in order to determine the petitioner's ICP Medicaid eligibility. The petitioner's counsel was unable to establish what happened to the deceased wife's pooled trust (\$20,000.00) after her death.
10. According to the Department's policy, to meet the Medicaid qualified trust criteria, the trust must state that upon the individual's death; the trust will pay the state. The petitioner's pooled trust execution was not clear because there were no options selected. As of the hearing date, no updated pooled trust was provided.

CONCLUSIONS OF LAW

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

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

13. Fla. Admin. Code R. 65A-1.303, Assets, states in part:

(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.

14. 42 U.S. Code § 1396p addresses pooled trusts for medical assistance paid on behalf of the beneficiary under the State plan and states in part:

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is

required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,...

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B) of this section, the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual...

(d)(4)(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter...emphasis added)

15. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passages 1640.0576.08, Exceptions for Trusts Set Up 10/1/93 or Later (MSSI, SFP) states:

The policies listed above in passage 1640.0576.07 do not apply to the following trusts:

1. Trusts established by a will (see passage 1640.0576.03)...

3. Pooled trusts for the disabled...

All special trusts must be forwarded to the Region or Circuit Program Office for review and Circuit Legal Counsel's written approval before the case can be approved, per guidelines in the Appendix-A-22.4, A-22.5 and A-22.6.

The following special trusts may be created on or after October 1, 1993, for disabled individuals if the trust meets the specific criteria indicated below:

...

Pooled trusts for the disabled: A trust containing the assets of an individual who is disabled, if:

1. it was established on or after 10/01/93;
2. the trust is established and managed by a nonprofit association;
3. a separate account is maintained for the beneficiary of the trust but, for purposes of investment and management, the trust pools the accounts;
4. the trust is established solely for the disabled individual by a parent, grandparent, legal guardian, court or the individual himself; and
- 5. to the extent that amounts remaining in the trust upon the individual's death are not retained by the trust, the trust pays to the state an amount equal to the total amount of medical assistance paid on behalf of the individual.**(emphasis added)

16. Fla. Admin. Code R. 65A-1.303 continues addressing Assets and states in part:

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

17. Fla. Admin. Code R. 65A-1.712 and 65A-1.716 address SSI-Related Medicaid

asset criteria and in part state:

65A-1.712

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual

is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C....

(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),...

1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual under age 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.

65A-1.716

(5) SSI-Related Program Standards.

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

1. \$2000 per individual.

18. According to the above authorities, a Medicaid qualifying pooled trust requires that, upon the death of the trustee, the trust pays back Medicaid (up to the amount Medicaid paid on behalf of the trustee). The pooled trust documentation shows the petitioner did not select an option to either retain all funds in the trust or for the trust to pay back Medicaid (up to the amount Medicaid paid). The findings show the petitioner's wife, who passed away on [REDACTED], also had set up a pooled trust on April 22, 2016; her pooled trust was funded with \$20,000.00 on May 16, 2016; after her death. The petitioner was the sole beneficiary of his wife's pooled trust. No documentation was provided to explain what happened to the deceased wife's \$20,000.00 pooled trust after she passed away.

19. In careful review of the authorities, evidence and testimonies, the undersigned concludes that the petitioner did not meet his burden of proof. The undersigned

concludes that the respondent's action to deny the petitioner's application for ICP Medicaid benefits 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 30 day of December , 2016,

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
Shane DeBoard, Esq.
Ryan Smollar, Esq.

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

FILED

Nov 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06638

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS .

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 10, 2016 at 8:30 a.m.

APPEARANCES

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

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for wisdom teeth extractions was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a letter and copies of x-rays as evidence for the hearing, which were marked Petitioner Exhibit 1.

Appearing as a witness for the respondent was Mindy Aikman, Grievance and Appeals Specialist, from Humana, which is the petitioner's managed health care plan. Also present as witnesses for the respondent were Jackeline Salcedo, Complaints and Grievance Specialist, and Dr. Susan Hudson, Dental Consultant, from DentaQuest, which reviews dental claims on behalf of Humana. Humana was included as an additional respondent in this proceeding since it is the petitioner's health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Case Summary, Authorization Request, Authorization Determination, Denial Notice, and Dental Services Criteria.

FINDINGS OF FACT

1. The petitioner is a sixteen (16) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.
2. On or about February 8, 2016, the Petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Humana to

perform extractions of four wisdom teeth (Teeth 1, 16, 17, and 32). DentaQuest denied this request on February 10, 2016 based on medical necessity considerations.

3. The denial notice also stated the following regarding the reason for the denial:

We cannot approve this request to remove your tooth because the information that your dentist sent shows that your teeth are not bad enough to be removed and show no sign of infection or pain. We have told your dentist this also.

4. The petitioner's mother stated her daughter need the extractions because she is in pain and the erupting wisdom teeth are pushing out the adjacent teeth. She also stated the extractions were approved a year ago, but the treating dentist at that time was on vacation and her daughter sought treatment from another dentist who submitted a new service request.

5. The respondent's expert witness, Dr. Hudson, stated that the denial of the wisdom teeth extractions was appropriate because there was no infection or malpositioning of the teeth. Pain can also be a basis to justify extraction of the wisdom teeth, but there must be chronic pain being treated by the provider which is beyond normal pain associated with an erupting tooth.

6. Ms. Salcedo from DentaQuest stated her records do not reflect a prior approval of the request for wisdom teeth extractions.

7. Services under the Medicaid State Plan in Florida are provided in accordance with the respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

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

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

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

12. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

13. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. The service at issue, tooth extraction, is a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. DentaQuest and/or Humana denied the wisdom teeth extractions due to medical necessity considerations.

15. The petitioner's mother believes the extractions should be approved because her daughter is in pain and the wisdom teeth are pushing out the adjacent teeth.

16. The respondent's witness stated the denial of the extractions was appropriate since there was no sign of infection or malpositioning of the teeth.

17. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for the extractions was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's dentist requested the extractions, this does not establish it is medically necessary. The respondent's witness testimony supports the denial of the requested service. In addition, there was insufficient evidence presented to establish that these services were approved one year ago as alleged by the petitioner.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 10 day of November, 2016,
in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

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

FILED

Nov 14, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06639

PETITIONER,

Vs.

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

And

MAGELLAN COMPLETE CARE,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 10, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's partial denial of the petitioner's request for dental services (deep dental cleaning) was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as a witness for the respondent was Michelle Rigler, Compliance Officer, from Magellan Complete Care, which is the petitioner's managed health care plan. Also present as witnesses for the respondent were Omeisha Smith, Complaints and Grievance Specialist, and Dr. Frank Mantega, Dental Consultant, from DentaQuest, which reviews dental claims on behalf of Magellan. Magellan was included as an additional respondent in this proceeding since it is the petitioner's health plan.

The respondent, Magellan, submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Case Summary, Authorization Request, Denial Notice, Dental Criteria, and Dental Plan Provisions.

FINDINGS OF FACT

1. The petitioner is a fifty (50) 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 from Magellan Complete Care, which utilizes DentaQuest for review of requests for dental services.
2. On or about August 12, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Magellan to perform deep dental cleaning of the upper and lower portions of his mouth (upper right, upper left, lower right, lower left quadrants). On or about August 16, 2016, Magellan

and/or DentaQuest denied the request based on medical necessity considerations. The notice specified the following reasons for the denial:

Your teeth must have noticeable bone loss or show on an x-ray that there is a hard substance built up on the root of the tooth. Your x-rays do not show that you have these issues.

3. The petitioner stated he needs the deep dental cleaning because he has periodontal disease. He stated he has lost molars on the lower right side of his mouth and another tooth in his upper arch and he can only chew on one side of his mouth.

4. The respondent's witness, Dr. Mantega, stated that the requested procedure code (4341) is applicable only when there are 4 teeth per quadrant. Another procedure code for deep cleaning (4342) is applicable when there are 1-3 teeth per quadrant, and Dr. Mantega stated this procedure code would probably be approved for the petitioner.

5. Dental services under the Medicaid State Plan in Florida are provided in accordance with the respondent AHCA's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

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. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

11. 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.

12. 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.

13. Managed care plans, such as Magellan, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Policy.

14. Although the initial denial notice indicated the requested services were denied due to medical necessity considerations, the testimony at the hearing indicated the services would probably be approved if a different procedure code was requested by the provider. Accordingly, the undersigned concludes the petitioner has not demonstrated the requested services should have been approved by DentaQuest. The petitioner should work with his provider to re-submit the request for services with the applicable procedure codes.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

FINAL ORDER (Cont.)

16F-06639

PAGE - 6

the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 14 day of November, 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
MAGELLAN HEARINGS UNIT

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

FILED

Dec 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06684
APPEAL NO. 16F-06685
APPEAL NO. 16F-06686
APPEAL NO. 16F-08498

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing for Appeals 16F-06684 through 16F-06686 on November 1, 2016 at 10:21 a.m.

Pursuant to notice, the undersigned convened a telephonic administrative hearing for Appeal 16F-08498 on December 15, 2016 at 11:37 a.m.

APPEARANCES

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

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

ISSUE

At issue is the respondent's action on June 23, 2016 to terminate the petitioner's Temporary Cash Assistance (TCA) due to a level I sanction for the month of August 2016.

Also at issue is the respondent's action on August 15, 2016 to terminate the petitioner's and the petitioner's wife's coverage under the Medicaid program.

Also at issue is the respondent's action on December 15, 2016 to approve Food Assistance Program (FAP) benefits in the amount of \$511 for the month of November 2016.

The respondent held the burden of proof for the TCA and Medicaid issues.

The petitioner held the burden of proof for the FAP approval.

PRELIMINARY STATEMENT

The hearing originally convened as scheduled on November 10, 2016 at 10:21 a.m.

Appearing as a witness for the respondent was Jeff Berkey, Quality Assurance (QA) Manager for Career Source.

The petitioner originally had an issue with the FAP under Appeal 16F-06683. This appeal was closed as withdrawn as the issue was resolved. The petitioner's issue with the Medicaid program for his sons has been resolved as they have received full-coverage Medicaid. Therefore, Appeal 16F-06686 is closed as withdrawn.

The petitioner has remaining issues with the TCA and the termination of Medicaid coverage for himself and his wife.

The hearing exceeded the allotted time. Therefore, it was necessary to schedule to reconvene. The hearing was scheduled to reconvene on November 14, 2016 at 10:15 a.m.

The hearing reconvened as scheduled on November 14, 2016 at 10:15 a.m.

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

The record was held open until 5:00 p.m. on November 14, 2016 to allow the respondent to provide additional evidence. Evidence was received and entered as the Respondent's Exhibit 3.

The record for Appeals 16F-06684 through 16F-06686 was closed at 5:00 p.m. on November 14, 2016.

The petitioner requested another hearing on November 14, 2016, as he has a new issue with the FAP benefits that resulted from a new application completed in September 2016. The hearing for Appeal 16F-08498 was scheduled for December 15, 2016 at 11:30 a.m.

The hearing convened as scheduled on December 15, 2016 at 11:37 a.m.

Jeff Berkey or another representative from Career Source was not present for the hearing that took place on December 15, 2016. The petitioner did not wish to reschedule to allow Career Source to be a witness for the respondent.

Evidence was submitted for Appeal 16F-08498 and entered as the Respondent's Exhibits 1 through 2.

The record was closed at the conclusion of the hearing for 16F-08498.

FINDINGS OF FACT

1. The petitioner, age 49, his wife, age 47, and their two children, JMB, age 19, and JPB, age 18, were previously receiving TCA and full-coverage Family-Related Medicaid benefits for the entire family.

2. The Career Source QA Manager contends that the petitioner's wife received a level I work sanction in June 2016. The Career Source QA Manager explained that the petitioner's wife began employment in June 2016 and was to provide verification of her new employment. The Career Source QA manager contends that the petitioner's wife did not provide verification until June 21, 2016. Therefore, the level I work sanction was lifted with compliance on June 17, 2016.

3. The QA manager contends that the petitioner received a level III sanction on February 11, 2016. The QA manager explained that the petitioner's level III sanction was lifted with good cause in March 2016.

4. The Department contends that the petitioner's household last received TCA benefits in the amount of \$303 for a household size of three in July 2016 but was no longer eligible for TCA due to the petitioner's wife's employment. Therefore, the sanction action that took place in June 2016 did not have an effect on the petitioner's TCA benefits for August 2016.

5. The Department's calculations for the TCA program for the month of August 2016 included the undisputed income in the amount of \$1548 minus \$90 disregard, equals \$1458. The \$1458 was then subtracted by \$110 to equal \$1348. (The petitioner received the \$200 disregard with the \$90 standard deduction along with the \$110

disregard.) The remaining income was then divided by two to result in a total countable income of \$674. The total countable income was compared to the TCA payment standard for a household size of three, which is \$303. The Department determined that the petitioner was not eligible for TCA benefits for the month of August 2016 since the total countable income in the amount of \$674 exceeded the TCA payment standard of \$303 for a household size of three.

6. The Department contends that the petitioner's household is no longer eligible for TCA benefits since JPB turned 18 during the month of August 2016.

7. The Department contends that the petitioner and his wife were receiving coverage for Medicaid until the youngest child turned 18. The Department explained that the petitioner and his wife previously derived their eligibility for Medicaid from JPB, who was under the age of 18 at the time. The Department contends that the petitioner and his wife were briefly covered under Transitional Medicaid until August 2016. The Department explained that the petitioner and his wife were then enrolled in the Medically Needy (MN) until October 2016. The Department explained that the petitioner's two sons are now receiving full-coverage Medicaid since the petitioner's wife is no longer employed as of September 23, 2016; she received her last check on October 4, 2016 in the gross amount of \$360 (*Respondent's Exhibit 2, page 12*).

8. The petitioner argues that the Department is confusing him because he received several Notices of Case Action. The petitioner believes he is entitled to TCA for August 2016. The petitioner does not dispute non-receipt of TCA for September 2016 since his wife was working. The petitioner argues that his son, JPB, is disabled

and is entitled to receive Medicaid. There was no evidence presented to show that the petitioner and his wife are disabled. The petitioner contends that his son, JPB, graduated high school in May 2016 and will be attending college starting in January 2017.

9. The Department subsequently approved the petitioner's FAP benefits effective November 2016 in the amount of \$511 and in the amount of \$649 for ongoing months. The Department explained that the petitioner was under a work sanction for the month of November 2016 and was ineligible for FAP benefits for himself.

10. The petitioner does not dispute the ongoing FAP benefit allotment in the amount of \$649. The petitioner does not agree with the amount of \$511 for November 2016. The petitioner does not understand why he received another work sanction in November.

11. The Department was unable to explain the sanction action that took place against the petitioner in November 2016. A witness from Career Source previously provided testimony on November 10, 2016 regarding the sanction imposed against the petitioner in February 2016 and the sanction that was imposed against the petitioner's wife in June 2016 but none was provided regarding the work sanction that was imposed for November 2016.

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.

The termination of Medicaid for the petitioner and his wife will be addressed first:

14. Fla. 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: ...
(c) ...For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI.

15. The above controlling authority states for coverage in the Family-Related Medicaid programs, before the parent can be eligible there must be at least one child under age 18.

16. Fla. Admin. Code R. 65A-1.702 "Special Provisions" states in 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. (emphasis added)

17. The above controlling authority instructs that when a person's eligibility ends under one Medicaid coverage group, the Department must determine eligibility under any other coverage groups **before** terminating Medicaid coverage. All individuals who lose Medicaid under a coverage group will continue to receive Medicaid until the redetermination is complete. The findings show that the petitioner and his wife derived their eligibility for Medicaid from their youngest son, who turned 18 in August 2016. The petitioner and his wife are not disabled. Therefore, the undersigned concludes that the Department was unable to continue full-coverage Medicaid for the petitioner and his wife during the ex-parte process.

18. Based on the findings and the above controlling authorities, the undersigned concludes the Department correctly determined petitioner and his wife are no longer eligible for Medicaid in the Family-Related program.

The termination of TCA benefits for the month of August 2016 will now be addressed:

19. Section 414.095 Florida Statutes, Determining eligibility for temporary cash assistance, states in part:

(2) ADDITIONAL ELIGIBILITY REQUIREMENTS:

(a) To be eligible for services or temporary cash assistance and Medicaid:

...

5. Each family must have a minor child and meet the income and resource requirements of the program. All minor children who live in the family, as well as the parents of the minor children, shall be included in the eligibility determination unless specifically excluded.

(b) The following members of a family are eligible to participate in the program if all eligibility requirements are met:

1. A minor child who resides with a parent or other adult caretaker relative.
 2. The parent of a minor child with whom the child resides.
- (10) DETERMINATION OF LEVEL OF TEMPORARY CASH ASSISTANCE.—Temporary cash assistance shall be based on a standard determined by the Legislature, subject to availability of funds. There shall be three assistance levels for a family that contains a specified number of eligible members, based on the following criteria:
- (a) A family that does not have a shelter obligation.
 - (b) A family that has a shelter obligation greater than zero but less than or equal to \$50.
 - (c) A family that has a shelter obligation greater than \$50 or that is homeless.

The following chart depicts the levels of temporary cash assistance for implementation purposes:

THREE-TIER SHELTER PAYMENT STANDARD

Family Size	Zero Shelter Obligation	Greater than Zero Less than or Equal to \$50	Greater than \$50 Shelter Obligation
3	\$198	\$258	\$303

- (11) DISREGARDS.—
- (a) As an incentive to employment, the first \$200 plus one-half of the remainder of earned income shall be disregarded. In order to be eligible for earned income to be disregarded, the individual must be:
1. A current participant in the program; or
 2. Eligible for participation in the program without the earnings disregard.

- (12) CALCULATION OF LEVELS OF TEMPORARY CASH ASSISTANCE.—
- (a) Temporary cash assistance shall be calculated based on average monthly gross family income, earned and unearned, less any applicable disregards. The resulting monthly net income amount shall be subtracted

from the applicable payment standard to determine the monthly amount of temporary cash assistance.

(b) A deduction may not be allowed for child care payments.

(c) The department may adopt rules governing the administration of this subsection and may establish criteria pertaining to types of budgeting, conversion factors, verification of income, treatment of self-employment income, treatment of child-support income, and treatment of other sources of income.

20. The Fla. Admin. Code R. 65A-4.209 sets forth income budgeting in:

(2) To be financially eligible for TCA, the total average gross monthly income less any applicable disregards of the standard filing unit cannot exceed the applicable payment standard for the assistance group. These standards and disregards are found in Sections 414.095(10) and (11), F.S. Monthly net income is calculated based on average gross monthly family income, earned and unearned, less any applicable disregards in accordance with Section 414.095(12)(a), F.S. The monthly amount of the TCA payment is determined by subtracting the monthly net income from the applicable payment standard.

(b) Total gross monthly income includes earned and unearned income from all sources.

21. The Policy Manual, CFOP 165-22, passage 2420.0300 Income Disregards

(TCA) states: "Income disregards are amounts subtracted from the gross earned income. Some examples are: 1. earned income disregard, 2. standard disregard..."

22. The Policy Manual, 165-22 at section 2420.0315 Eligibility for \$200 and 1/2

Disregard (TCA) states:

In order for a member of a Temporary Cash Assistance (TCA) standard filing unit (SFU) to receive the \$200 and 1/2 disregard, the individual must:

1. have been eligible for and received TCA in one of the past four months; or
2. have gross countable income (including earned and unearned income), less the \$90 standard earned income disregard, which is less than the applicable payment standard.

23. The above authorities explain that a family is eligible for TCA benefits if there is a minor child within the degree of relationship residing in the household with his or her parent(s). The findings show that the petitioner and his wife no longer have minor children under the age of 18 living in their home. Therefore, the undersigned concludes that the petitioner is no longer eligible to receive TCA due to not having a minor child living in the home.

24. In order for an assistance group to be financially eligible for TCA, the gross income, less the applicable earned income disregards, may not exceed the applicable payment standard for the assistance group,. Two of the income disregards are the earned income disregard and the standard disregard. The first \$200 plus one-half of the remaining earned income could be disregarded as an incentive of employment for the TCA program. In order to be eligible to receive the 200 and ½ disregard, the individual must have received Cash Assistance in one of the past four months or have gross countable income, minus the \$90 standard earned income disregard, that is less than the applicable payment standard.

25. The findings show that the petitioner received Cash Assistance in one of the past four months. Therefore, he was eligible for the 200 ½ disregard. The petitioner's wife's total gross income for the month of August 2016 was \$1548. The petitioner's wife's total gross income after the standard earned income disregard of \$90 results in \$1458 in countable income. The petitioner's wife's income was further reduced by the remaining \$110 to result in \$1348, which was divided by two to result in a total

countable income of \$674. The petitioner's wife's income is greater than the payment standard of \$303 for three persons.

26. After careful review, the undersigned concludes that the respondent correctly determined the petitioner to be ineligible for TCA benefits for the month of August 2016 as his wife's income exceeded the payment standard for a household size of three persons.

The approval of FAP benefits in the amount of \$511 for the month of November 2016 due to the work sanction imposed against the petitioner will now be addressed:

27. Federal regulations at 7 C.F.R. § 273.7 address Work provisions as follows:

(a) *Work requirements.* (1) As a condition of eligibility for food stamps, each household member not exempt under paragraph (b)(1) of this section must comply with the following Food Stamp Program As a condition of eligibility for food stamps, each household member not exempt under paragraph

(i) Register for work or be registered by the State agency at the time of application and every 12 months after initial registration...

(ii) Participate in a Food Stamp Employment and Training (E&T) program...

(b) *Exemptions from work requirements.* (1) The following persons are exempt from Food Stamp Program work requirements:

(i) A person younger than 16 years of age or a person 60 years of age or older...

(ii) A person physically or mentally unfit for employment...

(iii) A person subject to and complying with any work requirement under title IV of the Social Security Act...

(iv) A parent or other household member responsible for the care of a dependent child under 6 or an incapacitated person...

(v) A person receiving unemployment compensation...

(vi) A regular participant in a drug addiction or alcoholic treatment and rehabilitation program...

(f) *Failure to comply—(1) Ineligibility for failure to comply.* A nonexempt individual who refuses or fails without good cause... is ineligible to

participate in the Food Stamp Program, and will be considered an ineligible household member, pursuant to §273.1(b)(7).

(i) As soon as the State agency learns of the individual's noncompliance it must determine whether good cause for the noncompliance exists, as discussed in paragraph (i) of this section. Within 10 days of establishing that the noncompliance was without good cause...

(ii) The notice of adverse action must contain the particular act of noncompliance committed and the proposed period of disqualification... The disqualification period must begin with the first month following the expiration of the 10-day adverse notice period, unless a fair hearing is requested.

(iii) An E&T disqualification may be imposed after the end of a certification period...

(2) *Disqualification periods.* The following disqualification periods will be imposed:

(i) For the first occurrence of noncompliance, the individual will be disqualified until the later of:

(A) The date the individual complies, as determined by the State agency;

(B) One month; or

(C) Up to three months, at State agency option.

(ii) For the second occurrence, until the later of:

(A) The date the individual complies, as determined by the State agency;

(B) Three months...

(iii) For the third or subsequent occurrence, until the later of:

(A) The date the individual complies, as determined by the State agency;

(B) Six months...

28. The above authority sets forth the rules for the work provisions. The petitioner believes he is entitled to receive the full monthly allotment in the amount of \$649, rather than the reduced amount of \$511, for the month of November 2016. The petitioner believes he completed the requirements for the work program. The respondent was unable to provide testimony to support the work sanction that caused the FAP benefits to be \$511 for the month of November 2016. A representative from Career Source was not present to testify to support the sanction action. Therefore, the undersigned cannot conclude that the Department was correct in determining that the

petitioner was eligible for only \$511 for the month of November 2016 due to the imposed work sanction.

29. After carefully reviewing the evidence and controlling legal authorities, the undersigned cannot conclude that the Department was correct in determining that the petitioner was eligible for only \$511 for the month of November 2016 as Career Source was not present to give testimony as to the correctness of the sanction that was imposed against the petitioner's FAP benefits. Therefore, the Department is remanded with instructions to issue FAP benefits to the level it should have been without the sanction being imposed against the petitioner's FAP benefits, not duplicating any benefits already received.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the TCA and Medicaid appeals are denied.

The FAP appeal is granted. The Department is to take corrective action as directed in the above Conclusions of Law.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency

FINAL ORDER (Cont.)

16F-06684, 16F-06685, 16F-06686, and 16F-08498

PAGE -15

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 December , 2016,

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

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

FILED

Dec 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06708

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 3, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for dental services (partial lower dentures) was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was [REDACTED], dental assistant at her dentist's office. The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Susan Hudson, Dental Consultant, and Jackeline Salcedo, Grievance Specialist, from DentaQuest, which is the petitioner's dental services review organization. Also present as a witness for the respondent was Mindy Aikman, Grievance and Appeals Specialist, from Humana, which is the petitioner's managed health care plan. Humana was included as a respondent in this proceeding since it is the petitioner's health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Case Summary, Authorization Request, Denial Notice, and Dental Criteria.

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 Humana, which utilizes DentaQuest for review and approval of dental services.
2. On or about August 19, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Humana and/or DentaQuest for

approval of various dental services, including partial lower dentures (metal framework).

DentaQuest denied the request for partial lower dentures on August 24, 2016.

3. DentaQuest denial notice to the petitioner advised her of the following reason for the denial of her request for the partial dentures:

In order to get a partial denture, you must have at least 50% bone support for the tooth that is still in your mouth. Our dentist looked at the x-rays sent by your dentist. You have less than 50% bone support. We have also told your dentist this. Please talk to your dentist about other choices to fix your teeth.

4. The petitioner's witness stated she needs the lower dentures and she needs to have some teeth extracted.

5. The respondent's witness, Dr. Hudson, stated that the denial of the petitioner's request for the lower partial dentures was appropriate because some healthy teeth are needed for that type of denture and the petitioner has less than 50% bone support in her teeth. Dr. Hudson also advised that a resin-based denture would be more appropriate in the petitioner's case.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), 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.).
11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.
12. 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.”
13. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. Partial dentures and full dentures are covered services for adults under the Medicaid Program.

15. The petitioner's position is that she should be approved for the lower dentures because she needs them.

16. The respondent's witness stated resin-based dentures are more appropriate for the petitioner than metal-based dentures due to lack of healthy teeth.

17. After considering the evidence and testimony presented, the undersigned concludes the respondent correctly denied the petitioner's request for the partial lower metal-based dentures. The evidence demonstrates that resin-based dentures are a more appropriate alternative due to the condition of her teeth, and the petitioner should explore this option with her provider.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 07 day of December, 2016,

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
Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

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

FILED

Nov 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06734

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 14, 2016 at 1:30 p.m.

APPEARANCES

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

For the Respondent: Fathima Leyva, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for an exemption from mandatory enrollment in the Medicaid managed care program 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 a witness for the respondent was Mindy Aikman, Grievance and Appeals Specialist, from Humana, which is the petitioner's managed health care plan.

The respondent submitted a case summary which was marked as Respondent Exhibit 1.

Also present for the hearing was a Spanish language interpreter, [REDACTED] Interpreter Number [REDACTED], from [REDACTED].

FINDINGS OF FACT

1. The petitioner is a seven (7) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which is a managed care organization.
2. The petitioner's mother does not want her daughter to be covered by a managed care plan, but rather wants her to be covered by the fee-for-service Medicaid program (sometimes referred to as "straight Medicaid"). She stated her daughter has [REDACTED] and needs various therapy services and needs to see a neurologist and other medical specialists. She also stated she has had difficulty finding providers covered by the Human health plan, there are no nearby therapy providers, and she lacks transportation to travel to the provider locations. She also stated her daughter has applied for the Medicaid Waiver program, but she has not yet been approved by that program.
3. The Medicaid representative stated that Medicaid recipients, with limited exceptions, must be enrolled in a managed care plan. She also stated that if the petitioner is dissatisfied with the Humana health plan, she can change to a different

managed care health plan during her open enrollment period which is from April 5, 2017 through June 30, 2017.

CONCLUSIONS OF LAW

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

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

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

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

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

9. Medicaid recipients are required to enroll in a managed care health plan, with certain exceptions. Fla. Stat. § 409.965 states the following:

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.

10. Fla. Stat. § 409.972 further provides as follows:

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.

(2) Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program as provided under part III of this chapter.

11. Since the petitioner does not meet any of the criteria listed in the exceptions to mandatory enrollment, she is required to receive Medicaid services through the managed care program. She may be able to change health plans within the managed care program if she is dissatisfied with her current health plan, but she is still required to receive services through the managed care program. In the event the petitioner is

approved for the Medicaid Waiver program in the future, she may be exempt from mandatory enrollment in managed care at that time.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay 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 29 day of November, 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

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

FILED

Dec 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06742

PETITIONER,

Vs.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on November 29, 2016, at 4:20 p.m.

APPEARANCES

For the Petitioner: [REDACTED] pro se.

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 Amerigroup, the respondent, incorrectly denied his preauthorization request for services to be provided by an out-of-network doctor?

PRELIMINARY STATEMENT

██████████, Interpreter ██████████ with ██████████ provided Russian-English translation services for the hearing.

Vincent Pantone, Chief Medical Officer for Amerigroup, appeared as a witness for Amerigroup. The following individuals were present solely for observation: Heather Cappello, M.D., Medical Director for Amerigroup; Naveen Gande, M.D., Medical Director for Amerigroup; Ophelia Mall, M.D., Medical Director for Amerigroup; Deborah Greene, Grievances and Appeals Coordinator with Amerigroup; and Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration.

The respondent introduced Exhibits “1” through “3”, inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on December 6, 2016 for the respondent to provide the hearing officer and the petitioner the relevant portions of the Amerigroup member handbook and the pertinent law for this appeal. Once received, the information was accepted into evidence and marked as respondent’s Exhibit “4”. The hearing record was then closed on December 6, 2016.

FINDINGS OF FACT

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

1. The petitioner is an 82-year-old male. He resides in ██████████ County, Florida.
2. The petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.

3. The petitioner was an enrolled member of Amerigroup at the time that the decision in this matter was made. 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 has Medicare Part A and/or Part B as his primary insurance provider. Amerigroup is the petitioner’s Medicaid insurance provider.

5. On September 1, 2016, Amerigroup received a prior authorization request for services to be rendered by an out-of-network provider.

6. On September 6, 2016, an Amerigroup nurse administratively denied the petitioner’s prior authorization request. The notes associated with the denial state as follows:

No authorization is required from Amerigroup as we show this member has Medicare A and/or B as their primary insurance carrier. For coordination of benefits submit your claim with the Explanation of Benefits (EOB) from Medicare. Amerigroup is responsible to pay up to Medicaid/Medicare allowable or Amerigroup contracted rate.

7. Amerigroup mailed a Notice of Action dated September 7, 2016 to the petitioner explaining that it was denying the request. The Notice explains, in part:

The facts that we used to make our decision are: Our records show that you have a primary health insurance carrier that is not Amerigroup. Amerigroup is your secondary insurance carrier. This means that Amerigroup will not review your medical request but instead will pay based upon the claims submitted after your primary insurance carrier has paid. Therefore an authorization is not required nor will be provided by Amerigroup for this request. Please submit all medical review requests to your primary insurance carrier – Eligibility Files.

8. The petitioner requested an administrative hearing and this proceeding ensued.

9. The petitioner has Medicare A and/or B as his primary insurance carrier. The petitioner receives his Medicare benefits from an insurance company other than Amerigroup.

10. Amerigroup is the petitioner's secondary insurance carrier. Amerigroup administers the petitioner's Medicaid benefits.

11. The petitioner provided no testimony or evidence indicating that he filed a claim for payment with his primary insurance carrier, including an Explanation of Benefits form from Medicare.

CONCLUSIONS OF LAW

12. 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.

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

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

15. 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.

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

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

18. 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...

19. Section 409.907 discusses Medicaid provider agreements. Specifically, Section 409.907(3)(f) explains:

(3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:

...

(f) **Bill other insurers and third parties, including the Medicare program** [Emphasis added], before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person, and comply with all other state and federal requirements in this regard.

20. The Florida Medicaid Provider General Handbook – July 2012 is promulgated into law by Fla. Admin. Code Chapter 59G-5.020.

21. Page 1-12 of the Florida Medicaid Provider General Handbook addresses the responsibility for exhausting third party liability sources. It explains as follows:

Medicaid is the **payer of last resort**. [Emphasis added] If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.

If the amount of the third party payment meets or exceeds the Medicaid fee for the service, Medicaid will not reimburse for the service. If the third party payment amount is less than the Medicaid fee, Medicaid will reimburse the difference between the Medicaid fee and the third party payment minus any Medicaid copayment or coinsurance.

22. The Amerigroup FL, Inc. Provider Manual discusses Coordination of Benefits on Pages 121 and 122. It explains as follows:

State-specific guidelines will be followed when Coordination of Benefits (COB) procedures are necessary. Amerigroup agrees to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in the Amerigroup plan.

Amerigroup and our providers agree that the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. [Emphasis added] When Amerigroup is aware of these resources prior to paying for a medical service, we will avoid payment by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Amerigroup does not become aware of the resource until sometime after payment for the service was rendered, by pursuing postpayment recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount.

23. Medicare.gov is the official United States Government internet website for Medicare. Information at <https://www.medicare.gov/supplement-other-insurance/how-medicare-works-with-other-insurance/who-pays-first/which-insurance-pays> states as follows:

Medicaid never pays first for services covered by Medicare. It only pays after Medicare, employer group health plans, and/or Medicare Supplement (Medigap) Insurance have paid.

24. All of the sources above are in agreement that Medicaid is the payer of last resort and will only pay a claim after it has been processed by Medicare. Medicare must pay a claim first before Medicaid will evaluate the non-paid portion, if any, for payment. In

the present case, Amerigroup correctly denied the petitioner's preauthorization request for services to be provided by an out-of-network provider. A preauthorization request is not necessary. The petitioner should seek to receive the services from the provider, submit a claim to Medicare for payment and, if there is an outstanding balance after Medicare processes the claim, the petitioner can then submit a claim for payment of the outstanding balance to his Medicaid provider.

25. Pursuant to the above, the petitioner has not shown by a preponderance of the evidence that the respondent incorrectly denied his preauthorization request for services to be provided by an out-of-network provider.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)
16F-06742
PAGE - 8

DONE and ORDERED this 16 day of December, 2016,
in Tallahassee, Florida.

Peter J. Tsamis

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

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

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

FILED

Dec 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06745

PETITIONER,

Vs.

SUNSHINE HEALTH MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 20 [REDACTED]
UNIT: AHCA

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 14, 2016 at 10:22 a.m. in [REDACTED], Florida.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner

For the Respondent: Kizzy Alleyne
Paralegal
Sunshine Health

STATEMENT OF ISSUE

Petitioner is appealing the denial of thirty-one (31) hours per week of companion care services. Petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner was physically present in the hearing room.

Petitioner introduced Exhibits “1” through “3,” inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

Respondents Joerosa Davis, Manager of Appeals and Grievances, Kimberly Bouchette, Clinical Appeals Coordinator, and Shannon Leon, Director of Case Management from Sunshine Health, were physically present in the hearing room. Sunshine Health presented the following witnesses by telephone:

- Mario McDonnough, Appeals Coordinator, Kari Holtmann, Case Coordinator for Sunshine Health
- Dr. John M. Carter, MD., Medical Director for Long Term Care for Sunshine Health

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

Karen Naughton, Senior Human Services Specialist, Agency for Health Care Administration, and [REDACTED] Petitioner’s friend were physically present in the hearing room as observers.

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 59-year-old female who lives alone.
2. Petitioner is a Medicaid recipient enrolled with Sunshine Health (“Sunshine”) as her Long Term Care (“LTC”) plan and receives Medicare Part A and B as her primary insurance.

3. Petitioner's health conditions include:

- [REDACTED]

4. Petitioner's present services are :

- 14 hours per week in Homemaker services
- 7 hours per week in Personal Care services
- 21 hours per week total in combined home health services

5. On August 25, 2016, Sunshine received a request for an increase of 1 hour in homemaker services and 41 hours of companion care, for a total of 15 hours of Homemaker services and 41 hours of companion care. On August 30, 2016, Sunshine issued a Notice of Action partially denying the request as not being medically necessary. The Notice of Action stated:

The request for additional home services (an extra 1 hours/week Homemaker services + the addition of 41 hours/week Companion Care Services) is partially approved. Sunshine Health looked at the member's care needs, household, and present services.

....

Based on the member's present care needs and household Sunshine Health will approve the requested 1 hours/week Homemaker Services, and will approve the addition of 10 hours/week companion care services (and deny the remaining requested 31 hours/week companion care). The updated care plan approved by Sunshine Health will include 15 hours/week Homemaker services + 10 hours/week Companion Care

Services + 7 hours/week Personal Care Services, for a total of 32 hours/week combined home services.

The facts that we used to make our decision are: Sunshine Health Policy LT.UM.09 Long Term Care Ancillary Criteria.

6. Respondent's witness Dr. Carter read the definition of Adult Companion Care from Sunshine's Policy LT.UM.09 Long Term Care. Dr. Carter stated:

Adult Companion care is 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. The service includes light housekeeping tasks incidental to the care and supervision of the member. The provision of services may be provided at the member's residence or anywhere in the community where supervision and care is necessary. The services cannot be provided by a family member.

7. Companion care does not include hands-on care for activities of daily living ("ADL"). Companions provide socialization and supervision with tasks, and incidental assistance with some instrumental activities of daily living ("IADL").

8. Petitioner receives homemaker services and personal care services to help her in the home.

9. Petitioner completed a 701B Comprehensive Assessment ("701B") that reviewed her abilities to perform her ADL and IADL. According to the 701B, Petitioner needs no assistance in eating, using the telephone, and using transportation. She needs assistance (but not total help) with dressing, using the bathroom, transferring, walking/mobility, light housekeeping, managing money, and managing medication. She needs total assistance for bathing, heavy chores, preparing meals, and shopping. She uses assistive device with heavy chores, light housekeeping, preparing meals, and

shopping. At the time of the 701B, Petitioner never had assistance for all of these tasks, with the exception of using her assistive devices sometimes like her walker.

10. Petitioner has episodes of fainting spells, which she calls "topple." Topple is Petitioner stopping herself from fainting. However, sometimes she is unable to topple and she faints.

11. Petitioner's fainting spells are not medically diagnosed. Her physician is currently conducting tests to determine the cause of these periodic fainting spells.

12. Petitioner admits she is a high functioning adult, but wants someone in her home to watch her for possible fainting spells.

13. Petitioner drives her own vehicle on occasions when she needs something for herself.

14. Petitioner has a Personal Emergency Response System and a home health aide who comes to her home from 4pm to 9pm every day, seven (7) days a week.

15. Petitioner's home health aide provides for her needs during the week. She eats a light breakfast like a cereal bar, receives lunch from meals on wheels five (5) days per week, and the aide helps her with dinner.

16. Petitioner's home health aide does the laundry, helps with shopping, and cleaning the house throughout the week.

17. Respondent's witness Dr. Carter testified he reviewed all documentations submitted to him for home services. He reviewed case manager's 701B assessment, and physician's notes that listed multiple diagnoses with a history of [REDACTED].

18. Respondent's witness Dr. Cater testified Petitioner has assistive devices in her home; she drives her own vehicle on occasions, has the ability to eat without

assistance, takes her medication, uses ramps in the home, uses grab bars in the bathroom, and uses a shower chair to assist with taking a bath.

19. Based on his review, the Respondent's witness Dr. Carter determined Petitioner needed partial not total assistance with her ADLs and IDLs. He believes Petitioner's overall services are adequate.

20. Respondent's witness Dr. Carter testified Petitioner drives her own vehicle and has a valid driver's license. If Petitioner's physician required her to have around the clock care for [REDACTED], then Petitioner's physician has a legal duty to report her condition to the Florida Department of Motor Vehicles ("DMV") for having a significant or recurrent [REDACTED] problem.

21. Respondent's witness Dr. Carter testified a person with a severe case of [REDACTED] is not legally allowed to drive due to the inherent danger of harming self and others. An individual who suffers from severe [REDACTED] should not drive a motor vehicle.

22. Respondent's witness Dr. Carter testified Petitioner's physician provided no documentation emphasizing Petitioner suffers from severe fainting or [REDACTED]. The physician's prescription only requested home health services. The prescription did not provide the frequency or duration of home health services.

23. Respondent testified Petitioner has the discretion on how she uses the thirty-two (32) hours of home health services for the week. Petitioner can use the thirty-two (32) hours as companion care for the week.

CONCLUSION 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 Section 120.80, Florida Statutes.

25. This hearing was held as a de novo proceeding, in accordance with Florida Administrative Code Rule 65-2.056.
26. This is a Final Order, pursuant to Section 120.569 and 120.57, Florida Statutes.
27. The standard of proof in an administrative hearing is a preponderance of the evidence pursuant to Florida Administrative Code Rule 65-2.060(1).
28. Legal authority governing the Florida Medicaid Program is found in Florida Statutes Chapter 409, and in Chapter 59G of the Florida Administrative Code.
Respondent, AHCA, is the single state agency that administers the Medicaid Program.
29. 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”
30. Section 409.98, Florida Statutes, requires LTC plans include, among other services, personal care, home-delivered meals, case management, medication management, personal emergency response system, and transportation.
31. 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.
32. The definition of “medical necessary” is found in Florida Administrative Code Rule 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.

33. Sunshine concluded the ten (10) hours of companion care are sufficient to meet Petitioner's needs because she has in addition fifteen (15) hours per week of homemaker services, and (7) hours per week of personal care services for a total of thirty-two (32) hours per week of home health services. Petitioner has discretion in how she uses the thirty-two (32) hours per week.

34. Sunshine policy states, "Companion care assists or supervises the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services."

35. Petitioner has a home health aide that helps her with shopping, laundry, cleaning, and preparing meals. The home health aide satisfies her needs when she comes between the hours of 4 p.m. to 9 p.m. every day, seven (7) days per week. Petitioner can spread her home health hours throughout the day to satisfy her overall needs instead of using it in a set block of time.

36. Petitioner has a Personal Emergency Response System for when she has potential fainting spells. She has various assistive devices throughout her home like a walker, grab bars in the bathroom, and a shower chair. Petitioner admitted that she is a

high functioning adult. Petitioner receives home-delivered meals for lunch five days per week.

37. Petitioner's condition is not medically diagnosed by a treating physician that she has a severe case of [REDACTED]. Petitioner testified she drives her own vehicle when it is necessary. Respondent's witness Dr. Carter stated a person with a severe case of [REDACTED] is not legally allowed to drive due to the inherent danger of harming self and others.

38. Based on the totality of the evidence, Petitioner has not met her burden that thirty-one (31) additional hours per week of companion care services are medically necessary. More specifically, Petitioner's request fails under Florida Administrative Code Rule 59G-1.010 (a)(2) and (a)(5), which requires any authorized services not be in excess of a patient's need, and be furnished in a manner not intended for convenience.

39. Petitioner may wish to consider looking into assisted living facilities, which are fully staffed 24 hours a day. This facility may give Petitioner the comfort she needs of having someone on call for her potential fainting spells.

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 23 day of December , 2016, 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
Sunshine Hearings Unit

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

FILED

Dec 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06748

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 October 28, 2016, at 3:00 p.m.

APPEARANCES

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

For the Respondent: Fathima Leyva, Senior Program Specialist

STATEMENT OF ISSUE

At issue is the respondent's action partially denying the petitioner's request for additional home health services (companion services) under the Long Term Care (LTC)

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

PRELIMINARY STATEMENT

The petitioner submitted medical records as evidence for the hearing, which were marked as Petitioner Composite Exhibit 1.

Appearing as witnesses for the respondent were Dr. Sloan Karver, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding since it is the petitioner's health plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters and Denial Notice.

Also present for the hearing was a Spanish language interpreter [REDACTED] Interpreter Number [REDACTED] from [REDACTED].

FINDINGS OF FACT

1. The petitioner is ninety-two (92) years of age and lives with her daughter. The petitioner suffers from [REDACTED] and needs total assistance with activities of daily living.

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 a total of thirty-three (33) hours weekly of home health services (including personal care assistance, homemaker services, and companion services) through United. The petitioner is currently receiving the home health services from 7:00 a.m. to 3:00 p.m. daily, Monday to Thursday.

5. On or about August 26, 2016, the petitioner made a request to United Healthcare for 8 additional hours weekly of home health services (companion services). On August 31, 2016, United sent a letter to the petitioner denying her request for the additional home health services as not being medically necessary.

6. The petitioner's daughter stated her mother should be approved for the additional hours because she needs 2 additional hours daily of assistance Monday to Thursday since the daughter works until 6:00 p.m. on those days. She would like her mother to receive 2 more companion service hours from 3:00 p.m. to 5:00 p.m. on those days. She stated her mother also receives hospice services but the hospice only offered 1 hour of assistance daily with bathing, which she does not need because she is already being bathed during the hours currently approved through United Healthcare.

7. The respondent's witness, Dr. Karver, stated that the hospice actually offered 2 hours of additional assistance daily. She also stated United Healthcare will ensure

that the hospice provides these additional hours as companion services as requested by the petitioner.

CONCLUSIONS OF LAW

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

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

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

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner also currently receives Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

18. The AHCA contract also provides that a Plan “may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.”

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

20. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that her home health services should be increased under the LTC Program. The petitioner clearly needs assistance with all her activities of daily living (ADLs). However, she is currently approved for 33 hours weekly of home health services to assist her with bathing and other activities, which are being utilized for about 8 hours daily on the days her daughter is at work (Monday to Thursday). The petitioner may benefit from arranging the approved hours to be provided two or more separate times per day rather than a continuous 8 hour block of time.

22. In addition, United Healthcare has indicated the petitioner's hospice service will provide her with an additional 2 hours of companion services on Monday to Thursday.

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.)

16F-06748

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 06 day of December, 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Nov 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06751

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 October 17, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for [REDACTED] surgery was correct. The petitioner bears the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as witnesses for the respondent were Dr. Jeanette Rios, Medical Director, and Deborah Zamora, Grievance/Appeals Team Lead, from Simply Healthcare, which is the petitioner's managed health care plan. Simply Healthcare was included as an additional respondent in this proceeding since it is the petitioner's health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent exhibits: Exhibit 1 – Authorization Request; Exhibit 2 - Denial Letter; Exhibit 3 – Appeal Letter; Exhibit 4 – Medical Records; Exhibit 5 – Medical Criteria.

Also present for the hearing was a Spanish language interpreter [REDACTED], Interpreter Number [REDACTED] from [REDACTED].

FINDINGS OF FACT

1. The petitioner is a fifty-nine (59) 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.
2. On or about August 11, 2016, the petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Simply Healthcare to perform [REDACTED] ([REDACTED]). Simply Healthcare denied this request

on or about August 17, 2016 based on medical necessity criteria. The denial notice stated the following:

The documentation provided by your physician does not support the need for [REDACTED] surgery and, therefore, your request is not approved.

3. The petitioner has been diagnosed with [REDACTED]
[REDACTED] She is seeking the requested surgery as a means of achieving weight loss.
4. The respondent's witness, Dr. Rios, stated that the applicable medical necessity criteria for this type of surgery require there be documentation that the patient has actively participated in a weight loss program for at least 6 months. She stated the petitioner would meet criteria for the surgery based on her BMI (body mass index), but there is no record of a supervised weight loss program. She also stated that the petitioner's psychiatric medications may cause weight gain even if she were to have the surgery.
5. The petitioner stated she believes the surgery should be approved because of her medical issues. She stated she also suffers from [REDACTED] and takes 15 medications. She stated she has tried numerous diets, but the medication for her nerves stimulates her appetite. She also stated she has been hospitalized every 2 to 3 months due to [REDACTED], and has not been able to follow-up with a nutritionist.
6. Services under the Medicaid State Plan in Florida are provided in accordance with the respondent's (AHCA) Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012.

CONCLUSIONS OF LAW

7. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. § 120.80.
8. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
9. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
10. 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.).
11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA. The Medicaid Handbook referred to above is incorporated by reference in Fla. Admin. Code R. 59G-4.001.
12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. Although the petitioner testified she has tried to lose weight by dieting, she must also satisfy each of the remaining components of the rule's requirements concerning medical necessity. The respondent's medical expert testified that medical necessity guidelines require a documented trial and failure of a medically supervised weight loss program and this was not established in the petitioner's case. Although the petitioner's treating physician has requested the weight loss surgery, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above.

14. The petitioner has not established by a preponderance of the evidence that her requested weight loss surgery is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the submitted medical records contain some references that the petitioner was counseled by her physician regarding weight loss, diet, and exercise, the records do not contain sufficient documentation of a supervised weight loss program. After considering the evidence and relevant authorities set forth above, the undersigned concludes that the petitioner has not met her burden of proof in establishing that the respondent's action was incorrect.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 28 day of November, 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
SIMPLY HEARINGS UNIT

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

FILED

Dec 01, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06778

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on October 19, 2016 at approximately 11:56 a.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED] *pro se*

For the Respondent: Teshia Green, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of September 8, 2016 denying Medicaid eligibility for the petitioner after reporting a household change and enrolling her in the Medically Needy Program (MNP) with a Share of Cost (SOC). The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted a several packets of information that were entered into evidence and marked as Respondent's Exhibits "1" through "11".

The petitioner submitted a packet of information that was entered into evidence and marked as Petitioner's Exhibit "1".

FINDINGS OF FACT

1. On August 12, 2016, the petitioner submitted an application to the respondent requesting Food Assistance Program benefits, and Medicaid while requesting to add the Temporary Cash Assistance (TCA) benefit. Food and Cash assistance are not the issue of this appeal. The household reported six members; the petitioner, her husband, her three children, (9, 7 and 4) and their mutual child (>1). No assets were reported. Expenses reported include: rent, \$600; electricity, \$281; and water, \$180. Petitioner's husband's income from [REDACTED] of \$350 biweekly was reported and verified as August 12, 2016 - \$379.20, August 19, 2016 - \$509.95, August 26, 2016 - \$514 and September 2, 2016 - \$494.05. This income was considered as representative income as hours vary at the same rate of pay.

2. The petitioner was determined to be over-income for Medicaid eligibility and enrolled in the MNP with a SOC of \$1,114.

3. The respondent added together four weeks of weekly income, $\$379.20 + \$509.95 + \$514 + \$494.05 = \$1,897.20$ to arrive at a monthly gross income amount. This amount was considered the petitioner's modified adjusted gross income (MAGI). The household income of \$1,897.20 was compared to the income limit for an adult with a household size of six, \$487. As the income exceeded the income limit, the

standard disregard for a household of six was subtracted from the gross income, $\$1,897.20 - \$296 = \$1,601.20$, which also exceeds the income limit. The next step is to subtract the MAGI disregard for a household of six, $\$1,601.20 - \$136 = \$1,465.20$, which is also over the income limit for Medicaid. Since the petitioner was determined ineligible for Medicaid, the respondent enrolled her in the MNP.

4. The Medically Needy Income Limit (MNIL) is \$783 for a household of six. The petitioner was enrolled in the MNP with a SOC of \$1,114 ($\$1,879.20 - \783).

5. The petitioner, while Medicaid eligible, began the process to obtain dentures. The dentures were received but because of provider error, the petitioner is not able to use them. She seeks an exception to Medicaid eligibility rule or guidance for how she might procure a useful set of dentures. Medicaid benefits covered the original dentures and without Medicaid, the petitioner is having difficulty getting the problems corrected.

6. The petitioner did not dispute the income amount used by the respondent in the eligibility process.

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.

8. 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.

FAMILY-RELATED MEDICAID

10. The Family-Related Medicaid income criteria is set forth in 42 C.F.R 435.603. It states:

(a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

11. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid. It states:

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

...

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought,

the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

12. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

13. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, her husband and four children (six members). The findings show the Department determined the petitioner's eligibility with a household size of six to determine her eligibility for Medicaid.

14. 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.

15. The Policy Manual at 2630.0108 Budget Computation (MFAM), states:

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.

In computing the assistance group's eligibility, the general formula is:

Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income).

Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.

Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.

Step 4 - Compare the total countable net income to the coverage group's income standard.

If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.

Step 5 - Apply a MAGI deduction (5% of the FPL based on SFU size).

If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.

Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

16. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid

Income Limit as \$487, the MAGI Disregard as \$136 and a Standard Disregard of \$296

for an adult with household size of six to be eligible for full Family-Related Medicaid Program. It also indicates the MNIL to be \$783.

17. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid budget and found no exception to these calculations. The undersigned concludes that the petitioner is ineligible for full Medicaid and further concludes that MNP eligibility must be explored.

MEDICALLY NEEDED PROGRAM

18. Fla. Admin. Code 65A-1.701 "Definitions" defines share of cost (SOC) as, "Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month."

19. Fla. Admin. Code 65A-1.702 "Special Provisions" states in part:
"(13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual's or family's income."

20. The Policy Manual at passage 2630.0502 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.

21. 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.

22. The hearing officer found no exception to the MNP calculations. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found. The petitioner has failed to meet her burden to prove that she is eligible for full Medicaid.

23. It is not within the authority of the undersigned to grant exceptions to rule. The undersigned suggests you confer with the Agency for Healthcare Administration to see if any adjustments or concessions may be available to you as you received a medical device procured with Medicaid funds that you are unable to use at no fault of your own. To contact a Medicaid representative by phone, please call: 1-877-254-1055.

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 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.)

16F-06778

PAGE -9

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 December, 2016,

in Tallahassee, Florida.



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

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

FILED

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

Nov 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06825

PETITIONER,

VS.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter October 17, 2016, at 11:48 p.m.

APPEARANCES

For the Petitioner: [REDACTED], representative with [REDACTED]

For the Respondent: Corrie Driscoll, supervisor

STATEMENT OF ISSUE

At issue is the denial of Emergency Medicaid for Aliens (EMA) for the petitioner. The petitioner carries the burden of proof by a preponderance of evidence in this appeal.

PRELIMINARY STATEMENT

██████████, Office of Appeal Hearings, observed.

The petitioner presented one exhibit which was entered into evidence and marked as Petitioner's Composite Exhibit 1. The respondent presented one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

1. On July 5, 2016, the petitioner's representative submitted an application for EMA on her behalf. She requested coverage for June 13, 2016. Her household consisted of herself, her husband, and three children.
2. On July 7, 2016, the petitioner's representative submitted her identification and proof of Immigration and Naturalization Services (INS) status.
3. On July 8, 2016, the respondent mailed a Notice of Case action to the petitioner and her representative requesting her to provide proof of INS status and proof of identification. The notice advised that a Face to Face interview must be completed by July 18, 2016.
4. On July 27, 2016, the petitioner's representative submitted the requested information again but the Customer Authentication/Face to Face interview was not completed.
5. On July 28, 2016, the respondent reviewed the case and attempted to contact the petitioner's representative as the verification was past due.
6. On August 5, 2016, the respondent reviewed the petitioner's application and found that the Customer Authentication/interview was not completed. The respondent proceeded to deny the application.

7. On August 5, 2016, the respondent mailed a Notice of Case Action informing the petitioner and her representative that her application dated July 5, 2016, was denied.

The reason given for the denial was no household members were eligible for this program.

8. On August 10, 2016, the petitioner's representative called the respondent but was unable to make contact.

9. On August 11, 2016, the petitioner's representative attempted to contact the respondent by email in order to determine the reason for the denial.

10. On August 16, 2016, the petitioner's representative requested a hearing to challenge the respondent's action.

11. The petitioner's representative argued that the denial reason was vague and she did not understand why the EMA was denied.

12. The respondent acknowledged that the case processor did not use the appropriate denial reason code when the EMA was denied. The respondent also argued that the petitioner's representative attempted to contact the processor after the case was denied. The respondent explained that in May 2016, it started a new policy which requires all applicants to complete the Customer Authentication process.

CONCLUSIONS OF LAW

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

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

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

(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility... (c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later... If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension.

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

(4) If an applicant or recipient does not keep an appointment without arranging another time with the eligibility specialist; or does not sign and date the applications described in subsection (1); or does not submit required documentation or verification the Department will deny benefits as it cannot establish eligibility.

16. The above authority sets forth the requirement for the respondent to verify certain information and give written notice with a due date for its return. If the applicant does not provide the required verifications by the due date, the application will be denied. The respondent requested that the petitioner complete the authentication by July 18, 2016. The petitioner's representative did not complete the authentication process by the due date.

17. The Code of Federal Regulations at 42 C.F.R. § 435.407 sets forth the level of evidence required.

(e) *Evidence of identity.* The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the groups of documentary evidence of citizenship in the groups in paragraphs (b) through (d) of this section.

(1) Identity documents described in 8 CFR 274a.2(b)(1)(v)(B)(1).

(i) Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.

(ii) School identification card with a photograph of the individual.

(iii) U.S. military card or draft record.

(iv) Identification card issued by the Federal, State, or local government with the same information included on drivers' licenses.

(v) Military dependent's identification card.

(vi) Certificate of Degree of Indian Blood, or other American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. Acceptable if the document carries a photograph of the applicant or beneficiary, or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color...

18. In addition to the above authority, the Department's Transmittal NO: C16-04-0005 states, "Effective May 1, 2016, the Customer Authentication process must be completed for all applications..."

19. The designated representative argued that the respondent used an incorrect reason code for the denial of the EMA.

20. The respondent acknowledged that it did not use the correct reason code on the denial Notice of Case Action but neither the petitioner nor her representative completed the Customer Authentication process prior to the denial; therefore, it was a harmless error.

21. The evidence demonstrates that the respondent issued a written request for the petitioner to complete the customer authentication process by July 18, 2016. There was

no evidence presented to prove the petitioner's representative attempted to complete this process prior to the denial on August 5, 2016.

22. The undersigned reviewed Medicaid rules and regulations and found no exception that would allow the respondent to waive the Authentication process for EMA.

23. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet her burden of proof in this matter. The respondent's action to deny EMA is upheld.

DECISION

Based upon the foregoing Findings of Fact and Conclusion 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.)
16F-06825
PAGE -7

DONE and ORDERED this 07 day of November, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06833

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 10, 2016, at 10:05 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Pamela Wesley, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the denial of full Medicaid for both herself and her daughter (19 years) and enrollment in the Medically Needy Program with an estimated share of cost. She is seeking full Medicaid for her and her daughter. The respondent carries the burden of proof by preponderance of evidence in this appeal.

PRELIMINARY STATEMENT

The respondent presented six exhibits at the hearing which were entered into evidence and marked as Respondent's Composite Exhibits 1 through 6. The petitioner

provided one exhibit entered into evidence and marked as Petitioner's Composite Exhibit 1. The record was held open until November 14, 2016, for the respondent to provide income limits for full Medicaid benefits. The respondent provided one additional exhibit which was accepted into evidence and marked as Respondent's Exhibit 7. The record was closed on November 14, 2016.

FINDINGS OF FACT

1. In August 2016, the respondent received an alert advising that the petitioner's Supplemental Security Insurance (SSI) of \$733 ended and she was approved for Social Security Disability Income (SSDI) of \$1,384.
2. The respondent updated the petitioner's case with the SSDI income and ended the SSI income. The monthly household income exceeded the maximum income limit for full Medicaid benefits of \$241 for the daughter, and the maximum income limit for the petitioner of \$872. The respondent proceeded to enroll them in the Medically Needy Program with an estimated share of cost (SOC).
3. The daughter's eligibility was determined under the Family-Related Medicaid program. The Medically Needy Income Limit of \$387 for a household size of two was subtracted from the Modified Adjusted Gross Income (MAGI) of \$1,384 resulting in \$997 as the SOC. The petitioner is a tax filer with her daughter as her tax dependent.
4. The petitioner was reviewed under the SSI-Related program. A \$20 unearned disregard was subtracted from the petitioner's household income resulting in the total countable unearned income of \$1,364. This was compared to the income stand for an individual of \$872. The petitioner's monthly income was above the income standard for an individual. She was ineligible for full Medicaid.

5. The respondent determined the petitioner's SOC by subtracting the Medically Needy Income Limit (MNIL) for an individual from the total countable income of \$1,364, resulting in the petitioner's a SOC of \$1,184.
6. By the same notice dated August 9, 2016, the respondent notified the petitioner her daughter were enrolled in a Medically Needy SOC.
7. On September 15, 2016, the petitioner requested a hearing to challenge the respondent's actions.
8. The petitioner asserted that the money she is receiving is not enough to pay for monthly living expenses. She asserts that she is very sick and needs to see a doctor but cannot afford to pay for the doctor's visits as she is enrolled in the SOC.

CONCLUSION 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.

Family-Related Medicaid for the daughter will be addressed first

11. The daughter's Medicaid eligibility was determined under the Family Related Medicaid program.
12. 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.

13. 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.

14. The Department’s Program Policy Manual CFOP 165-22 (the Policy Manual) at passage 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group’s income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

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

16. 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).

17. The Policy Manual at Appendix A-7 states the Family-Related Medicaid Income Limit for a child age 19 and the household size of two is \$241, the Modified Adjusted Gross Income (MAGI) is \$67 and the Medically Needy Income Limit (MNIL) is \$387.

18. In accordance with the above controlling authorities, the undersigned determined eligibility for full Medicaid benefits for the daughter and did not find her eligible as the petitioner's MAGI was more than the income limit of \$241 for a household of two. Step 1: The petitioner's income of \$1,384 was used as the Modified Adjusted Gross Income. Step 2: There were no deductions provided, as there were no tax returns. Step: 3: A Standard disregard of \$146 was allowed resulting in the total countable net income of \$1,238. Step 4: The total countable net income of \$1,238 was compared with the income standard for a child who is 19 years and in an assistance group size of two. Step 5: Since it was greater than the income standard, the MAGI disregard of \$67 was subtracted, resulting to \$1,171. This was compared to the income limit of \$241 for full Medicaid. The petitioner's household income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner's daughter is ineligible for full Medicaid.

Family-related Share of Cost Medicaid for the daughter will be addressed second

19. The above cited authorities and policies address income standards and limits, calculating countable income, and income budgeting in the Family-Related Medically Needy Program. The daughter's eligibility was determined under the Family-Related Medicaid program. The Medically Needy Income Limit of \$387 for a household size of two was subtracted from the MAGI of \$1,384 resulting to \$997 as the daughter's SOC.

SSI-Related Medicaid (for the petitioner) will be addressed next

20. The petitioner has been determined disabled by Social Security. Her Medicaid eligibility was determined under the SSI-Related Medicaid Program.
21. 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...”
22. 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)...
23. 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...”
24. The Department’s Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, identifies 88% of the federal poverty level for SSI-Related Medicaid under the MEDS-AD Program at \$872 effective July 2016.
25. For the petitioner, the undersigned reviewed eligibility for full Medicaid under the SSI-Related program. A \$20 unearned income disregard was subtracted from the petitioner’s SSDI income of \$1,384, equaling \$1,364. The petitioner’s total countable

income of \$1,364 exceeds the income standard for full MEDS-AD as listed above. This was compared to the income limit for SSI-Related Medicaid of \$872, the petitioner was ineligible for full SSI-Related Medicaid benefits. The respondent's action to deny full Medicaid benefits for the petitioner was within the rules and regulation of the Program. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

The Medically Needy share of cost for the petitioner will now be addressed

26. 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."

27. 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.

28. Fla. Admin. Code R. 65A-1.702 (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."

29. Fla. Admin. Code R. 65A-1.701 (30) states, "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. The methods of determining the share of cost for Medically Needy Program benefits is set forth in the Fla. Admin. Code R. 65A-1.713. It states:

(1)(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 cost...

31. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, states, "Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Size 1 Level \$180."

32. 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.

33. A review of the rules did not find any exceptions to the income limits. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and did not find a more favorable outcome other than the SOC assigned by the respondent. Eligibility for full Medicaid is not found.

34. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner and her daughter in the Medically Needy Program

with the estimated SOC for her of \$1,184 and her daughter of \$997 is within the rules of the Program.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for full Medicaid benefits 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.

DONE and ORDERED this 12 day of December, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Nov 18, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06929

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 28, 2016 at 9:04 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Designated Representative with [REDACTED]

[REDACTED]

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

ISSUE

At issue is the respondent's action on July 6, 2016 to deny the petitioner's application for Family-Related Medicaid on its contention that she did not provide the information necessary to determine eligibility for the program.

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. On June 3, 2016, the petitioner's representative applied for Family-Related Medicaid on behalf of the petitioner (age 29) and her daughter (age 6). The petitioner's representative did not include on the application, the social security number for the petitioner's daughter. The petitioner answered "No" to the question of whether or not she was disabled (*Respondent's Exhibit 2, page 7*).

2. On June 7, 2016, the Department mailed to the petitioner and the petitioner's representative, the Notice of Case Action to request for the petitioner to provide the social security number for the petitioner's daughter. The information was due on June 17, 2016 (*Respondent's Exhibit 2, pages 10 through 11*).

3. The Department did not receive the social security number for the petitioner's daughter. The Department contends that the petitioner did not provide any verifications that she applied for a social security card for her daughter. Therefore, the Department denied the petitioner's application for Family-Related Medicaid.

4. The petitioner's representative does not agree with the Department's denial of the petitioner's application for Medicaid. The petitioner's representative believes that since the petitioner was not applying for Medicaid for her daughter, her daughter's social security number was not needed in order to approve the petitioner's application for Medicaid. The petitioner's representative argues that the petitioner should be

eligible for Medicaid coverage for herself since her daughter was living in the home with her at the time of the application. The petitioner's representative acknowledges that the petitioner did not provide the social security number for her child. The petitioner's representative was unable to explain why the petitioner did not provide a social security number for her child. The petitioner's representative believes that the petitioner's child is a citizen of the United States.

5. The Department explained that the parent draws eligibility from the child and since the petitioner's child was not eligible due to not providing her social security number, the petitioner was ineligible. The Department explained that the petitioner's case was automatically failed by the system since the petitioner's daughter did not have a social security number. The Department's representative believes that the petitioner's child was not born in Florida because she was unable to locate the child's birth record in the FLORIDA computer system.

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-1.203 (7) Administrative Definitions includes the definition of the standard filing unit as: "All individuals whose needs, income and/or

assets are considered in the determination of eligibility for a category of assistance.”

9. Fla. Admin. Code R. 65A-1.302 Social Security Numbers states:

(1) To be eligible for public assistance, the individual must either provide the social security number (SSN) when known for **each person whose needs are included in the assistance group or SFU** or, apply for a SSN for each individual who either does not have a number assigned or whose number is unknown. The client’s verbal statement is sufficient to verify this information.

(2) If the SSN is unknown or has never been obtained, the individual must apply for a SSN through the local Department office or Social Security Administration (SSA) office. If the individual chooses to apply for a SSN through the Department Office, the eligibility specialist sends the completed form SS-5, Application for SSN, and original evidence of age, identification and citizenship to the local SSA office. Assistance is not denied, delayed, or discontinued when the individual (or his representative) has applied through the welfare enumeration system for a SSN, pending issuance and/or verification.

(3) If the individual (or his representative) fails to provide or apply for a SSN on his own behalf or on the behalf of the child(ren) without good cause, the needs of the individual or child, whichever is applicable, must be excluded from the assistance group (**emphasis added**).

10. Fla. Admin. Code R. 65A-1.705 Family-Related Medicaid General Eligibility

Criteria states:

(7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested.

(c) 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 (**emphasis added**).

11. The above authorities explain that the standard filing unit (SFU) consists of individuals whose needs are included in the determination of eligibility for assistance.

The person applying for Medicaid is required to provide the social security number for

each person whose needs are to be included in the assistance group or SFU in order to be eligible for assistance. In order for a parent to be eligible for Medicaid, a child under the age of 18, with or without income, must be included in the SFU.

12. In this case, the findings show that the petitioner applied for Family-Related Medicaid, is not disabled, and has a child under the age of 18 living in the home. The findings also show that the petitioner did not provide, or apply for, the social security number for her minor child. Based on the above findings of facts and conclusions of law, the undersigned concludes that the respondent was correct to deny the petitioner's application for Medicaid due to her failure to provide the social security number for a required member of the SFU.

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 18 day of November , 2016,

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

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

FILED

Dec 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06944

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 19, 2016, at 11:40 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Roderika Mack, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the termination of full Medicaid benefits for her and the enrollment in the Medically Needy Program with an estimated share of cost. She is seeking full Medicaid. The respondent carries the burden of proof by preponderance of evidence in this appeal.

PRELIMINARY STATEMENT

The respondent presented six exhibits at the hearing which were entered into evidence and marked as Respondent's Exhibits 1 through 6. No exhibits were presented by the petitioner. Medicaid for the children is not at issue.

The undersigned found it necessary to reconvene. All parties reconvened on December 14, 2016 at 11:44 a.m. The record was held open until the end of business on December 14, 2016, for the respondent to provide its policy on loans. The information was received, entered into evidence and marked as Respondent's Exhibit 7, and the record was closed.

FINDINGS OF FACT

1. On August 15, 2016 the petitioner submitted a recertification application for Medicaid benefits for herself (age 41) and her two sons BA (age 8) and PB (age 18) at the time of application, but now 19 years of age. She reported that her household had no income. The respondent approved full Medicaid for all three household members.
2. The petitioner's son was employed and was paid biweekly. His income was not counted in the Medicaid budget. The respondent found out about the son's income and updated the Medicaid budget. The respondent added his two pays dated August 9, 2016 for \$413.13 and September 6, 2016 for \$582.91. This amount was then multiplied by a conversion factor of 2 resulting in the household's monthly of \$996.04. The petitioner's monthly household income exceeded the maximum income limit of \$303 for full Medicaid benefits in the Family-Related program. She was found ineligible for full Medicaid. The respondent proceeded to enroll her in the Medically Needy Program with an estimated share of cost (SOC).

3. The Medically Needy Income Limit of \$486 for a household size of three was subtracted from the Modified Adjusted Gross Income (MAGI) of \$996.04, resulting in \$510 as the SOC.

4. On September 20, 2016, the petitioner requested a hearing to challenge the respondent's actions.

5. The petitioner is a tax filer and claims her two children BA and PB as her dependents. She receives financial aid for graduate school tuition and living expenses in federal loans every semester. Her last loan was \$3,587. She receives loans from a friend if the federal loan is not enough to meet her living expenses.

6. The petitioner asserted that she cannot pay the SOC as it was too high. She stated that she was very sick and needed to see a doctor but could not afford to pay for the doctor's visits if she is enrolled in the SOC. She filed for Social Security Disability Insurance (SSDI) and is awaiting an interview.

CONCLUSION OF LAW

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

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

9. The petitioner's Medicaid eligibility was determined under the Family Related Medicaid program.

10. 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.

11. 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.

12. The Department's Program Policy Manual CFOP 165-22 (the Policy Manual) at passage 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by

each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

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

14. The Policy Manual at passage 1830.0200 addresses Earned Income (MFAM) 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.

15. The Policy Manual at passage 2430.0700 Income Conversion (MFAM) states:

Most income is received more often than monthly; that is; it is received weekly, biweekly, or semimonthly. Since eligibility and benefit amounts are issued based on a calendar month, income received other than monthly is to be converted to a monthly amount.

The following conversion factors based on the frequency of pay are used:

Weekly income (once a week): Multiply by 4.

Biweekly income (every two weeks): Multiply by 2.

16. The Policy Manual at passage 1830.1301 addresses Loans (MFAM) states, “All loans, including loans and mortgages from private individuals as well as commercial institutions are excluded income.”

17. 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).

18. The Policy Manual at Appendix A-7 states the Family-Related Medicaid Income Limit for a parent and the household size of three is \$303, the MAGI is \$84 and the Medically Needy Income Limit (MNIL) is \$486.

19. In accordance with the above controlling authorities, the undersigned reviewed the petitioner’s eligibility for full Medicaid benefits and did not find her eligible as the household’s MAGI was more than the income limit of \$303 for a household of three.

Step 1: The son’s income of \$996.04 was used as the MAGI. Step 2: There were no

deductions provided, as there were no tax returns. Step 3: A Standard disregard of \$101 was allowed resulting in the total countable net income of \$895.04. Step 4: The total countable net income of \$895.04 was compared with the income standard for a parent of assistance group size of three. Step 5: Since it was greater than the income standard, the MAGI disregard of \$84 was subtracted, resulting to \$811.04. This was compared to the income limit of \$303 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 Medically Needy share of cost will now be addressed

20. 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."
21. 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.
22. 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.

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

24. The Department's Transmittal No. P-15-09-0009, dated September 18, 2015, addresses Medically Needy Budgeting for Family-Related Medicaid and states:

SFU/Counting Income for Medically Needy

Staff will continue to determine the Medicaid Standard Filing Unit (SFU) based on expected tax filing information as provided by the individual. If an assistance group (AG) is ineligible for full Medicaid coverage due to income, eligibility for Medically Needy coverage must be determined.

A child with countable income must be excluded from the Family-Related Medically Needy AG if inclusion is not beneficial to the individual whose eligibility is being determined...

If the AG's countable income is less than or equal to the Medically Needy Income Limit (MNIL) for the remaining household size, open the AG for Medically Needy with a \$0 share of cost.

If the AG's countable income is greater than the MNIL for the remaining household size, enroll the AG in Medically Needy with a share of cost as determined by the remaining countable income.

25. The Policy Manual defines a child as, "An unmarried individual under the age of 21." According the above transmittal, the petitioner's son's income should be excluded from the SOC budget for the petitioner. The above authority states that all loans are excluded in the Family Related Medicaid budget.

26. The undersigned reviewed the respondent's determination of the petitioner's SOC and found the petitioner was eligible for a lower SOC. The above-cited excludes the petitioner's son's income in the Medically Needy budget (but not in the full Medicaid

budget). As such, once his income is removed, the petitioner is found to have a Zero SOC.

27. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program was correct; however, the SOC was overstated, as the petitioner has a zero share of cost. The Department is ordered to take corrective by excluding the son's income from the petitioner's Medically Needy budget. Once the corrective action is completed, a new Notice of Case Action is to be issued.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is partially denied and partially granted. The Department's action to terminate full Medicaid benefits and enroll the petitioner in the Medically Needy Program is upheld. The respondent overstated the petitioner's share of cost, and as such, she is found to have a zero share of cost. Corrective action is ordered.

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-06944
PAGE -11

DONE and ORDERED this 16 day of December, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Nov 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06949
APPEAL NO. 16F-08708
APPEAL NO. 16F-08709

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 [REDACTED]
UNIT: 88642

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 18, 2016 at 9:10 a.m.

APPEARANCES

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

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

ISSUE

The petitioner is appealing the Department's action on June 22, 2016 to impose a Child Support Enforcement (CSE) sanction against her Temporary Cash Assistance (TCA) benefits effective August 1, 2016 on its contention that she failed to cooperate with CSE.

The petitioner is also appealing the Department's action to reduce her Food Assistance Program (FAP) benefits from \$356 to \$193 effective August 1, 2016 based on the contention that she did not cooperate with CSE.

Also at issue is the Department's action to determine that the petitioner was no longer eligible for Medicaid on the contention that she did not cooperate with CSE.

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

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on October 20, 2016 at 11:30 a.m. On October 27, 2016, the petitioner contacted the Office of Appeal Hearings to request for the hearing to be rescheduled. The petitioner's request was granted. The hearing was rescheduled to November 18, 2016 at 9:00 a.m.

Evidence was submitted and entered as the Respondent's Exhibits 1 through 3. No evidence was submitted by the petitioner.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner (age 27) and her child, age six months, were receiving TCA, FAP, and Medicaid benefits.

2. On June 7, 2016, CSE mailed to the petitioner to inform her of the requirement to come into the office for her to be eligible to receive benefits under the TCA, Medicaid, and FAP programs. The letter further instructed her that failure to cooperate may result in her benefits not being approved (*Respondent's Exhibit 3, page 1*).

3. On June 21, 2016, the Department received a data exchange alert on its Data Exchange Inquiry Child Support Sanction screen (DECS), which requests sanctions to be imposed due to failure to cooperate with CSE. The DECS screen was notated with CSE Reason code of "345" (*Respondent's Exhibit 3, page 3*). The Department explained that the alert required it to impose a CSE sanction due to non-cooperation with CSE.

4. The Department's policy requires it to apply a CSE sanction against the non-compliant parent in the TCA, FAP, and Medicaid programs. The Department imposed a CSE sanction against the petitioner, who was identified as the non-compliant parent, and caused her to become ineligible for TCA, FAP, and Medicaid benefits, effective August 1, 2016. The petitioner's child remained eligible for the FAP and Medicaid programs.

5. On June 22, 2016, the Department mailed to the petitioner the Notice of Case Action to inform her of its action to terminate her TCA benefits, reduce her FAP benefits, and terminate her Medicaid benefits on the contention that she did not cooperate with the CSE program.

6. The petitioner disputes the Department's action and argues that she did not receive the notification from CSE to cooperate with providing information on the non-custodial parent. The petitioner argues that she would have cooperated with CSE if she were aware that she was required to cooperate with the agency.

7. The Department explained that the petitioner was nine months pregnant when she applied for the TCA, FAP, and Medicaid programs; she was not yet required to

cooperate with CSE since she was still pregnant when she applied for assistance. The Department further explained that the petitioner was required to cooperate with CSE once her child was born.

8. The Department contends that CSE mailed to her the Appointment Notice to inform her of the requirement to attend an appointment. The Appointment Notice was mailed to the petitioner at [REDACTED]. The Department believes that CSE did not receive any returned mail from the petitioner. The Department was given the opportunity to acquire a witness from CSE but none called in during the hearing.

9. The petitioner argues that she did not receive the Appointment Notice because her address is [REDACTED]. The petitioner believes she did not receive the Appointment Notice because CSE left off her apartment number on the notice.

10. The Department argues that the petitioner had plenty of opportunities to cooperate with CSE because she contacted the Department on a few occasions and was given the telephone number to CSE. The Department argues that the petitioner was informed of the requirement for her to cooperate with CSE during the phone calls. The Department explained that the petitioner subsequently complied with CSE on September 7, 2016 when she reported to the agency that she and the father to her child were living together and were an intact family. The Department lifted the CSE sanction and added the petitioner to the FAP and Medicaid case.

11. The petitioner argues that she was not able to get into contact with CSE each time she called. The petitioner argues that she was not aware that she could go into the local CSE office until she contacted the Department in September 2016. The petitioner contends that once she knew she could go into the local CSE office, she went to the office and cooperated. The petitioner explained that the father to her child moved into the home with her on September 1, 2016. The petitioner acknowledges that she is now receiving FAP and Medicaid benefits for herself after being added back into the programs.

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. Section 414.095, Florida Statutes states:

- (6) 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.

15. 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.

16. 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.

17. The above authority sets forth the rules for assigning the burden of proof in an administrative hearing. The Department held the burden of proof, as it terminated and reduced the petitioner's benefits. The Department asserts its action of reducing FAP and terminating TCA and Medicaid was due to petitioner failing to cooperate with CSE. The petitioner puts forth her reason for non-compliance as non-receipt of the appointment letter sent to her from CSE due to the exclusion of her apartment number on the letter. The Department contends that the CSE employee reported that there was no returned mail in the petitioner's case. However, there was no evidence or testimony from a representative from CSE that can be relied on to prove the correctness of the CSE sanction for non-cooperation. Therefore, the Department failed to meet its burden of proof regarding the correctness of the CSE sanction; there was no representative from Child Support Enforcement to testify or present evidence to support the sanction action.

17. After carefully reviewing the evidence and controlling legal authorities, the undersigned cannot conclude that the imposition of the child support sanction against the petitioner was correct. Therefore, the respondent's action to reduce the petitioner's

FAP and terminate the petitioner's TCA and Medicaid benefits effective August 1, 2016 is reversed. The Department is remanded with instructions to reinstate the petitioner's TCA and Medicaid benefits for August 2016 and restore FAP benefits at the previous level for the month of August 2016, not duplicating any benefits already received. The Department is remanded with instructions to determine eligibility for ongoing benefits beginning September 2016 to include the father to the petitioner's child, as the petitioner has acknowledged that the father to her child is now living in the home. The Department is to issue notice with appeal rights upon completion of its redetermination.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The Department's action to impose a child support sanction against appellant in the Temporary Cash Assistance, Food Assistance Program, and Medicaid Programs is reversed. The Department is to take corrective action and reinstate the Temporary Cash Assistance, Food Assistance Program, and Medicaid benefits to the levels received prior to the sanction action under appeal for the month of August 2016. The Department is remanded to determine ongoing eligibility beginning the month of September 2016. The Department is to issue notice with appeal rights.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

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 November , 2016,

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

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

FILED

Dec 19, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06953

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 10 [REDACTED]
UNIT: HMO

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on November 29, 2016, at 12:40 p.m.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's grandmother and legal guardian

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

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied her request for a crown on Tooth #13?

PRELIMINARY STATEMENT

The following individuals appeared as witnesses on behalf of Humana: Jackelyn Salcedo, 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, was present solely for the purpose of observation.

The respondent introduced Exhibits "1" through "8", inclusive, at the hearing, which were accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on November 30, 2016 for the respondent to provide the additional information submitted by the petitioner's dental provider for the reconsideration review and the Agency for Health Care Administration guidelines regarding the approval of crowns. Once received, this information was accepted into evidence and marked as respondent's Exhibit "9". The hearing record was thereafter closed on November 30, 2016.

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 17-year-old female. She resides in [REDACTED] Florida.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. Petitioner is an enrolled member of Humana. Humana is a health maintenance organization ("HMO") contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in Florida.
4. Petitioner's effective date of enrollment with Humana was August 1, 2016.

5. Humana provides certain dental benefits to its members.

6. Humana has contracted DentaQuest as its dental vendor. In its capacity as dental vendor, DentaQuest complete prior authorization reviews of requests for dental services submitted to it by Humana members or their providers.

7. On August 3, 2016, the petitioner's dentist submitted a preauthorization request to DentaQuest for procedure code D2751 (crown – porcelain fused to predominantly base metal) for petitioner's Tooth #13.

8. In a Notice of Action dated August 5, 2016, DentaQuest informed the petitioner it was denying her request for a crown on Tooth #13.

9. The Notice of Action states, in part:

We made our decision because:

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.

...

The facts that we used to make our decision are:

- Your x-rays show that your tooth is not bad enough to receive a crown. Your tooth has to have been badly broken or decayed to receive this service. There are other things your dentist can do to fix your tooth. We have told your dentist this also. Please talk to your dentist about other possible treatment plans for your tooth.

The DentaQuest guideline or policy used to support this decision was:

- DentaQuest Clinical Criteria for Crowns

10. DentaQuest sent an Authorization Determination letter dated August 4, 2016 to the petitioner's dental provider advising the provider of its decision to deny the petitioner's request for a crown on Tooth #13.

11. The petitioner's representative sent a Grievance/Appeal Request Form to Humana dated August 26, 2016 requesting an internal review of the decision to deny the petitioner's request for a crown.

12. In response to the petitioner's request for an internal reconsideration, a DentaQuest Dental Director re-reviewed the petitioner's request on or about August 30, 2016. The Dental Director made the following note on the Dental Consultant Review Form:

We received and reviewed all submitted documentation (radiographs, photographs, narrative) for the requested appeal determination. The denial is UPHeld for tooth #13 D2751 (Crown). This service is DENIED because the tooth does not appear to have significant breakdown, ie., documentation provided does not demonstrate that there is more than 50% of the incisal edge (with incisal angle involvement) fractured or decayed and/or 4 or more surfaces involved OR is there significant decay or restorations on the mesial and/or distal of the tooth, or cusp fractures on posteriors due to decay or trauma. Discoloration, deformation (Peg Laterals), Diastemas, completed RCT treatment with minimal access openings, and/or Attrition/Abrasion/Erosion of anterior teeth does not fulfill the criteria for approval for a crown under this plan.

13. DentaQuest sent an Authorization Determination letter dated August 30, 2016 to the petitioner's dental provider advising the provider of its decision to uphold the denial.

14. Petitioner's tooth #13 previously had a filling but no longer has one. It is unclear from the testimony and evidence what happened to the filling.

15. The petitioner's representative testified that the petitioner has had multiple infections and missed 11 days of school during this school year as a result of problems associated with tooth #13.

16. DentaQuest criteria for the approval of a cast crown on tooth #13 state that the tooth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp. Caries is the scientific term for decay.

17. Petitioner's tooth #13 does not meet the DentaQuest criteria for approval of a crown. It appears to only have three surfaces indicated.

18. Petitioner's tooth #13 is in need of restoration. Restoration could be done in the form of a filling, temporary filling, or a crown.

19. The placement of a crown on tooth #13 would be appropriate if there is enough damage to the tooth that it will not hold a filling.

20. The petitioner's dentist has not provided a narrative stating that tooth #13 cannot support a filling and such a determination cannot be made solely by examining the x-rays provided.

21. The dentist appearing at the hearing testified that she cannot determine only by looking at the x-rays whether tooth #13 is infected. Even if the tooth is infected, she would have no way of concluding the infection resulted from the lack of a crown on the tooth.

22. The respondent's witness testified that DentaQuest has not received any additional requests from the petitioner's dental provider for the crown or any other services since the initial request for the crown on August 3. She explained that if the

petitioner has a problem with an infection, she should return to her general dentist and, if the situation has gotten worse, the provider should submit an additional request for the crown and supply a narrative explaining the current situation and detailing why a crown is necessary. She also testified DentaQuest has not received any information from the dentist regarding an infection of the tooth.

CONCLUSIONS OF LAW

23. 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.

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

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

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

27. 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.).

28. 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.

29. 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...

30. 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.

31. 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.

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

[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).

33. 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.

34. 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.

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

36. 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.

37. 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....”

38. 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.”

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

40. Section 4.2.8 of the Dental Services Coverage Policy explains that Florida

Medicaid reimburses for all-inclusive restorative services for recipients under the age of 21 years including restorations and crowns. The services must be determined to be medically necessary.

41. The DentaQuest criteria for the approval of a crown for a minor recipient are as follows: "Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.

42. The petitioner provided no medical testimony or documentary evidence to support a conclusion that petitioner's tooth #13 meets the criteria in the paragraph above. The petitioner's x-rays indicate that three surfaces of the tooth are involved but not the cusp tip. The respondent's dental expert testified that the petitioner's tooth requires restoration; however, restoration may be made in the form of a filling, temporary filling, or a crown. Although a crown may be medically necessary if the tooth is damaged by decay or trauma to the degree that it cannot hold a filling, the petitioner's dental provider has not provided a statement confirming or even suggesting this. There is also no medical evidence suggesting that the lack of a crown is leading to infections, or even that the petitioner's tooth is infected. The respondent's witness testified that the petitioner's dentist has provided no information to DentaQuest regarding an infection of the tooth.

43. Pursuant to the above, the petitioner has not shown by a preponderance of the evidence that the respondent incorrectly denied her request for a crown on Tooth #13.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 19 day of December, 2016,

in Tallahassee, Florida.

Peter J. Tsamis

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

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

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

FILED

Nov 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06971

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 November 15th, 2016 at 9:59 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

For the Respondent: Mary Lou Dahmer, Senior Economic Self-Sufficiency Specialist II for the Hearings Unit

STATEMENT OF ISSUE

The petitioner is appealing the denial of his SSI-Related Medicaid recertification application. On the record, the burden of proof was assigned to the petitioner. However, after further review of the record, the hearing officer has determined that the burden of proof must be assigned to the respondent.

PRELIMINARY STATEMENT

Petitioner's exhibits 1 and 2 were admitted into evidence.

Respondent's exhibits 1 through 7 were admitted into evidence.

The record was left open until the close of business, November 18th, 2016, to allow the respondent time to provide additional evidence. The respondent submitted evidence timely and all additional documents were admitted and numbered exhibit 8 and 9, and the record was closed.

By way of a Notice of Case Action dated September 14th, 2016, the respondent informed the petitioner that his SSI-Related Medicaid was closing because he did not meet the disability requirement. On September 19th, 2016, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner applied for a review of his SSI-Related Medicaid on August 22nd, 2016. 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 47 at the time of the application. There are no children under the age of 18 living in the petitioner's household.
3. By way of Notice of Case Action the respondent informed the petitioner that his Medicaid application dated September 23rd, 2015, was approved. The petitioner's application was approved for SSI-Related Medicaid with a begin date of June 1st, 2015 after the application was reviewed by the Department of Disability Determination (DDD). DDD placed a review date of April 1st, 2016 on the petitioner's case. (See Respondent's Exhibit 8 p. 62) However, the respondent failed to close the petitioner's

Medicaid timely. The petitioner continued to receive Medicaid past the review date until the respondent closed it on September 30th, 2016.

4. The petitioner simultaneously applied for disability through the Social Security Administration (SSA) on September 23rd, 2015. The SSA denied the petitioner's application on March 29th, 2016. The petitioner applied for disability benefits a second time through an attorney but his application was denied again around May or June 2016. On July 28th, 2016, the attorney filed an appeal on the petitioner's behalf. A hearing date has not yet been scheduled.

5. The petitioner described his condition as a [REDACTED] [REDACTED] [REDACTED]. The petitioner also has severe pain in both feet and [REDACTED] both due to the [REDACTED]. The petitioner states his foot pain worsened in May 2016 but the [REDACTED] and [REDACTED] remain the same. The worsening foot pain has been reported to the petitioner's attorney.

6. The SSA denied the petitioner's his claim because the conditions were not severe enough to keep him from working. The conditions reviewed by SSA were [REDACTED]

7. On August 31st, 2016, the respondent forwarded the petitioner's disability documents to the DDD for review. DDD denied the petitioner's Disability Medicaid on September 12th, 2016, due to adopting the previous SSA denial decision.

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. 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 §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...

11. 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.

12. As established in the Findings of Fact, the petitioner's conditions are described as [REDACTED] and other conditions related to a [REDACTED]. According to the respondent's evidence (see R 3 p 29), DDD reviewed those conditions when making its determination and adopted SSA's denial. The petitioner acknowledged no new conditions. The findings show that the worsening foot pain occurred prior to the SSI-related Medicaid application in question. Therefore, the hearing officer concludes that the respondent's action to deny the petitioner's SSI-Related Medicaid application 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 indigence to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 29 day of November, 2016,

in Tallahassee, Florida.

FINAL ORDER (Cont.)

16F-06971

PAGE-6

Kimberly Vargo

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

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

FILED

Dec 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06995

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]

CO-RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on November 7, 2016 at 11:42 a.m.

APPEARANCES

For the Petitioner: [REDACTED], Mother

For the Respondent: Lisa Sanchez,
Medicaid/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny her request for: (1) dental procedure D7240-removal of impacted tooth-completely bony for tooth for wisdom teeth 1, 16, 17, 32; (2) dental procedure D9223-deep sedation/general anesthesia for each tooth extraction; and (3) dental procedure D9999-unspecified adjunctive procedure, by report. Because

the issue under appeal involves requests for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Appearing as Respondent's witnesses from Better Health were Dr. Merlin Osorio, Medical Director, and Debra Zamora, Grievance and Appeals Team Lead. Appearing as Respondent's witnesses from DentaQuest were Daniel Dorrego, D.D.S., Dental Consultant, and Omisha Smith, Appeals and Complaints Specialist.

Respondent's Exhibits 1 to 6 were entered into evidence. The record was held open to November 10, 2016 for a copy of Petitioner's dental x-ray and a narrative from Petitioner's dentist. Respondent provided the information on November 7, 2016, which was marked as Respondent Exhibit 7.

FINDINGS OF FACTS

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

1. Petitioner is an eighteen year-old Medicaid recipient enrolled with Better Health, a Florida Health Managed Care provider.
2. Better Health requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for dental procedure D7240-removal of impacted tooth-completely bony for tooth for wisdom tooth 1, 16, 17, 32; dental procedure D9223-deep sedation/general anesthesia for each tooth extraction; and dental procedure D9999-unspecified adjunctive procedure, by report. DentaQuest received the request on June 20, 2016.

4. DentaQuest made its determination on June 22, 2016, denying Petitioner's request for procedures D7240, D9223 and D9999. Notice was sent to Petitioner providing the denial reason for procedure D7240 for each wisdom tooth:

Your dentist has asked to remove your tooth. To approve this service you must have severe pain in your tooth, the tooth must be in a position that will not let it break through the gum by itself, and your gums or bone around the tooth are diseased. The root of your tooth must also be completely formed. Our dentist looked at the x-ray and the information from your dentist. It does not appear that this tooth needs to be removed. This service is not medically necessary.

5. Because the extractions were not approved, the four sedation requests, procedure D9223, were also denied. Procedure D9999 was denied for lack of a narrative describing the reason the service was needed.

6. Petitioner filed a timely fair hearing request on September 13, 2016.

7. Petitioner's mother explained that her daughter is experiencing headaches and pain due to the wisdom teeth. Petitioner had orthodontic work a year ago. Petitioner has been taking Advil for her headaches and pain for the past five months.

8. Respondent's medical director noted there were no clinical notes from a doctor regarding the source and cause of Petitioner's headaches. Petitioner's mother responded that when her daughter has a toothache, she gets headaches as well. The medical director explained there could be a number of different sources or causes for Petitioner's headaches.

9. Respondent's Statement of Matters explains in relevant part:

a case must demonstrate evidence of current pathology, infection, aberrant position, and/or continuous and/or recurring pain beyond normal eruption. This plan requires root formation to be radio graphically demonstrated...Provider does not indicate pain beyond normal eruption pain and does not confirm the presence of infection, nor does the narrative

mention if these teeth are not removed it would affect the member's overall health.

10. Respondent's dental consultant explained there were a number of factors that are assessed for the medical necessity of tooth extraction. First, the x-rays are reviewed for some form of pathology. None were found for Petitioner's wisdom teeth. Second, the teeth need to be shown in an aberrant position. Petitioner's wisdom teeth are not in an aberrant position or in contact with adjacent second molars.

11. Petitioner's mother explained one of her wisdom teeth (upper left) is now protruding and causing the most pain. Respondent advised a new x-ray and prior authorization needs to be submitted to request the tooth be extracted.

CONCLUSIONS OF LAW

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

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

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. Sections 409.971 – 409.973, Florida Statutes, establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance

program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

16. Section 409.912, Florida Statutes, provides the Agency may mandate prior authorization for Medicaid services.

17. Fla. Admin. Code R. 59G-1.010 (226) defines “prior authorization” as follows: “Prior authorization” means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

18. Fla. Admin. Code R. 59G-1.010 (166) provides:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

....

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

19. The May 2016 Florida Medicaid Dental Services Coverage Policy (Policy) has been promulgated into rule by Fla. Admin. Code R. 59G-4.060, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593>.

20. Pages 4 and 5 of the Policy explains the Early and Periodic Screening, Diagnosis, and Treatment requirements:

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

21. Petitioner's mother asserted the wisdom teeth are causing her daughter pain and headaches.

22. Respondent explained there is no medical documentation for the source or cause of Petitioner's headaches. Additionally, Respondent noted Petitioner's provider did not indicate in his narrative (accompanying the prior authorization request) that Petitioner's pain was beyond normal eruption pain.

23. While Petitioner is experiencing pain from her wisdom teeth, the severity has not been described as exceeding normal eruption pain.

24. Respondent found no pathology nor any aberrant positioning of the wisdom teeth. As a result, Respondent found no medical necessity for their extraction. Full weight was given to Respondent's expert witnesses.

25. Considering the totality of the documentary evidence and testimony, as well as the above cited definitions of medical necessity and EPSDT requirements, the undersigned finds Respondent correctly determined extractions of Petitioner's wisdom teeth are not medically necessary at this time.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)

16F-06995

PAGE - 8

DONE and ORDERED this 12 day of December, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07000

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 October 26, 2016 at 10:00 a.m.

APPEARANCES

For Petitioner: [REDACTED], Petitioner's mother

For Respondent: Monica Otalora
Senior Program Specialist

ISSUE

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

PRELIMINARY STATEMENT

The petitioner's clinical liaison from the [REDACTED] submitted two sets of documents as evidence for the hearing. The first set consisted of medical records and the authorization request, which were marked Petitioner Exhibit 1. The second document was an amended authorization request reflecting a different dosage for the medication, and this was marked Petitioner Exhibit 2.

Appearing as witnesses for the respondent were Susan Frishman, Senior Compliance Analyst, and Debra Smith, Clinical Pharmacist, from United Healthcare, which is the petitioner's managed health care plan.

The respondent submitted the following documents into evidence for the hearing, which were marked Respondent composite Exhibit 1: Statement of Matters, Authorization Request, Denial Notice, Medical Records, and Medication Criteria.

FINDINGS OF FACT

1. The petitioner is a twelve (12) 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 from United Healthcare.
2. On or about July 27, 2016, the petitioner's treating physician submitted a prior authorization request to United Healthcare for the prescription drug [REDACTED]. This medication is a growth hormone.
3. On July 27, 2016, United Healthcare denied the request for [REDACTED] as not being medically necessary. The denial notice stated the following:

██████████ or ██████████ is given to patients who are less than a certain height. The facts given to us do not show that you are less than this height. Please speak with your doctor about your choices. This decision was made per the United Healthcare Community Plan of Florida Growth Hormone Treatment in Children and Adults Guideline.

4. The petitioner's mother stated her son has been on a medication called ██████████ since 2014 to stop early puberty. He has grown 1 inch in the past year and he is growth hormone deficient. He is currently 4 feet, 11 inches tall and his sister is as tall as him, which has caused him emotional problems.

5. The respondent's witness, Ms. Smith, stated the denial was based on the applicable medical criteria for this medication which require that the patient must be at less than the 5th percentile of height based on the patient's age and sex. She also stated the patient's bone age must be at least 1 year behind the chronological age. She stated the petitioner did not meet these criteria.

6. Ms. Smith also stated the prescribed dosage in the original authorization request was an inappropriate dosage as it was a higher dose than normal for this medication. However, it should be noted that an amended dosage was submitted by the provider after the hearing.

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.
12. The Florida Medicaid Provider Handbook (Provider Handbook) 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.
13. In this proceeding, United 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 ..., or (b) prior authorized by a qualified clinical specialists 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 the 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. Pertaining to the Preferred Drug List (PDL), the Drug 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.

19. The issue of whether [REDACTED] is on the Medicaid Preferred Drug List was not at issue in this proceeding. The medication was denied based on medical necessity criteria.

20. The applicable medical criteria for [REDACTED] require the patient be at less than the 5th percentile in height and have a bone age of at least 1 year behind chronological age. The submitted medical records reflect the petitioner was at the 38th percentile in height and had a bone age of approximately 14 years. Therefore, neither of these criteria were met in this case.

21. The greater weight of evidence in this matter does not establish that the respondent's denial of [REDACTED] was improper.

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 13 day of December, 2016,

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

FINAL ORDER (Cont.)

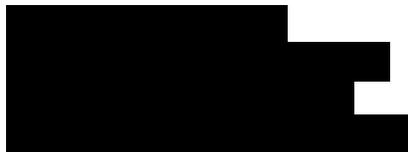
16F-07000

PAGE - 8

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07008

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 November 9, 2016, at 10:45 a.m.

APPEARANCES

For the Petitioner: [REDACTED]
Petitioner's mother

For the Respondent: Lisa Sanchez
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that it correctly denied the petitioner's request for Prescribed Pediatric Extended Care ("PPEC") Services?

6. The petitioner is susceptible to catching colds easily and has a history of

7. The petitioner is [REDACTED].

8. The petitioner is on a regular, age-appropriate, oral diet.

9. The petitioner is on a non-complex medication regimen. She takes her medications orally.

10. The petitioner periodically requires nebulizer treatments for her [REDACTED]. These treatments are administered as needed ("PRN") and it cannot be predicted when the petitioner will need a treatment.

11. The petitioner does not have a recent history of seizures.

12. The petitioner does not have a gastrostomy tube ("G-tube") or any other feeding tube.

13. The petitioner is not connected to a ventilator or respirator. She breathes independently.

14. The petitioner's representative described the petitioner as "low functioning".

15. The petitioner requires assistance with her activities of daily living ("ADLs").

16. The petitioner does not attend school.

17. The petitioner receives therapy services through her Prescribed Pediatric Extended Care provider.

18. The petitioner lives in the family home with her mother and two siblings. The petitioner's siblings are 18-years-old and 16-years-old.

19. There are no additional adults living in the family home.

20. The petitioner's mother has both a full-time job and a part-time job. She works from 8:30 a.m. to 4:30 p.m. Monday through Friday for the local school system and from 4:30 p.m. to 6:30 p.m. on Wednesday and Friday evenings providing behavior services.

21. A PPEC is a non-residential center that serves three or more medically dependent or technologically dependent recipients under the age of 21 who require short, long-term, or intermittent medical care due to medically-complex conditions. A PPEC offers services that meet the recipients' physiological, developmental, nutritional, and social needs.

22. The petitioner was approved to receive 512 partial-day units and 128 full-day units of Prescribed Pediatric Extended Care Services in the previous certification period which ran from February 20, 2016 through August 17, 2016.

23. On or about August 3, 2016, the petitioner's provider submitted a request to eQHealth Solutions for 488 partial-day units and 122 full-day units of Prescribed Pediatric Extended Care Services for the current certification period which runs from August 18, 2016 through February 3, 2017.

24. eQHealth Solutions is the Quality Improvement Organization contracted by the Agency for Health Care Administration to review requests by Medicaid recipients in the State of Florida for PPEC Services.

25. eQHealth Solutions is delegated the responsibility of determining whether a requested service is medically necessary under the terms of the Florida Medicaid Program. eQHealth Solutions has the authority to present a case and act as a witness for the Agency for Health Care Administration.

26. A request for Prescribed Pediatric Extended Care Services is submitted directly to eQHealth Solutions by a recipient's PPEC provider. Once eQHealth Solutions receives the information, it completes a prior authorization review – it reviews the written request to determine if the services requested are medically necessary.

27. Prescribed Pediatric Extended Care Services are normally requested and approved in six month increments.

28. The petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on August 8, 2016. The Physician Reviewer determined Prescribed Pediatric Extended Care Services are not medically necessary for the petitioner and denied all of the requested services. The Physician Reviewer explained the "[R]equested services are denied because the clinical information does not support the medical necessity."

29. The Physician Reviewer provided the following clinical rationale for the decision:

The patient is an 8 year old with [REDACTED] and recurrent upper [REDACTED] [REDACTED] requiring scheduled and as needed [REDACTED]. The patient has [REDACTED] and requires assistance with ADLs. The patient will be attending school. The patient is on an age-appropriate diet. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical necessity requirement of PPEC services.

30. Pursuant to a request from the petitioner, eQHealth Solutions completed an internal review of the denial on August 15, 2016. For the reconsideration review, the provider submitted an additional file in which documentation of an office visit dated August 11, 2016 was included. The document indicated that the recommendation was for the child to remain in PPEC due to her medical complexity. However, no additional

documentation was submitted to support the need for skilled nursing services which is a requirement for PPEC services.

31. The petitioner subsequently requested an administrative fair hearing and this proceeding ensued.

32. The Agency for Health Care Administration administratively approved the continuation of the petitioner's Prescribed Pediatric Extended Care Services pending the resolution of this appeal.

33. The respondent's witness testified that Prescribed Pediatric Extended Care is designed for children who require skilled nursing care. He testified that PPEC services are for children who have frequent seizures; require the use of a ventilator or respirator for breathing assistance; are connected to medical equipment; receive liquid substances intravenously; or have a gastrostomy tube or other feeding tube. The respondent's witness testified that the petitioner in the present case does not have a complex medication regimen and does not require skilled nursing services. He explained that PPEC services may not be approved solely to monitor for breathing problems and administer a nebulizer treatment if it becomes necessary. He explained any care provider may be trained to administer a nebulizer treatment.

34. The petitioner's mother expressed her concerns with the petitioner reentering the school system. She explained her fear that the petitioner's health will decline if she goes back to school because the petitioner is very susceptible to germs. She also explained that, in her experience working with disabled children in the school system, medium and high functioning children tend to get most of the attention and the petitioner may not receive the social interaction or therapeutic help that she needs.

CONCLUSIONS OF LAW

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

36. The Florida Medicaid Program is authorized by Chapter 409, Fla. Stat., and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

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

38. The respondent in the present case is proposing to terminate previously approved services. Therefore, in accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof is assigned to the respondent.

39. 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.).

40. 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...

41. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definitions for

Florida Medicaid purposes is contained in the Florida Administrative Code. Fla. Admin. Code R. 59G-1.010 states:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

42. Since the 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.

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

[A state] is required to provide private duty nursing services to [a child Medicaid recipient] who meets the EPSDT eligibility requirements, when such services are medically necessary to correct or ameliorate [his or her] illness and condition.

(2) A state Medicaid plan must include "reasonable standards ... for determining eligibility for and the extent of medical assistance" ... and such standards must be "consistent with the objectives of" the Medicaid Act, specifically its EPSDT program.

(3) A state may adopt a definition of medical necessity that places limits on a physician's discretion. A state may also limit required Medicaid services based upon its judgment of degree of medical necessity so long as such limitations do not discriminate on the basis of the kind of medical condition. Furthermore, "a state may establish standards for individual physicians to use in determining what services are appropriate in a particular case" and a treating physician is "required to operate within such reasonable limitations as the state may impose."

(4) The treating physician assumes "the primary responsibility of determining what treatment should be made available to his patients." Both the treating physician and the state have roles to play, however, and "[a] private physician's word on medical necessity is not dispositive."

(5) A state may establish the amount, duration, and scope of private duty nursing services provided under the required EPSDT benefit. **The state is not required to provide medically unnecessary, albeit desirable, EPSDT services.** However, a state's provision of a required EPSDT benefit, such as private duty nursing services, "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

(6) A state "may place appropriate limits on a service based on such criteria as medical necessity." In so doing, a state "can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis"

and my present its own evidence of medical necessity in disputes between the state and Medicaid patients. (see (citations omitted)) (emphasis added).

44. 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.

45. 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.

46. 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.

47. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013 (“PPEC Handbook”) is promulgated into law by Florida Administrative Code Rule 59G-4.260.

48. Page 2-1 of the PPEC Handbook lists the requirements for receiving PPEC services. Page 2-1 states:

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

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

49. Fla. Admin Code R.59G-1.010 defines “medically complex” and “medically fragile” as follows:

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

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

50. The testimony and documentary evidence in the instant matter do not establish the medical necessity of Prescribed Pediatric Extended Care Services for the petitioner. The petitioner is not on a complex medication regimen, nor does she require

the provision of skilled nursing services. Although the petitioner's mother presented a well-thought case and did an excellent job advocating for the petitioner, the petitioner's level of illness does not reach the level of "medically complex" or "medically fragile," as defined in the Florida Administrative Code.

51. After carefully reviewing the EPSDT and medical necessity requirements set forth above, the hearing officer concludes the respondent has demonstrated by a preponderance of the evidence that it correctly denied the petitioner's PPEC Services.

DECISION

Based upon the foregoing, the petitioner's appeal is DENIED and the decision of the Agency for Health Care Administration is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 27 day of December, 2016,
in Tallahassee, Florida.



Peter J. Tsamis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

16F-07008

PAGE - 13

Office: 850-488-1429

Fax: 850-487-0662

Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To:

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

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

FILED

Dec 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07014

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 [REDACTED]

CO-RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on November 7, 2016 at 10:01 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Father

For the Respondent: Jerome Hill,
Medicaid Fair Hearing Supervisor,
Agency for Health Care Administration

STATEMENT OF ISSUE

Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny her request for dental procedure D7210-surgical removal of erupted tooth requiring removal of bone and/or section of tooth (tooth extraction) for tooth 21 and 28 and related request for procedure D9223-deep sedation/general anesthesia for each tooth extraction, and D9999-unspecified

adjunctive procedure, by report. Because the issue under appeal involves a request for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Mindy Aikman, Grievance and Appeals Specialist, appeared as Respondent's witness from Petitioner's managed care plan Humana. Dr. Daniel Dorrego, Dental Consultant, and Jackelyn Salcedo, Complaints and Grievance Specialist, appeared as Respondent's witnesses from DentaQuest.

Respondent's Exhibits 1 and 2 were entered into evidence.

FINDINGS OF FACTS

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

1. Petitioner is a sixteen year-old Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider.
2. Humana requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for procedure D7210-surgical removal of erupted tooth requiring removal of bone and/or section of tooth (tooth extraction) for tooth 5, 12, 21 and 28; related requests for procedure D9223-deep sedation/general anesthesia for each tooth extraction; and D9999-unspecified adjunctive procedure, by report. DentaQuest received the request on September 6, 2016.
4. DentaQuest made its determination on September 6, 2016, approving procedures D7210 and D9223 for tooth 5 and 12. DentaQuest denied procedures

D7210 and D9223 for tooth 21 and 28. DentaQuest also denied Petitioner's request for procedure D9999. DentaQuest's Authorization Determination completed on September 6, 2016 provides the following reasons for the denials:

- Procedure D7210-surgical extraction for tooth 21 and 28: Per Dental Director review, the x-rays do not support the code requested. A less severe extraction code would be considered.
- Procedure D9999-Please resubmit with a narrative describing this treatment and/or a narrative regarding medical necessity.

5. Notice of Action was sent to Petitioner on September 7, 2016 advising medical necessity was not found for Petitioner's request for surgical extraction of tooth 21 and 28.

6. Petitioner filed a timely fair hearing request on September 14, 2016.

7. Petitioner's father stated he showed Respondent's denial letter to Petitioner's dentist, who insists surgical extraction is necessary for tooth 21 and 28.

8. Respondent's dentist explained the x-ray submitted by Petitioner's dentist was reviewed for three criteria necessary for surgical extraction of a tooth. Only one condition needs to be met to qualify for surgical extraction:

- I. 75% or more of the tooth is missing due to trauma or decay. This is not present in the x-ray for either tooth 21 or 28;
- II. The tooth must exhibit an extreme curve of the root. This is not present in the x-ray for either tooth 21 or 28; or
- III. The tooth must exhibit two or more root structures. Neither tooth 21 nor 28 meets this requirement.

Respondent's dental consultant stated dental extraction code D7140 would qualify for approval for tooth 21 and 28.

9. Petitioner's father understood the reason for denial of surgical extraction of tooth 21 and 28 and had no questions for the dental consultant or any further comments.

CONCLUSIONS OF LAW

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

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

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

13. Sections 409.971 – 409.973, Florida Statutes, establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

14. Section 409.912, Florida Statutes, provides the Agency may mandate prior authorization for Medicaid services.

15. Fla. Admin. Code R. 59G-1.010 (226) defines "prior authorization" as follows: "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

16. Fla. Admin. Code R. 59G-1.010 (166) provides:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

....

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

17. The May 2016 Florida Medicaid Dental Services Coverage Policy (Policy) has been promulgated into rule by Fla. Admin. Code R. 59G-4.060, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration’s website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593> .

18. Pages 4 and 5 of the Policy explains the Early and Periodic Screening, Diagnosis, and Treatment requirements:

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

19. Petitioner's father asserts Petitioner's dentist insists surgical extraction of tooth 21 and 28 is necessary.

20. Respondent's dental consultant explained in detail why surgical extraction of tooth 21 and 28 is not medically necessary. The dental consultant, and the Notice of Action, explained a less severe code (D7140) is appropriate.

21. Considering the totality of the documentary evidence and testimony, as well as the above cited definitions of medical necessity and EPSDT requirements, the undersigned finds the Respondent correctly determined surgical extraction of Petitioner's tooth 21 and 28 is not medically necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 12 day of December, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Nov 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07021
16F-07022
16F-07712

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 88007

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:19 a.m. on October 19, 2016.

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: 1) decrease the petitioner's Food Assistance (FA), 2) increase the petitioner's Medically Needy (MN) Share of Cost (SOC) and 3) decrease the petitioner's Medicare Savings Plan (MSP) from Special Low-income Medicare Part B (SLMB) to Qualifying Individual 1 (QI1) is proper. The petitioner carries the burden of proof by a preponderance of the evidence

for the FA issue. The respondent carries the burden of proof by a preponderance of the evidence for the MN and MSP issues.

PRELIMINARY STATEMENT

The petitioner did not submit exhibits. The respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record was closed on October 19, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received: \$121 in FA benefits, MN with a \$935 SOC and MSP SLMB.
2. On September 7, 2016, the petitioner submitted a paper recertification application for FA, MN and MSP benefits for certification period starting in October 2016. The application lists income from Social Security (SS) and Veterans Affairs (VA); expenses listed include \$605 rent, utilities and medical. Petitioner is the only individual in his household.
3. The Department verified that the petitioner receives \$1,135 from the SS and \$133.17 from the VA. The Department also verified with the petitioner that he has \$220.25 in monthly medical expenses. The following is the Department's FA budget calculation:

\$220.25	medical expenses
<u>-\$ 35.00</u>	<u>medical deduction</u>
\$185.25	excess medical expenses
\$1,135.00	SS
<u>+\$ 133.17</u>	<u>VA</u>
\$1,268.17	total income
<u>-\$ 157.00</u>	<u>standard deduction</u>
<u>-\$ 185.25</u>	<u>excess medical expenses</u>
\$ 925.92	adjusted income

\$ 605.00	shelter/rent
+\$ 338.00	standard utility allowance (SUA)
<hr/>	
\$ 943.00	shelter/utility cost
-\$ 462.96	50% adjusted income (\$925.92/2)
<hr/>	
\$ 480.04	excess shelter deduction
\$ 925.92	adjusted income
-\$ 480.04	excess shelter deduction
<hr/>	
\$ 445.88	adjusted income after deduction

\$445.88 X 30% = \$134 (round up) FA benefit reduction

4. The maximum FA benefit amount for a household size of one is \$194. Subtracting \$134 (FA benefit reduction) from \$194 results in \$60 monthly FA.

5. The following is the Department's calculation of the petitioner's MN SOC:

\$1,268.17	total income
-\$ 20.00	unearned income disregard
-\$ 180.00	MN income level (MNIL)
<hr/>	
\$1,068.00	SOC – cents dropped

6. The following is the Department's calculation of the petitioner's MSP:

\$1,268.17	total income
-\$ 20.00	unearned income disregard
<hr/>	
\$1,248.17	total countable income

7. MSP has three types of Buy-In Programs; Qualified Medicare Beneficiary (QMB), SLMB and QI1. Buy-In Programs are programs that pay for the Medicare premium.

8. For the petitioner to be eligible for MSP, his income cannot exceed the Buy-In Programs income standards; \$990 for QMB, \$1,188 for SLMB and \$1,337 for QI1.

9. Petitioner's \$1,248.17 countable income exceeds the income standard for QMB and SLMB.

10. On September 14, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying his MN increased to \$1,068 and he was no longer eligible for SLMB, effective October 2016.

11. On September 15, 2016, the Department mailed the petitioner a NOCA, notifying his FA decreased to \$60 effective October 2016.

12. The petitioner did not dispute the Department's calculations. Petitioner contends that nothing has changed from the previous certification, he does not understand the reason for the decrease in his FA and MSP and increase in his MN SOC.

13. The Department's representative explained that at the previous certification the petitioner was not receiving \$133.17 income from the VA, which is the reason for the FA and MSP decrease and the MN SOC increase.

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.

FOOD ASSISTANCE ISSUE

16. Federal Regulation at 7 C.F.R § 273.9, defines income in the FA determination and in part states:

- (b) Definition of income. Household income shall mean all income from whatever source...
- (2) Unearned income shall include, but not be limited to...

(ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits...

17. In accordance with the above authority, the Department included the petitioner's \$1,135 income from SS and \$133.17 income from the VA in the FA determination.

18. Federal Regulation at 7 C.F.R § 273.9, defines allowable deductions in the FA determination and in part states:

(d) Income deductions. Deductions shall be allowed only for the following household expenses:
(1) Standard deduction...
(3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month...
(6) Shelter costs...
(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions...
(C) The cost of fuel for heating; cooling (i.e., the operation of air conditioning systems or room air conditioners); electricity or fuel used for purposes other than heating or cooling; water; sewerage; well installation and maintenance; septic tank system installation and maintenance; garbage and trash collection; all service fees required to provide service for one telephone
(iii) Standard utility allowances... Only utility costs identified in paragraph (d)(6)(ii)(C) of this section must be used in developing standards...

19. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1, sets forth for a household size of one the following:

\$194	maximum FA benefit
\$157	standard deduction
\$338	SUA

20. Federal Regulation at 7 C.F.R. § 273.10, explains income and deduction calculations:

(e) Calculating net income and benefit levels —(1) Net monthly income.
(i) To determine a household's net monthly income, the State agency shall...

- (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members...
- (C) Subtract the standard deduction.
- (D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed \$35. If so, subtract that portion which exceeds \$35...
- (H) Total the allowable shelter costs... Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost...
- (I) Subtract the excess shelter cost...
- (2) Eligibility and benefits...
 - (ii)(A)... the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income...

21. The cited authorities set forth income and allowable deductions in the FA benefit determination. In accordance with the authority, the Department subtracted allowable deductions (standard deduction, excess medical expenses, shelter and SUA) in the petitioner's FA calculation to arrive at \$60 FA benefits monthly.

MEDICALLY NEEDED SHARE OF COST ISSUE

22. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income

Eligibility Criteria, states in part:

- (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
 - (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level...
 - (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...

23. 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.

24. Policy Manual, CFOP 165-22, appendix A-9 (July 2016), identifies \$872 as 88 percent of the FPL for an individual.

25. Petitioner's \$1,268.17 monthly income exceeds the \$872 income limit to be eligible for full Medicaid.

26. Federal Regulation at 20 C.F.R. § 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..."

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

28. In accordance with the cited authorities, the Department deducted \$20 unearned income and \$180 MNIL from the petitioner's \$1,268.17 household income, to arrive at \$1,068 SOC (17 cents dropped).

MEDICARE SAVINGS PLAN ISSUE

29. The Fla. Admin. Code R. 65A-1.702, Special Provisions, explains the Buy-In Programs 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.)...

30. The Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility

Criteria in part 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...

(b) For QMB, income must be less than or equal to the federal poverty level...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid...

31. Policy Manual, CFOP 165-22, appendix A-9 (July 2016), identifies the MSP Program income standards as: \$990 for QMB, \$1,188 for SLMB and \$1,337 for QI1.

32. Federal regulation at 20 C.F.R. § 416.1124(c) (12) establishes a \$20 disregard for "the first \$20 of any unearned income in a month". The Department deducted \$20 from petitioner's \$1,268.17 monthly unearned income to arrive at \$1,248.17 countable income.

HEARING OFFICER'S CONCLUSIONS

33. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof on the FA issue. The undersigned concludes that the Department's action to reduce the petitioner's FA benefits to \$60 monthly is proper.

34. Also in careful review of the cited authorities and evidence, the undersigned concludes that the Department met its burden of proof on the MN SOC and MSP issues. The undersigned concludes that the Department's action to increase the petitioner's MN SOC to \$1,068 and approve MSP Q11 is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the respondent's actions are 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 November, 2016,

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

Dec 05, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07023

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 [REDACTED]
UNIT: 88672

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 25, 2016 at 8:45 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Martha Lopez, Operations Management Consultant I

STATEMENT OF ISSUE

At issue is the respondent's action to terminate the petitioner's Medicare Savings Plan (MSP) benefits and deny request for the MSP benefits at recertification is proper. The burden of proof was assigned to the petitioner during the hearing. After further review by the undersigned, the burden of proof was reassigned to the respondent by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted no exhibits. The respondent submitted a 30-page exhibit which was marked and entered as Respondent's Composite Exhibit "1".

FINDINGS OF FACT

1. MSP is a Medicaid Buy-in Program in which the State of Florida pays the Medicare premiums. The petitioner was previously receiving MSP under the Qualifying Individual 1 (QI 1) plan.
2. On September 7, 2016, the petitioner submitted an application for recertification of MSP.
3. The petitioner's household consists of the petitioner and his wife.
4. The petitioner receives Social Security Administration (SSA) income of \$1,268 per month. His wife receives \$561 SSA income per month.
5. The respondent determined the petitioner total unearned income to be \$1,829.
6. To be eligible for QI 1, a couple's income (minus any applicable disregards) cannot exceed \$1, 803.
7. In calculating the MSP budget, the respondent applied a \$20 disregard, determining the petitioner's countable income as \$1,809.
8. The petitioner's countable income of \$1,809 exceeds the \$1,803 income limit.
9. On September 23, 2016, the respondent sent the petitioner a Notice of Case Action informing him the household was denied the QI 1: "Reason: Your household's income is too high to qualify for this program."
10. The petitioner timely requested the hearing.

11. The petitioner does not dispute the household income calculations. The petitioner asserts he just wants to know if the decision can be overturned since it is only \$6.

CONCLUSIONS OF LAW

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

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

13. Fla. Admin. Code R. 65-1.702 Medicaid Special Provisions, states in relevant part:

(12) Limits of Coverage.

(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...

(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)...

14. Fla. Admin. Code R. 65A-1.713, SSI-Related Income Eligibility Criteria, states in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...

(b) For QMB, income must be less than or equal to the federal poverty level...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid...

15. The Department's Program Policy Manual (The Policy Manual), CF-OP 165-22, at Appendix A-9, identifies MSP income standards for a couple, effective July 1, 2016 as follows:

QMB	SLMB	QI 1
\$1,335	\$1,602	\$1,803

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

17. In accordance with the above mentioned authorities and policy manual, the respondent deducted \$20 unearned income from the household's total unearned income of \$1,829 to arrive at \$1,809.

16. In careful review of the cited authorities and the budget calculations completed by the respondent, the undersigned could not find a more favorable outcome.

17. Based on the cited authorities and evidence, the undersigned concludes the respondent followed rule in terminating the petitioner's QI 1 benefits and denying reapplication for QI 1 due to exceeding the income standard set for a couple.

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 05 day of December, 2016,

in Tallahassee, Florida.

Pamela B. Vance

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

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

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

FILED

Dec 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07052

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 November 17, 2016, at 10:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Barbara Dean, supervisor.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her full Medicaid benefits and enrollment in the Medically Needy Program with an estimated share of cost (SOC). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any exhibits for consideration. The respondent submitted nine (9) exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 9.

FINDINGS OF FACT

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

1. On June 16, 2016, petitioner submitted an application requesting Food Assistance Program (FAP) and Medicaid benefits for her family. Her household comprises of herself and two children under six years old, See Respondent's Exhibit 1.
2. Petitioner is gainfully employed. She is a tax filer with the children as her tax dependents. She works 40 hours per week and gets paid biweekly and provided the following paystubs; \$819.50.50 on 6/17/16; \$877.25.13 on 6/3/16; \$880 on 5/20/16 and \$264 on 5/6/16, see Respondent's Exhibits 2 & 3. Based on the income information, petitioner was approved for the Medically Needy benefits for herself. The children were approved for full Medicaid.
3. On June 28, 2016, the respondent sent the petitioner a Notice of Case Action informing her she was approved for the Medically Needy Medicaid with a \$1,274 SOC, see Respondent's Exhibit 2. The SOC has since been adjusted to \$1,080 after review.
4. Petitioner is seeking full Medicaid benefits for herself and is challenging her enrollment in the Medically Needy Program. Originally, in determining eligibility for Medicaid for the petitioner, the respondent's used petitioner's base rate of \$11 per hour for a 40-hour week to arrive at a \$440 weekly salary. This amount was multiplied by 4

to arrive \$1,760 modified adjusted gross income (MAGI). Respondent counted three members in the petitioner's standard filing unit (SFU). The household income was then compared to the income limit for an adult with a household size of three (\$303). The income exceeded the maximum limit, resulting in petitioner being found ineligible for full Medicaid benefits.

5. As petitioner was determined ineligible for full Medicaid, respondent enrolled her in the Medically Needy Program. To determine the estimated SOC for the petitioner, the Medically Needy Income Level (MNIL) of \$486 for a standard filing unit size of three was subtracted from the MAGI (\$1,760), resulting in an estimated SOC of \$1,274. See Respondent's Exhibit 7. On September 23, 2016, the petitioner requested an appeal challenging the Department's action of denying her full Medicaid benefits and her enrollment in the Medically Needy Program with an estimate SOC of \$1,274.

6. After a review, respondent recalculated petitioner's SOC. The Medicaid budget for August 2016 shows the MAGI as \$1,566.82. Respondent used the same SFU and methodology above and determined petitioner's updated SOC as \$1,080, see Respondent's Exhibit 8.

7. Respondent explained that the petitioner was evaluated under the Family-Related Medicaid coverage group and since her household income exceeded the income limit, she was not eligible for full Medicaid. She explained that household expenses like shelter, utilities and childcare are not allowed under the Medicaid Program. Additionally, she explained that petitioner's SOC amount is directly dependent on the household MAGI.

8. Petitioner did not dispute any facts presented by respondent. During the hearing, the petitioner explained that her income is not enough to cover her household expenses and she cannot afford any out-of-pocket medical expenses. She has medical issues that require medical attention and had to postpone her follow-up appointment because she does not have any Medicaid coverage. Respondent explained how the Medically Needy Program works and advised the petitioner to submit medical bills every month for tracking to get her Medicaid activated.

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. 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.

12. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid:

(f) Household—(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent...

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

...

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

13. The Department's Program Policy Manual CFOP 165-22 (the Policy Manual) at passage 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

14. In accordance with the above controlling authorities, the Medicaid household group is the petitioner and her two children (three members). The findings show the Department determined the petitioner's eligibility with a household size of three for Medicaid. The undersigned concludes the Department correctly determined the petitioner's household size as three for Medicaid.

15. Federal regulations at 42 C.F.R. § 435.603(d) Application of modified gross income (MAGI) defines Household Income and states:

(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

16. The Policy Manual at passage 1830.0200 addresses Earned Income (MFAM) 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.

17. The Department's Policy Manual section 2630.0108 Budget Computation (MFAM):

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.

In computing the assistance group's eligibility, the general formula is:
Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income).
Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.
Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.

Step 4 - Compare the total countable net income to the coverage group's income standard.

If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.

Step 5 - Apply a MAGI deduction (5% of the FPL based on SFU size).

If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.

Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

18. 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.

19. The above allows for the use of the conversion factor of 4 if income is received weekly (and of 2 if received biweekly) for Medicaid eligibility determination. The undersigned could not find a better outcome in determining the household income.

20. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for petitioner. The undersigned concludes that petitioner is not eligible for full Medicaid under the Family-Related Medicaid Program. Respondent proceeded to explore the Medically Needy Program. The undersigned recognizes the petitioner's concerns about her medical needs. However, the controlling legal authorities do not allow for any more favorable outcome.

21. 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”.

22. 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.

23. 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.

24. In accordance with the above controlling authorities, respondent determined petitioner’s SFU as a household of three based on her tax filing status.

25. Effective April 2016, the Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7. It indicates that the MNIL for a household of three is \$486.

26. Originally, petitioner’s SOC was estimated to be \$1,274, after a subsequent review, it was reduced to \$1,080. The hearing officer reviewed the respondent’s most recent SOC calculation and could not find a more favorable outcome.

27. 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 full Medicaid under the Family-Related Medicaid coverage group and her enrollment in the Medically Needy Program is correct.

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 12 day of December, 2016,
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

Dec 05, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

████████████████████
████████████████████
████████████████████

APPEAL NO. 16F-07113

PETITIONER,

Vs.

CASE NO. ██████████

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 ██████
UNIT: 88287

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 29th, 2016 at 8:36 a.m.

APPEARANCES

For the Petitioner: ██████████, pro se.

For the Respondent: Mary Lou Dahmer, Senior Economic Self-Sufficiency Specialist II for the Hearings Unit

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 an interpreter for the petitioner was ██████████, interpreter number ██████████, from ██████████.

The petitioner did not present any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 4 were admitted into evidence.

By way of a Notice of Case Action dated September 13th, 2016, the respondent informed the petitioner that his SSI-Related Medicaid was denied because he did not meet the disability requirement. On September 26th, 2016, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner submitted an online application for SSI-Related Medicaid on September 9th, 2016. 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 51 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 26th, 2016. SSA denied the petitioner's application on September 14th, 2016 with the denial reasons N01 or No Pay-Excessive Income and non-disability issues. At the time of the September 2016 SSA application, the petitioner was receiving short term disability payments through Hartford Insurance. The petitioner did not appeal the SSA denial. On November 28th, 2016, the petitioner applied for disability benefits a second time through SSA and is awaiting a decision.
4. The petitioner described his condition as a [REDACTED]. [REDACTED]. All conditions were reported to SSA on the July 26th, 2016, application.

The petitioner states his condition worsened in August 2016 prior to applying for SSI-Related Medicaid.

5. The September 9th, 2016 application did not list the petitioner as being disabled. However, on September 12th, 2016, the petitioner claimed disabled during his eligibility interview. The respondent denied the SSI-Related Medicaid portion of the application on September 12th, 2016. According to the respondent, the application was denied in error.

6. The respondent forwarded the petitioner's disability documents to the Department of Disability Determination (DDD) for review on October 24th, 2016. DDD denied the petitioner's Disability Medicaid on November 28th, 2016, due to adopting the previous SSA denial decision. The respondent received an electronic data confirmation the day of the hearing confirming the denial. In addition to adopting the previous SSA decision, DDD added the denial code N36 or Non-Pay Insufficient or No Medical Data Furnished. To date, a Notice of Case Action regarding the most recent denial has not been issued.

7. The petitioner disagrees with the respondent's position that the denial of his application based on insufficient medical data is correct. The petitioner asserts he has supplied medical records to the respondent on three separate occasions and does not understand why it was insufficient.

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. 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 §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...

11. 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.

12. The hearing officer notes the petitioner's concerns regarding his medical documentation. However, the Findings of Fact show that the respondent sent the disability documents to DDD for review. As established in the Findings of Fact, the petitioner's conditions are described as a [REDACTED] [REDACTED]. According to the petitioner, these conditions were reported to SSA at the time of the July 26th, 2016 application. The petitioner acknowledged no new conditions. The findings show that the condition worsened prior to the SSI-related Medicaid application in question. Therefore, the hearing officer concludes that the respondent's action to deny the petitioner's SSI-Related Medicaid application was correct. The petitioner must await the decision of his application filed with the SSA; the petitioner may then 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 indigence to waive those fees. The

FINAL ORDER (Cont.)
16F-07113
PAGE-6

Department 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 December, 2016,

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

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

FILED

Dec 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07169

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 16, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for dental services (partial lower dentures) was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as witnesses for the respondent were Dr. Frank Mantega, Dental Consultant, and Evie Labady, Grievance Specialist, from DentaQuest, which is the petitioner's dental services review organization. Also present as a witness for the respondent was Stacy Larsen, Operations Specialist, from Humana, which is the petitioner's managed health care plan. Humana was included as a respondent in this proceeding since it is the petitioner's health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Case Summary, Authorization Request, X-rays, Denial Notice, and Dental Criteria.

FINDINGS OF FACT

1. The petitioner is a fifty-one (51) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.
2. On or about September 2, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Humana and/or DentaQuest for approval of various dental services, including partial lower dentures. DentaQuest denied the request for partial lower dentures on September 8, 2016 as not being medically necessary.

3. DentaQuest's denial notice to the petitioner advised her of the following reason for the denial of her request for the partial lower dentures:

You still have enough teeth to properly chew your food, therefore, you do not qualify for a partial denture. We have told your dentist this also. Please talk to your dentist about other choices to treat your teeth.

4. The petitioner stated she only has one tooth in her lower arch and cannot chew her food.

5. The respondent's witness, Dr. Mantega, stated that the denial of the petitioner's request for the lower partial dentures was appropriate because the x-rays show she has 10 teeth in occlusion (contact between upper and lower teeth). He stated the criteria for dentures require the individual to have less than 8 teeth in occlusion. He also stated that if the petitioner had recent tooth extractions, new x-rays would need to be submitted to re-evaluate the need for dentures.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

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

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

10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), 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.).

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. 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.”

13. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. Partial dentures and full dentures are covered services for adults under the Medicaid Program.

15. The petitioner's position is that she should be approved for the lower dentures because she only has one tooth in her lower arch.

16. The respondent's witness stated the lower dentures were properly denied since the submitted x-rays show the petitioner has ten teeth in occlusion.

17. After considering the evidence and testimony presented, the undersigned concludes the respondent correctly denied the petitioner's request for the partial lower dentures. The evidence demonstrates that she does not meet the criteria for dentures since she has more than 8 teeth in occlusion. If the condition of the petitioner's mouth and teeth has changed, she should speak with her dental provider regarding submitting current x-rays with a new request for the dentures to DentaQuest.

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 30 day of December , 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

FILED

Dec 27, 2016

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07170

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 [REDACTED]
UNIT:AHCA

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 7, 2016 at 3:03 p.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 partially deny Petitioner's initial request for six hours of personal care services (PCS) per day, seven days per week, for the certification period August 1, 2016 through January 31, 2017. Because the matter at issue is an initial request for services, Petitioner is assigned the burden of proof.

PRELIMINARY STATEMENT

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

Respondent's Exhibits 1 to 5 were entered into evidence. Respondent's Exhibit 2 is a memo dated January 4, 2016 that explains AHCA has contracted with eQHealth Solutions, Inc. (eQHealth) as the Quality Improvement Organization (QIO) to perform prior authorizations of home health services, as well as other Medicaid services. As the QIO, eQHealth has the authority to make medical necessity determinations on behalf of AHCA.

Petitioner has been approved two hours of Personal Care Services Monday through Friday, 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 20 year-old Medicaid recipient. He is diagnosed with [REDACTED]
[REDACTED]
2. Petitioner lives with his mother, step-father, and sister. The mother works from 7:30 a.m. to 4:30 p.m. Petitioner attends school from 8:00 a.m. to 2:30 p.m.
3. Petitioner is ambulatory and uses communication devices. He is semi-independent with his personal hygiene.
4. Petitioner is [REDACTED], especially at night. He does not wear diapers.
5. Petitioner receives 45-49 hours of respite services per month.

6. Until he reached age 18, Petitioner received supportive services through Advocates for the Rights of the Challenges (ARC). After he aged out of the ARC program, the mother provided for her son's needs. She is now working again and is not home as much as she has been in the past.

7. Petitioner's mother explained she is not as available as she has been in the past because she has other children and is looking to work more hours and advance in her career.

8. Petitioner's mother explained two hours of personal care services (PCS), which is currently approved, does not take into consideration the travel time to and from work.

9. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for personal care services (PCS) through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the hours requested pursuant to the requirements and limitations of the Medicaid State Plan.

10. A request for service is submitted by a provider along with all information and documentation necessary for the QIO to make a determination of medical necessity for the level of service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

11. On July 20, 2016, Petitioner's provider submitted a request for six hours of PCS seven days per week for the certification period August 1, 2016 through January 31, 2017.

12. On August 18, 2016, an eQHealth Solutions physician consultant reviewed the request and partially denied the PCS services. On August 22, 2016, Respondent sent a Notice of Outcome to Petitioner approving two hours of PCS Monday through Friday. The notice provided the reason for the partial denial: "the services are not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code (F.A.C.), specifically the services must be: Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs."

13. On August 22, 2016, Respondent also sent a Notice of Outcome to the requesting provider. This notice provided the physician reviewer's principal reason for the partial service denial:

The recipient is a 19-year-old male, with [REDACTED] He is occasionally [REDACTED] and wears diapers; incontinence is especially at night time. He uses a communication device (I-touch). He needs constant reminders to complete ADLs. He is ambulatory and semi-independent with his personal hygiene. He is able to have a regular diet. The recipient receives some hours of respite care. He attends school Monday thru Friday from 8 am – 3 pm. He lives with his sister, step-father, and his mother. The recipient's mother works Monday thru Friday 7:30 am – 4:40 pm. The provider has requested PCS for 6 hrs/day 7days/week. Medical necessity for PCS is supported by the submitted documentation.

The notice also included the following clinical rationale for the decision:

Based on the information provided and the recipient's medical condition, PCS are warranted. However, the provider's requested hours are excessive. Recommend approval of 2 hrs PCS Monday-Friday to assist with PCS. The mother is available before school and after work. If the mother works some of the weekends, a separate modification request may be submitted if PCS are needed. The remainder of the requested time is not medically necessary and appears to be for monitoring. The Florida Medicaid Home Health Services and Limitations Handbook notes that PCS are not to be used for monitoring or supervision.

14. On August 26, 2016, Petitioner requested a reconsideration review.

15. Respondent completed the reconsideration review on August 29, 2016 and sent a Notice of Reconsideration to the Petitioner on September 12, 2016. The notice upheld the initial partial denial.

16. Petitioner filed a timely request for a fairing hearing on September 19, 2016.

17. Petitioner's mother explained that her son was receiving after school supportive services from Advocates for Rights of the Challenged (ARC). Petitioner was no longer eligible for ARC services when he turned 18 years old. Petitioner's mother provided care for her son until recently. She is now working and not as available to meet her son's needs. Petitioner's mother asserted Petitioner needs one hour in the morning from 7:30 to 8:30 a.m. and three hours in the afternoon from 3:00 p.m. to 6:00 p.m.

18. Petitioner's mother stated she is not always available to care for her son because she has other children, other non-work related activities, and travel time to and from work that has not been considered in Respondent's approval of PCS hours.

19. Petitioner likes cleaning up after himself but needs help taking his medications and storing them properly. He also needs help with toileting and personal hygiene. Petitioner needs assistance keeping his living space clean. He also needs assistance walking from the front door of his home to the curb to board his ride to school.

20. Respondent's physician consultant reviewed Petitioner's medical history and the supporting documentation submitted with the request for PCS services. The physician consultant explained approval of PCS was based on Petitioner's medical needs for addressing his activities of daily living (ADLs). What ADL needs cannot be provided by the parent(s) would be met with the approved PCS hours.

21. Respondent's physician consultant reviewed Petitioner's Support Plan, dated February 1, 2106. The support plan is developed by Petitioner's waiver support coordinator as supporting documentation for services provided by the Agency for Persons with Disabilities. He observed the support plan states: "Recently [Petitioner] has learned to help with chores including doing dishes, putting stuff away with verbal prompts. [Petitioner] is becoming semi-independent with his personal hygiene."

22. Petitioner's support plan also states he "engages in numerous maladaptive behaviors including self-injurious behavior (biting), foot stomping with occasional injury, spitting, and property destruction, disruptive, repetitive, withdrawal, and socially inappropriate behaviors."

23. Based on Petitioner's level of self-sufficiency, the mother's availability before and after work, and her availability on Saturday, Respondent's physician consultant agreed two hours of PCS per day, Monday through Friday, is sufficient to meet Petitioner's ADL needs.

CONCLUSIONS OF LAW

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

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

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

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

28. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

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

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

30. The Florida Medicaid Home Health Services Coverage and Limitations Handbook (Handbook), October 2014, has been promulgated by reference in the Florida Administrative Code at 59G-4.130(2). On page 2-25 of the Handbook, it provides an explanation of parental responsibility in providing care:

Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider 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. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

Medicaid can reimburse personal care services rendered to a recipient whose parent or legal guardian is not able to provide ADL or IADL care. Supporting documentation must accompany the prior authorization request in order to substantiate a parent or legal guardian's inability to participate in the care of the recipient.

31. On page 1-3, the Handbook provides the following definition for babysitting: "The act of providing custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient."

32. On page 2-12 of the Handbook, it includes babysitting on a list of services not reimbursable as a Medicaid home health service.

33. Because Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

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

34. Regarding EPSDT requirements, The State Medicaid Manual, published by the Centers for Medicare and Medicaid Services, states in relevant part:

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** [Emphasis Added].

35. The parties agree Petitioner needs assistance with his activities of daily living (ADL's) and maintaining his health and well-being. Respondent has determined two hours of Personal Care Services (PCS) per day, Monday through Friday, is medically necessary to provide for Petitioner's ADL needs. Petitioner is requesting six hours per day, seven days per week.

36. Petitioner's mother provided testimony her son needs one hour of PCS in the morning and three hours of PCS in the afternoon, from 3:00 p.m. to 6:00 p.m.

37. Respondent's physician consultant considered Petitioner's medical needs, his school schedule, the mother's work schedule, and Petitioner's level of semi-independence. He agreed with the two physician reviewers who completed the initial determination and the reconsideration request. He stated two hours of PCS were sufficient to meet Petitioner's needs.

38. The undersigned has reviewed the EPSDT requirements and all the above cited authorities and applied these to the totality of the evidence. Petitioner has not established, by the greater weight of the evidence, that Respondent's action in this matter was incorrect. While Petitioner's behavioral issues indicate he cannot be left

alone, supervision is not a covered PCS service. Any PCS hours that exceed his need for ADL assistance are considered supervision.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 27 day of December, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07178

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 October 24, 2016 at 3:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's mother

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's partial denial of the petitioner's request for wisdom teeth extractions was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was his sister [REDACTED]. The petitioner did not submit any documents as evidence for the hearing.

Appearing as witnesses for the respondent were Dr. Daniel Dorrego, Dental Consultant, and Omeisha Smith, Complaint and Grievance Specialist, from DentaQuest, which reviews dental claims on behalf of Simply Healthcare. Also present as witnesses for the respondent were Deborah Zamora, Appeals Manager, and Dr. Merlin Osorio, Medical Director, from Simply Healthcare, which is the petitioner's managed health care plan. Simply Healthcare was included as an additional respondent in this proceeding since it is the petitioner's health plan.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters and Authorization Request; Exhibit 2 – Denial Notice; Exhibit 3 – Dental Review Form.

FINDINGS OF FACT

1. The petitioner is a nineteen (19) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan from Simply Healthcare, which utilizes DentaQuest for review and approval of dental services.
2. On or about September 12, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Simply Healthcare and/or DentaQuest to perform extractions of four wisdom teeth (Teeth 1, 16, 17, and

32). Simply Healthcare and DentaQuest partially denied this request on September 15, 2016 – approving two extractions and denying two extractions.

3. The denial notice stated the two extractions were denied as not being medically necessary. This denial notice also stated the following regarding the reason for the denial:

The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us you are in pain. Please follow up with your dentist.

4. The petitioner's sister stated her brother is [REDACTED] and has difficulty expressing himself. She stated her brother is experiencing pain and discomfort in all 4 wisdom teeth. He takes pain relief medication for the pain and cannot eat normally. He also experiences headaches due to the pain and has difficulty sleeping.

5. The respondent's witness, Dr. Dorrego, stated that the extraction of the 2 upper wisdom teeth were denied because the teeth did not show any sign of infection and they were in position to erupt normally. The lower wisdom teeth were approved for extraction because of their positioning. He also stated the provider did not submit any narrative describing the nature or intensity of the pain or the need for pain medication.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

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

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

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

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. The service at issue, tooth extraction, is a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. DentaQuest approved extractions of two teeth but denied the extraction of two others due to medical necessity considerations.

14. The petitioner's sister believes all four extractions should have been approved because her brother is in pain and has difficulty eating and sleeping.

15. The respondent's witness stated that the denial of the two extractions was appropriate because those teeth did not show any signs of infection and were in position to erupt normally.

16. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for the two extractions was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's dentist requested the extractions, this does not establish it is medically necessary. The respondent's witness testimony supports the denial of the requested service. The petitioner should confer with his provider

concerning the possibility of submitting a more detailed narrative to DentaQuest so that the need for the service can be re-reviewed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 07 day of December, 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
SIMPLY HEARINGS UNIT

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

FILED

Dec 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07215
16F-07216
16F-07217

PETITIONERS,

Vs.

MANAGED CARE ORGANIZATION, AND AGENCY FOR HEALTH CARE
ADMINISTRATION
CIRCUIT: 15 [REDACTED]
UNIT:

RESPONDENT.

/

ORDER OF DISMISSAL

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matters on December 16, 2016, at 1:00 p.m. The hearing was convened in [REDACTED], Florida.

[REDACTED], the petitioners' grandmother, appeared on behalf of the petitioners, [REDACTED] (collectively referred to as the "petitioners"). Linda Latson, R.N., Registered Nurse Specialist and Fair Hearing Liaison with the Agency for Health Care Administration, the respondent, appeared on behalf of the Agency for Health Care Administration. Ellyn Theophilopoulos, J.D., M.D., Senior Medical Director for eQHealth Solutions, appeared as a witness on behalf of the Agency.

ORDER (Cont.)
16F-07215
16F-07216
16F-07217
PAGE - 2

The issue in this appeal is the denial of continued Prescribed Pediatric Extended Care ("PPEC") services for the petitioners.

During the course of the hearing, the petitioners' grandmother explained that, upon learning more about what PPEC services entail, she determined that PPEC services are not appropriate services for the petitioners; rather, the petitioners need to be enrolled in an academic program that will help them learn and obtain an education. The petitioners' grandmother thereafter verbally withdrew the petitioners' hearing requests on the record.

Dr. Theophilopoulos, the respondent's witness, then offered to contact the case coordinator at the children's PPEC center to secure the case coordinator's assistance in transitioning the children to an appropriate academic program.

Pursuant to the above, these appeals are hereby DISMISSED.

DONE and ORDERED this 28 day of December, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 15, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07218

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 28, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner's mother

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for dental/orthodontic services (braces) was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as witnesses for the respondent were Dr. Daniel Dorrego, Dental Consultant, and Rosa Reyes, Complaint and Grievance Specialist, from DentaQuest, which is the petitioner's dental services review organization. Also present as a witness for the respondent was Mindy Aikman, Grievance Specialist, from Humana, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: case summary, claim form, authorization request, orthodontic evaluation form, authorization determination, and denial notice.

Also present for the hearing was a Spanish language interpreter, [REDACTED] Interpreter Number [REDACTED], from [REDACTED].

FINDINGS OF FACT

1. The petitioner is a thirteen (13) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Humana, which utilizes DentaQuest for review and approval of dental services.

2. On or about October 4, 2016, the petitioner's treating dentist or orthodontist (hereafter referred to as "the provider"), requested prior authorization for orthodontic treatment (braces). DentaQuest, on behalf of Humana, denied this request on October 7, 2016.

3. The denial notice stated the request for braces was denied since it was not medically necessary. This denial notice also stated the following regarding the reason for the denial:

You need to get a score of 26 points on a test that gives points for crowded, missing, and crooked teeth as well as spacing. Your test score was less than 26 so we cannot approve braces for you. We have told your dentist this also. Please talk to your dentist about your choices to treat your teeth. 5 points.

4. The petitioner's mother stated her daughter needs braces because her teeth may not come out properly which may cause her to need surgery later.

5. The respondent's expert witness, Dr. Dorrego, testified that the denial of the petitioner's request for the braces was appropriate because an individual must have a score of 26 or higher on the evaluation form which is used to assess the need for braces. The petitioner's dentist reached a score of 16 on the evaluation form. Dr. Dorrego also stated that impacted teeth are not considered to be a qualifier for braces and the petitioner did not meet any other qualifying conditions for braces. He also stated there is no evidence of infection at this time.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage and Limitations Handbook ("Dental Handbook"). The Dental Handbook was recently replaced by the Dental Services Coverage Policy ("Dental Policy").

CONCLUSIONS OF LAW

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

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

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

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

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA. The Medicaid Handbook and the Dental Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

13. Braces are a covered service for individuals under age twenty-one (21) in the Florida Medicaid Program. The Dental Handbook, on page 2-15, states the following in reference to orthodontic services:

Orthodontic procedures may be reimbursed for Medicaid recipients under age 21.

Prior authorization is required for all orthodontic services. Orthodontic services are limited to those recipients with the most handicapping malocclusion. A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malpositions of the teeth.

14. The Dental Handbook also describes an evaluation form used to assess the need for orthodontic treatment. This form is referred to as "The Medicaid Orthodontic Initial Assessment Form (IAF)" and the form calculates a numerical score based on the individual patient's conditions. The Dental Handbook, on page 2-18, describes the scores as follows:

A score of 26 or greater may indicate that treatment of the recipient's condition could qualify for Medicaid reimbursement, and the orthodontic provider should submit a prior authorization request to Medicaid for consideration of orthodontic services. A score of 26 or greater on the IAF is not a guarantee of approval. It is used by the provider to determine

whether diagnostic records should or should not be sent to the orthodontic consultant.

A score of less than 26 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied.

This does not say that such cases do not represent some degree of malocclusion, but simply that the severity of the malocclusion does not qualify for coverage under the Florida Medicaid Orthodontic Program.

When the IAF score is less than 26, but the strategical positioning of the malocclusion constitutes a serious impediment or threat to normal growth, development and function of the jaws or dentition, the provider must submit a completed prior authorization, IAF, diagnostic photographs, panoramic x-ray and study models to the Medicaid orthodontic consultant for determination of medical necessity.

15. The Dental Policy makes no reference to the assessment form or the 26 point requirement. However, the petitioner's request for braces was evaluated using that form and criteria.

16. The petitioner's mother believes the braces should be approved so that her teeth may come out properly and she can avoid a possible surgery in the future.

17. The respondent's witness stated that the braces were denied since the petitioner's score on the evaluation form was less than 26 (her score was 16) and there was no sign of infection or other qualifying condition for braces.

18. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for the braces was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's orthodontist requested the braces, this does not establish it is medically necessary. The respondent's witness testimony supports the

denial of the request for braces, both under the 26 point criteria as well as the medical necessity criteria listed above.

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 15 day of December , 2016,

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

FINAL ORDER (Cont.)

16F-07218

PAGE - 8

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

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

FILED

Dec 15, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07225

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 October 28, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for a knee walker was correct. The petitioner bear 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 Deborah Zamora, Grievance and Appeals Team Lead, Dr. Merlin Osorio, Medical Director, and Vicki Camero, Regulatory Affairs Director, for Simply Healthcare, which is the Petitioners' managed health care plan.

The respondent submitted the following documents into evidence which were marked Respondent composite Exhibit 1: Authorization Request (including medical records) and Denial Notice.

FINDINGS OF FACT

1. The Petitioner is a fifty-two (52) 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.
2. On or about September 18, 2016, the petitioners' treating physician submitted an authorization request to Simply Healthcare for approval of a knee walker.
3. On or about September 19, 2016, Simply Healthcare denied the pre-authorization request for the knee walker. The denial notice stated the following:

Your request for the above mentioned item, test, or procedure has been denied because it is not covered by Medicaid.
4. The petitioner stated she needs the knee walker because she recently had surgery on her foot/heel and she cannot put any weight on her foot.

5. Ms. Zamora from Simply Healthcare stated the petitioner was approved for a wheelchair but the knee walker is not a covered item under the health plan.
6. Dr. Osorio from Simply Healthcare stated a walker with a seat is a covered item, but the knee walker is not. He also stated a wheelchair should meet the petitioner's mobility needs.
7. Services under the Medicaid State Plan in Florida are provided in accordance with the respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July, 2012, and the Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

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 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.).
12. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered

by the respondent, AHCA. The Medicaid Handbook and the DME Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

13. The DME Handbook lists various types of medical equipment which are covered by the Florida Medicaid Program. The DME Handbook also states the following on page 2-3:

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 age 21 years of age, refer to the DME and Medical Supply Services Provider Fee Schedules and the service specific requirements described in this handbook.

14. The knee walker requested by the petitioner is not listed as a covered benefit or service in either the DME Handbook or the accompanying fee schedules.

15. Managed care plans, such as Simply Healthcare, are required to comply with the various Medicaid Handbooks and regulations.

16. After considering all the documentary evidence and witness testimony presented, the undersigned concludes Simply Healthcare correctly denied the petitioners' request for the knee walker.

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

FINAL ORDER (Cont.)

16F-07225

PAGE - 5

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 15 day of December , 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
SIMPLY HEARINGS UNIT

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

FILED

Nov 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07302, 07303,
07304, 07305

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 [REDACTED]
UNIT: 883CF

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on October 27, 2016 at approximately 1:00 p.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED] (DR), *pro se*, [REDACTED], (JM) *pro se*

For the Respondent: Ed Poutre, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of June 28, 2016 terminating petitioner DR's Food Assistance Program (FAP) benefits and her Medicaid and Medicaid Savings Program (MSP) benefits effective July 31, 2016. The petitioner is also appealing the termination of petitioner JM's FAP coverage effective July 31, 2016.

As this action is the result of a reported change, the respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted a packet of information which was entered into evidence and marked as Petitioner's Exhibits "1" through "5".

The respondent submitted a packet of information which was entered into evidence and marked as Respondent's Exhibits "1" through "12".

The hearing officer did not notice that these hearings were from the same household at the time of scheduling and did not originally schedule JM's hearing to coincide with DR's. Combining the arguments into one hearing was discussed and under no objection the hearing continued for all four assistance groups (AGs) for which a hearing was requested.

FINDINGS OF FACT

1. On June 27, 2016, the petitioners reported to the customer call center (CCC) that they were moving to Las Vegas on July 6, 2016 and provided their new address. This change was acted on the same date with all benefits except JM's Medicaid closing out effective July 31, 2016. JM's Medicaid closed effective August 31, 2016. The reason for the case closure was the loss of residency in the state of Florida.
2. On June 28, 2016, a notice of case action (NOCA) was mailed to the petitioner informing her that her case was closing effective July 31, 2016 per her request.
3. The petitioner testified that Nevada residency is not established automatically upon moving there. Before being allowed to apply for benefits in Nevada, they were required to have Nevada driver licenses and voter registration cards issued with their

new demographic information which involved a 10-day delay while a Homeland Security check was completed.

4. The petitioner left furniture and other belongings in Florida as they had not seen the apartment they were renting and there was a possibility that they might return and continue to reside in Florida. Leases overlapped and the petitioner had an apartment in both Florida and Nevada for the month of July 2016. The petitioner opted to remain in Nevada.

5. The petitioners stated their intent was to leave Florida on July 6, 2016 and move to Nevada.

6. The petitioner believes that until she met the requirements to apply for benefits and had gained her documentation of Nevada residency she was still a resident of Florida and therefore eligible for benefits that would not overlap benefits received in Nevada. Nevada Medicaid began for them effective October 2016, with FAP benefits beginning effective September 2016.

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.

8. 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.

FOOD ASSISTANCE PROGRAM

10. The Code of Federal Regulations 7 C.F.R §273.3 addresses residency, and states, in pertinent relative part: “(a) A household shall live in the State in which it files an application for participation.” ...

11. The Department’s Policy Manual, CFOP 165-22, at passage 1410.0310,

Temporary Absence from the State (FS), further specifies:

Temporary absence from the state exists when a visit for a period of less than one calendar month is made out of the state and the intent is to return. Household members away from home because of a vacation or illness will maintain their household member status if they are in the home during any part of the calendar month. If the absence is to cover a full calendar month, the individual(s) should be removed from the assistance group. These changes should be reported prior to departure.

12. The above guidelines establish that eligibility for FA remains in effect if an individual is out of the state for less than one calendar month. If absence from the state occurs for a full calendar month, the individual is to be removed from the assistance group and is no longer eligible to receive FA benefits in Florida. The evidence shows that the petitioner left Florida July 6, 2016. The evidence shows that FA benefits were issued from Florida through July 2016 and ending before August 2016. The undersigned concludes that the respondent correctly issued and ended FA benefits.

MEDICAID PROGRAMS

13. Federal Regulations at 42 C.F.R § 435.403(h) states in pertinent part: “(1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence is the State where the individual is living and – (i) Intends to reside, including without a fixed address...”

14. The above guideline links eligibility to receive Medicaid benefits from a state to being a resident of that state with having the intent to reside being a determinant factor. The petitioner left the state of Florida with the intent to live in the state of Nevada on July 6, 2016. The undersigned concludes that the respondent's action to terminate Medicaid benefits from the State of Florida effective July 31, 2016 to be 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 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 November , 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 19, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07321

PETITIONER,

Vs.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 9, 2016 at 10:11 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Sheila Broderick, registered nurse specialist

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to receive 6 to 10 hours of personal care services (PCS) daily 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 eQ Health Solutions (eQ) to conduct prior services authorizations for certain Medicaid services, including PCS.

By notice dated September 24, 2016, eQ informed the petitioner that his request for 6 to 10 hours daily of PCS weekdays for the certification period September 19, 2016 – November 17, 2016 was denied in-part. eQ approved 2 hours daily of PCS weekdays.

The petitioner requested reconsideration.

By notice dated September 28, 2016, eQ informed the petitioner that the original partial-denial decision was upheld.

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

Present as witnesses for the petitioner: [REDACTED] behavioral analyst with the [REDACTED]; [REDACTED], waiver support coordinator with the Agency for Persons with Disabilities (APD); and [REDACTED] chief executive officer with Developmental Disabilities Providers. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Composite Exhibit 1.

Present as a witness for the respondent: Dr. Darlene Calhoun, physician reviewer with eQ. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was closed on November 9, 2016.

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 8) has been diagnosed with [REDACTED]

[REDACTED] The petitioner ambulates without assistance, but is mostly non-verbal. The petitioner requires assistance with all the activities of daily living, both verbal direction and hand-over-hand physical assistance. The petitioner requires monitoring and supervision during all waking hours due to severe behavioral issues. The petitioner lives in the family home with his mother and father. They are his only natural supports.

2. The petitioner is enrolled in APD's Medicaid iBudget Waiver. The iBudget Waiver provides support services, home and community based, to individuals with defined developmental disabilities. The petitioner's approved waiver services include waiver support coordination and respite care. Respite care provides staff to care for the petitioner when his natural supports, parents, are not available. The petitioner receives approximately 274 quarter hours or 68.5 hours of respite care monthly through the waiver.

3. Individuals who qualify for participation in the iBudget Waiver also qualify for State Plan Medicaid services. On or about September 7, 2016, the petitioner requested PCS through State Plan Medicaid, 6 to 10 hours daily on weekdays.

4. AHCA contracts with eQ to perform prior service authorizations for home health services. eQ reviews the service order submitted by the treating physician, clinical records, and all other supporting documentation to make the determination. eQ has no direct contact with the petitioner or the petitioner's family.

5. The service order completed by the petitioner's treating physician is dated September 7, 2016 and lists the petitioner's diagnoses as [REDACTED]. The physician requested 6 hours of PCS Monday – Friday and 4 additional hours daily when school is not in session. The level of care requested was home health aide. The reason for the requested service was listed as, "[REDACTED], patient unable to care for himself."

6. The documentation submitted to eQ also included a Personal Care Services Plan of Care which described the petitioner's need for hand-over hand assistance with "bathing and grooming, oral hygiene, oral feedings and fluid intake, toileting and elimination, meal preparation and light house work."

7. The documentation submitted to eQ also included a Physician Visit Documentation form which describes the patient and the patient's ongoing need for home health services. The petitioner's form reads in pertinent part:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED].

8. A Functional Behavior Assessment dated June 23, 2016 addresses the petitioner's behavioral issues and reads in part:

[Petitioner] was diagnosed with [REDACTED] around age...3 years old...[Parents] have requested ABA services to address behavioral issues...in order to decrease motor stereotypy that is becoming more intense as well as increase independent play...[Petitioner] has very limited verbal skills. His expressive repertoire is restricted to highly preferred items, which are mostly food related...communicates his wants/needs by leading his parents to what he wants...requires physical assistance with most activities of daily living, which includes verbal directives as well as gestural/physical prompting and assistance...fully toilet trained at the age of 6 and continues to toilet independently, although he needs assistance with wiping and at times reminders to use the restroom if he is busy with an activity...history of behavioral problems related to hitting, kicking, tantrums, hitting self, and other disruptive behaviors...has not received behavioral services in recent years...some online ABA training, but...trouble implementing procedures...behavior has increasingly gotten worse as he has aged. He continues to struggle with hitting, kicking, screaming, crying, throwing himself on the floor, and hitting himself, and recently his behavior has resulted in damage to the home (damage to TV, broke bed). His behaviors are very intrusive and become consuming to his parents, as he must be monitored at all times and his parents cannot do things separately from him as he will not engage in independent activities.

9. Both parents work outside the home weekdays. The work schedules provided to eQ show that they leave the home at approximately 7:00 a.m. and return at approximately 7:00 p.m.

10. The petitioner attends elementary school weekdays from 7:30 a.m. to 2:45 p.m., except early release Wednesday, on that day the petitioner's school day ends at 1:45 p.m.

11. PCS provides assistance with the activities of daily living (ADLs), bathing grooming, dressing, toileting, meal preparation, light housekeeping, etc. eQ determined that 2 hours of PCS daily was sufficient to address the petitioner's ADLS.

12. eQ concluded that the petitioner's primary need is for supervision of behaviors. PCS is not a supervisory service. State Plan Medicaid does not include a provision for supervision (monitoring or babysitting) services.

13. Dr. Darlene Calhoun, physician reviewer with eQ, appeared as a respondent witness during the hearing. Dr. Calhoun opined that the petitioner has no complex medical condition that requires more than 2 hours of assistance with ADLs daily. Dr. Calhoun opined that the petitioner's primary need is for assistance with several behavioral issues. State Plan Medicaid PCS does not cover supervision or monitoring services. PCS assists with ADLS and light housekeeping. PCS providers are not mental health professionals and are not trained to address behavioral issues.

14. The petitioner's father and additional witnesses explained that he requires 24/7 supervision and monitoring to ensure his health and safety due to [REDACTED] and other behavioral issues. The witnesses argued that his supervision needs go hand-in-hand with his need for assistance with ADLs; the petitioner requires continuous care all day long. The parents must work to support the household, neither can afford to stay at home. Standard day care facilities are not able to address the petitioner's behavioral issues. The family is able to care for the petitioner in the mornings; they need support services after school and during school holidays.

15. The respondent proposed that the petitioner's parents use combination of the State Plan Medicaid PCS and iBudget Waiver respite services to ensure that the petitioner's personal care and supervision needs are met; one service beginning where the other service ends, so the coverage is seamless.

CONCLUSIONS OF LAW

16. 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.

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

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

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

20. 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.).

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

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

“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.

23. 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.

24. 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.

25. The Florida Medicaid Personal Services Coverage Handbook (PCS Handbook) is promulgated into law by Chapter 59G of the Florida Administrative Code.

26. The PCS Handbook addresses who can receive services on page 2:

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.

27. The PCS Handbook defines service coverage and parental responsibility on page 3:

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:

- 1) 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
- 2) Is under the care of a physician and has a physician's order for personal care services
- 3) Requires more extensive and continual care than can be provided through a home health visit
- 4) Requires services that can be safely provided in their home or the community

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 PCS Handbook addresses non-covered services on page 4 and explains that State Plan Medicaid does not reimburse for supervision, assistance with homework, respite, or babysitting services.

29. The petitioner requested 6 to 10 hours of PCS daily through Medicaid. The respondent determined that the petitioner's PCS needs could be met with 2 hours of services daily.

30. The evidence proves that the petitioner does not have complex medical care needs. He does not require mechanical devices to maintain life. He feeds and takes medications by mouth. He is continent of bowel and bladder. The petitioner requires hand-over-hand assistance with ADLs. However, there is no evidence that he requires more than 2 hours of PCS daily to address his ADLs.

31. The evidence proves that the petitioner's primary need is for supervision and monitoring of severe behavioral issues. The controlling legal authorities explain that PCS does not cover supervision or monitoring services.

32. 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 19 day of December, 2016,
in Tallahassee, Florida.



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

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

FILED

Dec 27, 2016

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07326

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 13, 2016 at 1:34 p.m.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Lisa Sanchez, Medical/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's request for continued Prescribed Pediatric Extended Care (PPEC) services for full days (up to twelve hours), Monday through Friday for the certification period of August 30, 2016 to February 23, 2017, was correct. Because the matter under appeal involves a termination of PPEC services, the burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Dr. Darlene Calhoun, Physician Reviewer for eQHealth Solutions, Inc.

Appearing as witnesses for Petitioner from [REDACTED] (a/k/a Advanced Pediatric Management) were: [REDACTED] Registered Nurse, Director of Nursing and [REDACTED] Administrator.

[REDACTED] from [REDACTED], provided Spanish translation for Petitioner's mother, who only speaks Spanish.

Respondent's Exhibits 1 through 5 were entered into evidence.

Petitioner has been administratively approved to continue receiving PPEC services 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 two-year-old male Medicaid recipient. He has been diagnosed with [REDACTED] (repair done June 2014) [REDACTED]

[REDACTED] repaired October 2015), [REDACTED]
[REDACTED]
[REDACTED]

2. Petitioner takes albuterol as needed. [REDACTED] were discontinued in June 2016 [REDACTED] was to have been discontinued from June 2016 to fall 2016. However, Petitioner's witness advised [REDACTED] has continued to be prescribed and

administered to Petitioner. He was to be placed back on [REDACTED] in the fall since he has severe respiratory distress and frequent hospitalizations during winter months.

3. Petitioner is on a regular diet.

4. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the 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 of service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

6. On August 30, 2016, a request to continue PPEC full services (up to 12 hours) Monday through Friday was submitted by the provider on behalf of the Petitioner for the certification period August 30, 2016 to February 23, 2017.

7. On September 9, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on September 21, 2016, which notified Petitioner that PPEC full services were denied. The rationale for the denial was that the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code.

8. On September 21, 2016, a "Notice of Outcome-Denial" was issued to

Petitioner's provider and provided the following clinical rationale:

The patient is a 2-year old with [REDACTED]. The patient is status post [REDACTED] repair in June 2014 and status post [REDACTED] on October 2015. The patient is on an as needed [REDACTED] only. The patient is no longer on [REDACTED] or [REDACTED] medications. There is an anticipation that the [REDACTED] will begin again during the fall and winter months. The patient has not required any [REDACTED] in the past several months. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient no longer appears to have a skilled need and does not meet the medical necessity requirement of PPEC services.

9. On September 12, 2105, Petitioner requested a reconsideration review.

10. Respondent completed the reconsideration review on September 15, 2016 and sent a Notice of Reconsideration to the Petitioner on October 5, 2016. The notice upheld the initial denial.

11. On September 29, 2016, Petitioner filed a timely request for a fair hearing.

12. Respondent's physician reviewer witness reviewed Petitioner's medical status as reflected in paragraph 1 above. She reviewed the first physician reviewer's decision, as reflected in paragraph 8 above. She reviewed the second physician reviewer's decision which included the observation that no other nursing needs were reported other than monitoring of the patient's cardiac status. (See page 14 of Respondent's Exhibit 5.)

13. Respondent's physician reviewer witness reviewed the supporting documentation submitted by Petitioner in support of the request for continued PPEC services. She referenced a Home Health Assessment completed March 16, 2016 and noted the recommended medications have changed since the assessment. She observed on the PPEC plan of care for the current certification period that all the medications are

prescribed "as needed" except for [REDACTED], which is twice a day. The physician reviewer witness noted, on an office visit dated June 20, 2016, all medications had been stopped effective that day, except for [REDACTED]. After completing her review of all the documentation, she reserved her final decision until after the Petitioner's presentation.

14. Petitioner's witness explained Petitioner remains on [REDACTED] because PPEC never received the order to discontinue it and Petitioner's pediatrician continued to prescribe [REDACTED]. Petitioner's witness identified [REDACTED] as a pulmonary medication. She advised nurses continue their daily assessments of Petitioner for any cardiac complications. Petitioner has an appointment with his cardiologist to assess the possible need for additional cardiac surgery.

15. Respondent's physician reviewer witness noted [REDACTED] is prescribed for asthma and expressed concern it was continuing to be prescribed. Respondent's witness opined there was no medical need for the cardiac assessments. Respondent's witness found no need for skilled nursing services.

CONCLUSIONS OF LAW

16. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

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

18. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

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

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

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.”

21. Rule 59G-1.010 (164), Florida Administrative Code defines “medically complex” as: a person who “has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.”

22. Rule 59G-1.010 (165), Florida Administrative Code defines "medically fragile" as:

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

23. Because Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

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

24. In reviewing the appeal for compliance with EPSDT requirements, PPEC services are part of Florida's Medicaid State Plan of services. The agency has administratively approved ongoing PPEC services pending the outcome of this appeal. Therefore, Respondent would need to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

25. The Florida Medicaid Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook- September 2013 (PPEC Handbook) is promulgated by Rule 59G-4.260, Florida Administrative Code, and provides the following purpose and definition of PPEC on page 1-1:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

26. On page 2-1, the PPEC Handbook provides the following requirements for those who can receive PPEC services:

To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:

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

27. On page 2-5, the PPEC Handbook provides a list of excluded services:

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.
- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, and child life.

28. Respondent's physician reviewer witness reviewed the documentation submitted in support of the request for PPEC services. She reviewed the supporting documentation submitted by Petitioner and after hearing Petitioner's testimony, she found no need for skilled nursing services.

29. Petitioner's witness argued that [REDACTED] is a pulmonary medication and nurses continue to assess Petitioner for any cardiac complications.

30. Respondent's witness noted [REDACTED] is a medication for asthma and was ordered to be discontinued. She also noted there was no medical basis provided for nurses to continue cardiac assessments.

31. After reviewing the evidence and testimony, as well as the above cited authorities, including the EPSDT requirements, the undersigned finds Petitioner does not have a current need for skilled nursing services. PPEC services, therefore, are not medically necessary.

32. If Petitioner needs skilled nursing services in the future, her provider can submit the appropriate request with the required supporting documentation.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If Petitioner disagrees with this decision, Petitioner may seek a judicial review. To begin the judicial review, Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

FINAL ORDER (Cont.)
16F-07326
PAGE - 10

DONE and ORDERED this 27 day of December, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07351

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 in person at [REDACTED] FL [REDACTED], in the above-referenced matter on November 10, 2016 at approximately 2:55 p.m. CST.

APPEARANCES

For the Petitioner: [REDACTED], *pro se*

For the Respondent: Steve Kent, economic self-sufficiency specialist supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's August 26, 2016 action in determining her Share of Cost (SOC). Petitioner also had issue with the Department's response to her request for information and access to her case for her to prepare for this hearing. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was entered into evidence and marked as Respondent's Exhibits "1" through "8".

The petitioner submitted a packet of information that was entered into evidence and marked as Petitioner's Exhibits "1" through "8". During the course of the hearing, petitioner submitted additional documents that were entered into evidence and marked as Petitioner's Exhibit "9".

FINDINGS OF FACT

1. On August 10, 2016, petitioner submitted a paper application for recertification of her Medicaid benefits. The household was enrolled in the Medically Needy Program (MNP) with a Share of Cost (SOC) of \$3000. Petitioner filed a hearing request on September 30, 2016 disagreeing with the budgeting.
2. On September 30, 2016, petitioner submitted another Medicaid application. This application was denied for not submitting verification of income.
3. Upon the respondent's review in preparation for this hearing, it was discovered that income had been provided and a determination of eligibility was completed using petitioner's 2015 tax return schedule C, which documented self-employment income and expenses.
4. Upon discussion of application times and budgets, it was agreed upon by both parties that the SOC issue had been resolved; however, the petitioner voiced her concerns about the barriers put before her as she attempted to prepare for this hearing.
5. Petitioner stated that the respondent refused to allow her access to her case record. She stated that requested a fair hearing August 25, 2016, which was not acted

upon. She stated that after calling the Office of the Inspector General, her hearing request was received. The respondent offered no argument concerning petitioner's concerns about case access or possible alternate hearing requests.

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.
7. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
8. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
9. The hearing officer accepts the consensus reached by both parties concerning the issue of the SOC and considers it moot now.
10. The petitioner does have a right to examine her case record and any documents to be used at the hearing. There is a standard for submitting hearing requests as well. As to some of the other concerns raised at the hearing, the hearing officer understands these issues, but lacks any jurisdiction to rule on them. The petitioner is advised to take up any of these issues with the region's Client Relations Coordinators. They can be reached at 1-866-286-3609.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied as the petitioner is no longer seeking remedy regarding her Share of Cost.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of December, 2016,

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 [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Dec 23, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07376

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 December 5, 2016 at 10:00 a.m.

APPEARANCES

For Petitioner: [REDACTED], Grandmother

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

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's request for continued Prescribed Pediatric Extended Care (PPEC) services for full days (up to twelve hours), Monday through Friday for the certification period of August 23, 2016 to February 15, 2017, was correct. Because the matter under appeal involves a termination of PPEC services, the burden of proof is assigned to the Respondent.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Dr. Ellyn Theophilopoulos, Physician Reviewer for eQHealth Solutions. Appearing as a witness for Petitioner was [REDACTED]. [REDACTED] is Petitioner's PPEC provider.

Respondent's Exhibits 1 through 4 were entered into evidence.

Administrative notice was taken of Florida Statutes 400.902 and 400.914 as well as the agency's Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

Petitioner has been administratively approved to continue receiving PPEC services 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 four-year-old female Medicaid recipient. She is diagnosed with

[REDACTED]

[REDACTED]

2. Petitioner eats a regular diet and takes no medications. She is ambulatory with the use of leg braces. She receives physical therapy, speech therapy, and occupational therapy at [REDACTED] along with her PPEC services.

3. Petitioner lives with her grandmother. She attends school from 8:00 a.m. to 1:00 p.m. and receives PPEC services after school.

4. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the 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 of service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

6. On August 23, 2016, a request to continue PPEC full services (up to 12 hours) Monday through Friday was submitted by the provider on behalf of the Petitioner for the certification period August 23, 2016 to February 15, 2017.

7. On August 26, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on August 31, 2016, which notified Petitioner that PPEC full services were denied. The rationale for the denial was that the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code.

8. On August 31, 2016, a "Notice of Outcome-Denial" was issued to Petitioner's provider and provided the clinical rationale as:

The patient is a 4-year old with [REDACTED]
[REDACTED] The patient is ambulatory and on a regular diet.
The patient is on no medications. The patient receives therapies while

attending PPEC. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient does not appear to have a skilled need and does not meet the medical necessity requirement of PPEC services.

9. Petitioner did not request a reconsideration review.

10. On October 3, 2016, Petitioner filed a timely request for a fair hearing.

11. Respondent's physician consultant reviewed the documentation submitted by Petitioner in support of the request for PPEC services. She noted there was no information documenting the need for skilled nursing intervention. She explained the therapies Petitioner receives at PPEC can be provided in other settings.

12. The PPEC Plan of Care, dated August 23, 2016, provides a list of general care Petitioner receives:

- Nurse to complete daily head-to-toe assessment.
- TPR (temperature) daily.
- Daily hygiene requirements (total care).
- Nurses to do daily follow up of developmental therapies/goals including but not limited to ROM (range of motion) and in accordance with therapies plan of care.
- Daily medication administration monitoring-monitor side effects, instruct patient's family about importance of medication compliance.
- Nurse to assess family/caregiver knowledge & compliance with child's care needs and provide education/reinforcement of skills as indicated.

The first page of the PPEC Plan of Care lists no medications for the Petitioner.

13. Respondent's witness observed the PPEC Plan of Care does not reflect any skilled nursing service needs.

14. Petitioner's witness explained Petitioner cannot receive the patience and nurturing care of professionals at a regular day care center that she currently receives at PPEC. Petitioner is visually impaired and needs constant redirection to avoid bumping into walls or other patients. Petitioner's witness asserts monitoring of

Petitioner's progress with her therapy goals is necessary to ensure she does not regress.

15. Petitioner has frequent [REDACTED] because she does not drink enough fluids. She has no urology diagnosis associated with her [REDACTED].

16. While Petitioner needs supervision for her safety, Respondent's witness explained that monitoring or supervision is not a covered Medicaid service and cannot be the basis for PPEC services.

CONCLUSIONS OF LAW

17. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to Florida Statutes, §§ 120.569 and 120.57.

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

19. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

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

21. Rule 59G-1.010 (166), Florida Administrative Code defines "medically necessary" or "medical necessity" as follows:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

22. Rule 59G-1.010(164), Florida Administrative Code, defines "medically complex" as follows: a person has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

23. Rule 59G-1.010(165), Florida Administrative Code, defines "medically fragile" as:

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

24. Because Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES. --The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical

and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

25. In reviewing the appeal for compliance with EPSDT requirements, PPEC services are part of Florida's Medicaid State Plan of services. The agency has administratively approved ongoing PPEC services pending the outcome of this appeal. Respondent needs to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

26. The Florida Medicaid Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook- September 2013 (PPEC Handbook) is promulgated by Rule 59G-4.260, Florida Administrative Code, and provides the following purpose and definition of PPEC on page 1-1:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

27. On page 2-1, the PPEC Handbook provides the following requirements for those who can receive PPEC services:

To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:

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

28. On page 2-5, the PPEC Handbook provides a list of excluded services:

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.
- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, and child life.

29. Petitioner's witness and grandmother asserts PPEC services are necessary to monitor Petitioner and prevent her from self-injury or regression in her development. Petitioner's witness and grandmother argue PPEC provides ongoing professional assessment not available at a regular day care center.

30. Respondent's physician consultant reviewed the documentation submitted in support of the request for PPEC services. She explained there was no information indicating a need for skilled nursing intervention.

31. In reviewing the evidence and testimony, as well as the authorities cited above, Petitioner does not meet Medicaid's definition for being medically fragile or medically complex. Additionally, there is no documented need for skilled nursing intervention which is required for PPEC services to be medically necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 23 day of December, 2016,

in Tallahassee, Florida.



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

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

FILED

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

Dec 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07507

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 November 16, 2016, at 8:30 a.m.

APPEARANCES

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

For the Respondent: Monica Otalora, Senior Program Specialist

STATEMENT OF ISSUE

At issue is the respondent's action denying the petitioner's request for additional home health services (personal care, homemaker, and companion services) under the

Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as witnesses for the respondent were Dr. Marc Kaprow, Medical Director, and Christian Laos, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional party to this proceeding since it is the petitioner's health plan.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Statement of Matters, Denial Notice, and Medical Records.

FINDINGS OF FACT

1. The petitioner is forty-seven (47) years of age and lives with his sister. The petitioner suffers from [REDACTED] and needs assistance with all his activities of daily living such as feeding and bathing. He has had [REDACTED].

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. He receives services under the plan from United Healthcare.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions

and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as United Healthcare provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner is currently approved for a total of twenty-one (21) hours weekly of home health services (including 14 hours of personal care and 7 hours of homemaker services) through United. The petitioner is currently receiving the home health services from 8:00 a.m. to 11:00 a.m. daily.

5. On or about September 6, 2016, the petitioner made a request to United Healthcare for 14 additional hours weekly of home health services (companion, personal care, and/or homemaker services). On September 12, 2016, United sent a letter to the petitioner denying his request for the additional home health services as not being medically necessary. The denial notice stated the following:

The health plan will not cover the other hours you asked for. The other hours are in excess of your needs. Hours in excess of your needs are not medically necessary.

6. The petitioner's sister stated her brother should be approved for the additional hours because he needs 24 hour supervision and his condition is worsening. She also stated she has her own medical issues and has two small children to take care of. She does not work outside the home and she is her brother's sole caretaker. She stated her brother does not sleep at night and he will sometimes rub feces all over his body and bedroom. She stated she would use any additional home health hours during the afternoons.

7. The respondent's witness, Dr. Kaprow, stated the petitioner was originally getting 14 hours of assistance weekly and 7 additional hours were approved after receiving the request for more hours. He stated the currently approved hours are meeting the petitioner's ADL (activities of daily living) needs and additional personal care services are not medically necessary. However, he also stated he would approve 7 additional hours weekly of companion services rather than personal care. He also stated respite care services may be available to the family to provide a break to the caregiver.

CONCLUSIONS OF LAW

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

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

10. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the issue involved a request for an increase in services. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

11. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program.

The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

12. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

13. The petitioner requested a fair hearing because he believes his services under the Program should be increased.

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

15. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

16. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

17. The petitioner has also requested Companion care services, which are defined in the contract as follows:

Non-medical care, supervision and socialization provided to a functionally impaired adult. Companions assist or supervise the enrollee with tasks such as meal preparation or laundry and shopping, but do not perform these activities as discreet services. The provision of companion services does not entail hands-on nursing care. This service includes light housekeeping tasks incidental to the care and supervision of the enrollee.

18. The AHCA contract also provides that a Plan "may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose."

19. Fla. Stat. § 409.912 requires that the respondent, AHCA, "purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care."

20. The Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

21. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has demonstrated that he needs additional home health services since United Healthcare indicated it would be willing to approve 7 additional hours weekly of companion services. However, medical necessity for 14 additional hours weekly has not been established. The evidence indicates the petitioner's needs can be met with 28 total hours of assistance weekly.

22. In addition, United Healthcare has indicated the petitioner may be able to receive respite care services to provide a break to his caregiver.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, in part, and the petitioner shall receive an additional 7 hours weekly of companion services..

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 28 day of December , 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

FILED

Dec 27, 2016

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-07514

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 7, 2016 at 10:02 a.m.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Lisa Sanchez, Medical/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's request for continued Prescribed Pediatric Extended Care (PPEC) services for full days (up to twelve hours), Monday through Friday for the certification period of October 8, 2016 to April 5, 2017, was correct. Because the matter under appeal involves a termination of PPEC services, the burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Dr. Darlene Calhoun, Physician Reviewer for eQHealth Solutions, Inc.

Respondent's Exhibits 1 through 11 were entered into evidence.

Petitioner has been administratively approved to continue receiving PPEC services 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 three-year-old female Medicaid recipient. She is diagnosed with

[REDACTED]

[REDACTED]

[REDACTED]

2. Petitioner eats an age-appropriate diet and takes pediasure as a supplement to help her gain weight. She has failed to gain weight for several months. Petitioner is not on a complex medication regimen. She takes [REDACTED] daily, [REDACTED] twice a day, and albuterol as needed.

3. Petitioner lives with both parents who work full time. She attends school from 8:00 a.m. to 1:00 p.m. and receives PPEC services after school.

4. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization

review determines the medical necessity of the 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 of service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

6. On September 29, 2016, a request to continue PPEC full services (up to 12 hours) Monday through Friday was submitted by the provider on behalf of the Petitioner for the certification period October 8, 2016 to April 5, 2017.

7. On October 3, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on October 5, 2016, which notified Petitioner that PPEC full services were denied. The rationale for the denial was that the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code.

8. On October 5, 2016, a "Notice of Outcome-Denial" was issued to Petitioner's provider and provided the clinical rationale as:

The patient is a 3-year old with [REDACTED]
[REDACTED]
[REDACTED] he patient has not required any cardiac or respiratory interventions. The patient is on one scheduled [REDACTED] medication for the [REDACTED]. The patient is noted to have poor nutrition and poor weight gain. The patient has had no hospitalizations or emergency room visits. The patient is on an age-appropriate diet with supplementation. The patient is not on a complex medication regimen. The clinical information provided does not support the medical necessity

of the requested PPEC services. The patient no longer appears to have a skilled need and does not meet the medical necessity requirement of PPEC services.

9. Petitioner did not request a reconsideration review.

10. On October 10, 2016, Petitioner filed a timely request for a fair hearing.

11. Respondent's physician reviewer witness observed eQHealth Solutions

"Outpatient Review History," noting a nurse reviewer's recommendation was:

Recommend denial of PPEC services due to lack of skilled need. [Petitioner] has no current cardiac issues and no recent respiratory issues. Her main issue is failure to thrive and poor nutrition. She is on oral antibiotic [REDACTED] (twice a day) with albuterol PRN (as needed).

(See Respondent Exhibit 4, page 11.)

12. Respondent's physician reviewer witness explained that when a nurse reviewer cannot approve the requested service, the request is reviewed by a physician reviewer. The first physician reviewer who completed the medical necessity assessment of Petitioner's PPEC request was not the physician reviewer witness. The first physician reviewer's clinical rationale for denial Petitioner's request for PPEC services is reflected in paragraph 8 above.

13. Respondent's physician reviewer witness reviewed the documentation submitted by Petitioner in support of the request for PPEC services including, but not limited to: a Home Health Assessment completed September 15, 2016; Care Coordinator notes dated November 22, 2016; a PPEC Plan of Care dated September 25, 2016; and a Pediatric Re-Assessment completed September 8, 2016. She noted there was no documented need skilled nursing intervention.

14. Petitioner's mother advised that due to her daughter's frequent [REDACTED], [REDACTED], Petitioner's urologist is scheduling a urodynamic study for her. Depending on the results, a permanent catheter may be installed.

15. Respondent's physician reviewer witness explained that Petitioner needs to wait for the results of the study and the recommendation of her urologist. It Petitioner needs an intermittent catheterization, a visiting nurse can provide the required service and PPEC would not be appropriate.

CONCLUSIONS OF LAW

16. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

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

18. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

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

20. Rule 59G-1.010 (166), Florida Administrative Code defines "medically necessary" or "medical necessity" as follows:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

21. Rule 59G-1.010 (164), Florida Administrative Code defines "medically complex"

as: a person who "has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention."

22. Rule 59G-1.010 (165), Florida Administrative Code defines "medically fragile" as:

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

23. Because Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered. Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

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

24. In reviewing the appeal for compliance with EPSDT requirements, PPEC services are part of Florida's Medicaid State Plan of services. The agency has administratively approved ongoing PPEC services pending the outcome of this appeal. Therefore, Respondent would need to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

25. The Florida Medicaid Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook- September 2013 (PPEC Handbook) is promulgated by Rule 59G-4.260, Florida Administrative Code, and provides the following purpose and definition of PPEC on page 1-1:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

26. On page 2-1, the PPEC Handbook provides the following requirements for those who can receive PPEC services:

To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:

- Be Medicaid eligible.
- Diagnosed with a medically-complex or medically fragile condition as defined in Rule 59G-1.010, F.A.C.
- Be under the age of 21 years.

- Be medically stable and not present significant risk to other children or personnel at the center.
- Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.

27. On page 2-5, the PPEC Handbook provides a list of excluded services:

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.
- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, and child life.

28. Respondent's physician reviewer witness reviewed the documentation submitted in support of the request for PPEC services. She explained there was no information indicating a need for skilled nursing intervention. She supported the denial of PPEC services as not medically necessary.

29. Petitioner's mother advised that her daughter may have a permanent catheter installed depending on the results of a urodynamic study. The results of the study are needed before medical necessity for PPEC services can be assessed.

30. After reviewing the evidence and testimony, as well as the above cited authorities, including the EPSDT requirements, the undersigned finds Petitioner does not have a current need for skilled nursing services. PPEC services, therefore, are not medically necessary.

31. If Petitioner needs skilled nursing services in the future, her provider can submit the appropriate request with the required supporting documentation.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 27 day of December, 2016,
in Tallahassee, Florida.



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

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

FILED

Dec 27, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16F-07540

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 01 [REDACTED]

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on December 5, 2016 at 11:35 a.m.

APPEARANCES

For Petitioner: [REDACTED],
Pro se

For Respondent: Cindy Henline,
Medical/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

Petitioner is appealing the Agency for Health Care Administration's (AHCA) decision, through DentaQuest, to deny Petitioner's request for the following dental procedures:

- D3310 (endodontic therapy) for tooth# 7, 8, 9, and 10;
- D2954 (prefabricated post and core in addition to crown) for tooth # 7, 8, 9, and 10;

- D2752 (crown) for tooth# 7, 8, 9, and 10;
- D5213 (maxillary partial denture) – upper arch; and
- D5214 (mandibular partial denture) – lower arch.

The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

Appearing as Respondent's witness from Molina Healthcare was Carlos Galvez, Government Contracts Specialist. Appearing as Respondent's witnesses from DentaQuest were Dr. Susan Hudson, Dental Consultant, and Jackelyn Salcedo, Complaints and Grievance Specialist. Charles Kieffer, Complaints and Grievance Specialist for DentaQuest, appeared as an observer.

Respondent's Composite Exhibit 1 was entered into evidence. Within the exhibit is a DentaQuest Authorization Determination form dated September 22, 2016. The form indicates authorization is not required for procedure D7140 (extraction) for tooth # 2, 3, 4, 5, 12, 13, 14, 18, 19, 20, 21, 22, 28, 29, and 32. The form also indicates authorization is not required for procedure D2331 (resin based composite-two services, anterior) for tooth # 6 and 11. These procedures are not under appeal.

FINDINGS OF FACTS

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

1. Petitioner is a 39 year-old Medicaid recipient enrolled with Molina Healthcare (Molina), a Florida Health Managed Care provider.
2. Molina requires prior authorization for services related to dental care and has subcontracted with DentaQuest to review prior authorization requests.

3. Petitioner's dentist sent a prior authorization request for procedure D3310 (endodontic therapy), D2954 (prefabricated post and core in addition to crown) and D2752 (crown) for tooth # 7, 8, 9, and 10, which DentaQuest received on September 20, 2016.

4. DentaQuest sent a Notice of Action to Petitioner on September 22, 2016 denying procedures D3310, D2954, and D2752 as not covered services.

5. Petitioner's dentist in the same prior authorization requested approval for procedure D5213 (maxillary partial denture-cast metal framework with resin denture bases) for a partial upper denture and procedure D5214 (mandibular partial denture-cast metal framework with resin denture bases) for a lower partial denture.

6. In DentaQuest's September 22, 2016 Notice of Action to Petitioner, the upper and lower partial dentures were denied and the following explanation was provided:

Our dentist looked at your x-rays sent by your dentist. The x-rays must show that the teeth still in your mouth needed for this service are healthy. Your remaining teeth are not healthy. They have large cavities or not enough bone support. We have also told your dentist. Please talk to your dentist.

7. In the DentaQuest Authorization Determination form dated September 22, 2016, the determination reason for the upper and lower dentures also provides "Per Dental Director review, a resin base partial or a full denture would be considered." (See Respondent Exhibit 1, page 8.)

8. Petitioner filed a timely fair hearing request on October 11, 2016.

9. Petitioner explained she has been attempting to get her teeth fixed for over a month. Recently she broke a front tooth but has not been able to get a dentist to fix it. She stated she is experiencing severe pain at this time with this tooth.

10. Respondent explained procedures D3310 (endodontic therapy), D2954 (prefabricated post and core in addition to crown) and D2752 (crown) for tooth # 7, 8, 9, and 10 are not covered by Medicaid for members over 20 years of age.

11. Respondent further explained that Petitioner needs to talk with her dentist for a dental treatment plan, including but not limited to obtaining partial resin upper and lower dentures.

CONCLUSIONS OF LAW

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

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

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. Sections 409.971 – 409.973, Florida Statutes, establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the mandatory services that must be provided.

16. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

17. Fla. Admin. Code R. 59G-1.010(226) defines “prior authorization” as: “Prior authorization” means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

18. Fla. Admin. Code R. 59G-1.010 (166) provides:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

....

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service [emphasis added].

19. The May 2016 Florida Medicaid Dental Services Coverage Policy (Dental Policy) has been promulgated into rule by Fla. Admin. Code R. 59G-4.060, which provides:

(1) This rule applies to any person or entity prescribing or reviewing a request for dental services and to all providers of dental services who are enrolled in or registered with the Florida Medicaid program.

(2) All persons or entities described in subsection (1) must be in compliance with the provisions of the Florida Medicaid Dental Services

Coverage Policy, May 2016, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <http://www.flrules.org/Gateway/reference.asp?No=Ref-06593>.

20. On page 3 of the Dental Policy it states under paragraph 4.2 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 schedule(s)**, or as specified in this policy:" (Emphasis added.)

21. Florida Medicaid's current Dental General Fee Schedule, promulgated January 1, 2016, shows procedures D3310 and D2954 are covered by Medicaid for recipients up to the maximum age of 20. Procedure D2752 is not a covered benefit regardless of age.

22. Medical necessity for procedures D3310, D2954, and D2752 was not assessed because they are not covered services for the Petitioner.

23. Respondent explained the cast metal partial upper (D5213) and partial lower dentures (D5214) could not be approved for Petitioner because of the unhealthy condition of her teeth. Resin based partial dentures would be considered.

24. The undersigned has considered the totality of the documentary evidence and testimony, as well as the above cited authorities. Petitioner has failed to meet her burden of proof. Testimony by Respondent's dental consultant was given full weight. The undersigned finds Respondent correctly denied Petitioner's requests for procedures D3310 (endodontic therapy), D2954 (prefabricated post and core in addition to crown) and D2752 (crown) for tooth # 7, 8, 9, and 10, because these procedures are not covered benefits for Petitioner. Respondent correctly denied Petitioner's request for

procedures D5213 and D5214 because the metal partial dentures are not appropriate for Petitioner's mouth because of her unhealthy teeth.

25. Petitioner should contact her dentist to discuss a treatment plan, including dental care for the front tooth currently causing her severe pain.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the Petitioner disagrees with this decision, the Petitioner may seek a judicial review. To begin the judicial review, the Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 27 day of December, 2016,
in Tallahassee, Florida.



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

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

FILED

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

Dec 30, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07567

PETITIONER,

Vs.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 15, 2016 at 1:30 p.m.

APPEARANCES

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

For the Respondent: Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's action to partially deny the petitioner's request for Speech Therapy (ST) service hours for the certification period September 20, 2016 through March 18, 2017, was correct. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as a witness for the respondent was Rakesh Mittal. M.D., 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: Statement of Matters, Outpatient Review History, Denial Notices, and Speech Therapy reports.

FINDINGS OF FACT

1. The petitioner's ST service provider, [REDACTED] (hereafter referred to as "the provider"), requested the following ST service hours for the certification period at issue: 12 units (3 hours) weekly. Each unit is the equivalent of fifteen (15) minutes.
2. eQHealth Solutions, Inc. is the Quality Improvement organization (QIO) contracted by the respondent to perform prior authorization reviews for therapy services. The provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner's medical conditions; his functional limitations; and other pertinent information related to the household.
3. eQHealth Solutions' personnel had no direct contact with the petitioner, his family, or his physicians. All pertinent information was submitted by the provider directly to eQHealth Solutions.
4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 9 years old
- Diagnosis includes [REDACTED]

5. The petitioner was previously approved to receive 12 units weekly of ST services in the prior certification period. He also currently receives physical therapy, occupational therapy, and behavioral therapy services.

6. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the ST provider.

The therapy goals included the following:

- Improving overall receptive and expressive language skills
- Improving social language skills
- Improving speech production to facilitate speech intelligibility

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and partially denied the requested ST services, approving 8 units (2 hours) weekly rather than the requested 12 units (3 hours) weekly. A notice of this determination was sent to all parties on September 24, 2016. The notice stated the following rationale for the partial denial:

The request is excessive based on the severity of the delay, goals submitted and the progress made over many years of therapy. Four units two times per week is sufficient therapy at this developmental age.

8. The above notice stated that a reconsideration review of this determination by eQHealth could be requested, and additional information could be provided with the request for reconsideration. A reconsideration review was not requested in this case.

9. The petitioner thereafter requested a fair hearing and this proceeding followed.

10. The respondent's witness, Dr. Mittal, testified that the reduction of the petitioner's speech therapy service to 2 hours weekly was appropriate because he has been receiving 3 hours weekly of services since 2011 and still has severe deficits. He also stated the speech therapy reports make no mention of what progress or improvements have been made.

11. The petitioner's mother stated her son has made improvement in his speech ability and has demonstrated progress in his speech therapy. She stated her son previously could not talk or communicate, and now he is able to communicate his needs.

12. The petitioner's mother also mentioned her son previously had a [REDACTED] [REDACTED] for feeding, but he now eats normally. She also stated her son has [REDACTED] as well as [REDACTED] and [REDACTED]

13. ST service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Therapy Services Coverage and Limitations Handbook ("Therapy Handbook"), effective August, 2013.

CONCLUSIONS OF LAW

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

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

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 since the petitioner had been previously approved for 12 units (3 hours) weekly of speech therapy service and the respondent is seeking to reduce this service to 8 units (2 hours) weekly. 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. 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.

19. The petitioner has requested ST 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.

20. 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.

21. 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.

22. The service the petitioner has requested (ST services) is one of the services provided by the state to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Fla. Stat., states, in part:

Any service under this section shall be provided only when medically necessary ...

23. 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

¹ "You" in this manual context refers to the state Medicaid agency.

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.

24. 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.

25. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested ST services.

26. In the petitioner's case, the respondent has determined that 8 units (2 hours) weekly of ST service is medically necessary, rather than the 12 units (3 hours) weekly requested by the petitioner. The petitioner was previously approved for 12 units of speech therapy weekly.

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

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

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

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

28. 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.

29. ST services, also referred to as speech-language pathology services, are described on page 1-4 of the Therapy Handbook as follows:

Speech-language pathology services involve the evaluation and treatment of speech-language disorders.

Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate, maintain communication functioning, acquire a skill set, restore a skill set, and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

30. The Therapy Handbook on page 2-2 sets forth the requirements for ST services, as follows:

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service.

31. The petitioner's physician ordered a ST service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

32. The respondent's witness, Dr. Mittal, stated he believes the services should be reduced at this time since the petitioner still has severe deficits despite receiving 3

hours weekly of ST services since 2011. He also stated the speech therapy reports do not specify what progress or improvements have been made during therapy.

33. The petitioner's mother believes the services should continue at the previous level of 3 hours weekly since her son has made a lot of progress in his therapy.

34. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the respondent has met its burden of proof in demonstrating it was correct in reducing the requested speech therapy services for the certification period at issue. Although the petitioner's mother stated he has been making progress in his therapy, the submitted speech therapy reports contain no information detailing his progress towards meeting therapy goals. The lack of documentary information supports the respondent's decision to reduce services at this time.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

FINAL ORDER (Cont.)

16F-07567

PAGE - 11

DONE and ORDERED this 30 day of December , 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT

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

FILED

Dec 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07575
APPEAL NO. 16F-07576

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: [REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 14, 2016, at 8:38 a.m., and reconvened on December 1, 2016 at 1:37 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Dotlin Williamson, supervisor

STATEMENT OF ISSUE

At issue is the denial of Food Assistance Program (FAP) benefits and the denial of full Medicaid for her son (JA) and his enrollment in the Medically Needy Program with an estimated share of cost. She is seeking full Medicaid for him. The petitioner carries the burden of proof by preponderance of evidence in both the FAP appeal and the Medicaid appeal.

PRELIMINARY STATEMENT

The respondent presented two exhibits at the hearing which were entered into evidence and marked as Respondent's Composite Exhibits 1 and 2. The petitioner did not present any exhibits. The record was held open until November 19, 2016, for the petitioner to provide her evidence. The petitioner provided two exhibits which were accepted into evidence and marked as Petitioner's Composite Exhibits 1 and 2.

After reviewing the evidence the undersigned found it necessary to reconvene. The parties reconvened on December 1, 2016.

FINDINGS OF FACT

1. On September 26, 2016, the petitioner submitted an application for Food Assistance Program (FAP) benefits and Medicaid benefits for herself and her family. Her household consists of herself (age 30), her husband, RA (age 43), their three children, JA (age 9), DA (age 4) and EA (age 3), and her mother-in-law, JT (age 70). Both the petitioner and her husband are employed. The petitioner is paid biweekly and her husband is paid weekly. Her monthly expenses are rent of \$670, water of \$177, electricity of \$475 and telephone of \$157. The petitioner's husband does not have any legal Immigration and Naturalization Service (INS) status. The petitioner is a tax filer with the children as her tax dependents.
2. The respondent added both the petitioner's and her husband's monthly incomes to determine the household monthly income. The household income was prorated in the FAP budget as the petitioner's husband had no INS status.
3. The respondent determined FAP eligibility using the petitioner's pays for September 13, 2016 of \$852.36 and September 2, 2016 of \$852.36. Her average pay

was found and then multiplied by a conversion factor of 2.15 resulting to \$1,832.57. Her husband's average pay was found using his paystubs, September 9, 2016 of \$480, September 16, 2016 of \$480, September 23, 2016 of \$480 and September 30, 2016 of \$640, for a total of \$560. It was then multiplied by a conversion factor of 4.3 to get \$2,408. This was divided by six to get \$401.33 and then multiplied by five (the number of eligible members) resulting to \$2,006.66 as the husband's monthly income. The petitioner's monthly income was added to her husband's, resulting in the gross monthly household income of \$3,839.22. The respondent applied the following deductions.

Earned Income (husband & wife)	\$3,839.22
Total household income	\$3,839.22
Earned Income Deduction	(-\$767.84)
Standard deduction for a household of 5	(-\$197)
Adjusted income after deductions	\$2,874
Shelter costs	\$670
Standard utility Allowance	\$338
Total rent/utility cost	\$1,008
Shelter standard (50% adjusted income)	\$1,437.19
Excess shelter deduction	\$0.00
Adjusted income	\$2,874
Excess Shelter Deduction	\$0.00
Adjusted income after shelter deduction	\$2874.38
Maximum net monthly income for HH of 5	\$2,370

4. The respondent determined that the petitioner was ineligible for FAP benefits as her household's adjusted income was more than the maximum net monthly income for a household size of five.

5. On October 11, 2016, the respondent mailed the petitioner a Notice of Case Action, informing her that her FAP application dated September 26, 2016, was denied.

The reason given for the denial was that her household income was too high to qualify for this program.

Medicaid issue

6. The petitioner's household monthly income was determined according to the Medicaid guidelines by converting her husband's weekly income to monthly and the petitioner's biweekly income to monthly and added them together. The husband's weekly average pay of \$560 was multiplied by conversion factor of 4, resulting to \$2,240 and the petitioner's biweekly average pay of \$852.36 by 2, resulting to \$1,704.72. The respondent added the husband's monthly income of \$2,240 to the wife's monthly income of \$1,704.72 resulting to \$3,944.72 as the total household's income. It was then compared to the maximum income for a child age 9 who is residing in a household of size 5.

7. The respondent determined the household monthly income of \$3,944.72 exceeded the maximum income limit for full Medicaid benefits of \$3,163. The respondent explored continuous Medicaid for JA and found he had already received six months of continuous Medicaid. The respondent proceeded to enroll JA in the Medically Needy Program with an estimated share of cost (SOC).

8. The Medically Needy Income Limit of \$684 for a household size of five was subtracted from the MAGI \$3,944.72 resulting to \$3,260 as the SOC.

9. By same notice dated October 11, 2016, the respondent notified the petitioner her son JA was eligible for continued Medicaid coverage under the Medically Needy program.

10. On October 10, 2016, the petitioner requested a hearing to challenge the respondent's actions.

CONCLUSION 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.

The FAP benefits issue will be addressed first.

13. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states:

- (a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet...
- (b) Definition of income...
 - (1) Earned income shall include:
 - (i) All wages and salaries of an employee...

14. The respondent must follow these federal budgeting guidelines when determining eligibility. It also directs the respondent to consider income from wages as earned income that must be included in the eligibility determination.

15. Federal Regulations 7 C.F.R. § 273.10 addresses income and calculating net income and benefit levels:

- (c)(2) *Income only in month received.* (i) Income anticipated during the certification period shall be counted as income only in the month it is expected to be received, unless the income is averaged. Whenever a full

month's income is anticipated but is received on a weekly or biweekly basis, the State agency shall convert the income to a monthly amount by multiplying weekly amounts by 4.3 and biweekly amounts by 2.15, use the State Agency's PA conversion standard, or use the exact monthly figure if it can be anticipated for each month of the certification period...

16. The biweekly factor was used to determine the petitioner's monthly income and the weekly factor was used to determine the husband's monthly income. The respective monthly incomes were added together to get the monthly household income. No mathematical errors were found in the conversion to monthly income.

17. Federal regulation 7 C.F.R. § 273.9(d) sets forth the specific deductions as follows:

(1) *Standard deduction*...

(2) *Earned income deduction*. Twenty percent of gross earned income as defined in paragraph (b)(1) of this section.

(3) *Excess medical deduction*. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled...

(4) *Dependent care*. Payments for the actual costs for the care of children or other dependents when necessary for a household member to accept or continue employment, comply with the employment and training requirements as specified under §273.7(e), or attend training or pursue education which is preparatory to employment, except as provided in §273.10(d)(1)(i)...

(5)(ii) *Excess shelter deduction*. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed. If the household does not contain an elderly or disabled member, as defined in §271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area...

(D) The shelter costs for the home if temporarily not occupied by the household because of employment or training away from home, illness, or abandonment caused by a natural disaster or casualty loss. For costs of a home vacated by the household to be included in the household's shelter costs, the household must intend to return to the home; the current occupants of the home, if any, must not be claiming the shelter costs for food stamp purposes; and the home must not be leased or rented during the absence of the household...

(iii) *Standard utility allowances.* (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction: an individual standard for each type of utility expense; a standard utility allowance for all utilities that includes heating or cooling costs (HCSUA); and, a limited utility allowance (LUA) that includes electricity and fuel for purposes other than heating or cooling, water, sewerage, well and septic tank installation and maintenance, telephone, and garbage or trash collection. The LUA must include expenses for at least two utilities. However, at its option, the State agency may include the excess heating and cooling costs of public housing residents in the LUA if it wishes to offer the lower standard to such households. The State agency may use different types of standards but cannot allow households the use of two standards that include the same expense...

18. The Food Assistance standards for income and deductions appear in the Department's Program Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1. The 200% Federal Poverty level (FPL) for a household size of five effective October 2016 is \$4,740. A five-person assistance group's net income limit is \$2,370, the standard deduction is \$197 and the Standard Utility Allowance is \$338.

19. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

(1) Net monthly income (i)...

(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income...

(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions. If the State agency has chosen to treat legally obligated child support payments as an income exclusion in accordance with §273.9(c)(17), multiply the excluded earnings used to pay child support by 20 percent and subtract that amount from the total gross monthly income.

(C) Subtract the standard deduction.

(D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed \$35. If so, subtract that portion which exceeds \$35.

(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.

(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.

(2) Eligibility and benefits...

(ii)(A)...the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30% of the household's net monthly income...

(iii) To determine the amount of the prorated allotment, the State agency shall use either the appropriate Food Stamp Allotment Proration Table provided by FNS...

20. The above-cited regulation describes the eligibility process and defines deductions. The petitioner was credited with an earned income deduction and a standard deduction. Her budget was also reviewed for an excess shelter deduction but was not found eligible. There is no indication the petitioner was eligible for any other deductions.

21. After considering the evidence, the testimony and the appropriate authorities cited above, the hearing officer could not find the petitioner eligible for FAP benefits as the monthly adjusted household income exceed the maximum income limit for FAP benefits for a family of five.

Medicaid Benefits will now be addressed

22. The petitioner's son, JA's Medicaid eligibility was determined under the Family Related Medicaid program.

23. 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.

24. 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.

25. The Department's Program Policy Manual CFOP 165-22 (the Policy Manual) at passage 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

26. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, her husband, their three children. The findings show the respondent's determined the petitioner's eligibility with a household size of five for Medicaid. The undersigned concludes the Department correctly determined the petitioner's household size as five for Medicaid.

27. 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).

28. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a child age 9 and the household size of five as \$3,156, the Modified Adjusted Gross Income (MAGI) of \$119 and the Medically Needy Income Limit (MNIL) of \$684.

29. In accordance with the above controlling authorities, the undersigned reviewed eligibility for full Medicaid benefits for the petitioner's son and did not find him eligible, as the modified adjusted gross income was more than the income limit of \$3,153 for a household of five. Step 1: The undersigned added the husband's income of \$2,241.60 to the petitioner's income of \$1,704.72 resulting to the modified adjusted gross income of \$3,946.32. Step 2: There were no deductions provided, as there was no tax return. Step: 3: No standard disregard was allowed as the child was between ages 6-18. The total income remained \$3,946.32. Step 4: The total countable net income of \$3,946.32 was compared with the income standard for five person for child age 9 of \$3,153. Step 5: Since it was greater than the income standard, the MAGI disregard of \$119 was subtracted, resulting to \$3,827.31. This was compared to the income limit of \$3,153 for full Medicaid. The petitioner's income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner's son 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

30. 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.”
31. Fla. Admin. Code 65A-1.702 “Special Provisions” states in part:
(10) Enrollment. The enrollment period under the Medically Needy program begins with the month the individual satisfies the non-financial and resource eligibility criteria, but not earlier than the third month prior to the month of application.
(13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual’s or family’s income.
32. The Policy Manual at passage 2630.0500 Share of Cost (MFAM) states:

The Share of Cost (SOC) refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.
Eligibility must be determined for Medically Needy any time the assistance group meets all technical factors but the income exceeds the appropriate income limit for Medicaid.
To calculate the share of cost, compare the countable net income to the Medically Needy Income Level based on the size of the standard filing unit. The difference is the assistance group’s share of cost.
33. In accordance with the above controlling authorities, respondent determined petitioner’s SFU as a household of five based on her tax filing status.
34. 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...”

35. The Medically Needy Income Level (MNIL) appears in The Policy Manual at Appendix A-7. Effective April 2016, the MNIL for a household size five is \$684.

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

37. The undersigned carefully reviewed the respondent's determination of the petitioner's son's SOC of \$3,260 and could not find a more favorable outcome. The undersigned concluded that the respondent's action to deny full Medicaid benefits and to enroll JA in the Medically Needy Program was correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for FAP benefits is denied and the respondent's decision is upheld.

The petitioner's appeal for full Medicaid is denied and the respondent's decision is upheld. As to the petitioner's SOC, 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.)
16F-07575, 07576
PAGE -15

DONE and ORDERED this 12 day of December, 2016,
in Tallahassee, Florida.

Christiana Gopaul-Narine

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

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

FILED

Dec 05, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07583
APPEAL NO. 16F-07721

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 November 9, 2016 at 3:12 p.m., and reconvened on November 14, 2016 at 11:07 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Ronda Lanum, supervisor and Robnet Dukes,
Operations Management Consultant I

STATEMENT OF ISSUE

At issue is the amount of Food Assistance (FA) benefits approved at recertification. The petitioner carries the burden of proof by preponderance of evidence in this appeal.

PRELIMINARY STATEMENT

The petitioner terminated the call before the hearing process was completed. The undersigned found it necessary to reconvene the hearing as the petitioner thought the hearing was finished when it was not.

The respondent presented six exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 6. The petitioner presented one exhibit which was entered into evidence and marked as petitioner's Exhibit 1. The record was held open until November 24, 2016 for the petitioner to provide her mortgage and tax information and for the Department to provide an updated FA budget, and a new Notice of Case Action. No additional information was received from the petitioner or the respondent. The hearing officer allowed additional time for the respondent to update the case as the Department was closed due to a holiday. The record was held open until November 30, 2016. The respondent provided a property tax statement, Social Security statement, payment detail, a mortgage contract, a new FA budget, FA issuance history, and a new Notice of Case Action. They were accepted into evidence and marked as Respondent's Composite Exhibits 7, 8 and 9. The record was closed on November 30, 2016.

On October 21, 2016, the petitioner submitted an application for Medicaid benefits which is currently pending. As the application is currently pending the petitioner verbally withdrew the Medicaid appeal at the hearing on November 14, 2016.

FINDINGS OF FACT

1. The petitioner was receiving FA benefits in the amount of \$194 in a prior certification. That certification ended on September 30, 2016. She recertified and was determined eligible to receive \$16 monthly effective October 2016.
2. On August 26, 2016, the petitioner submitted a recertification application. She is the only member in her assistance group (AG). She is 70 years old and receives Social Security retirement (SS) of \$1,481. She is also receiving Medicare Part B of \$104.80. On her application, she reported shelter expense for mortgage of \$250. Her mortgage is currently in foreclosure. She reported utility expenses for water of \$200, telephone of \$200, electricity of \$400 and a \$77 for a loan.
3. The respondent found the petitioner eligible for FA benefits of \$16 monthly by subtracting a standard deduction of \$157 and her monthly expenses of \$172.57 from her monthly household income of \$1,681.
4. On September 12, 2016, the respondent mailed the petitioner a Notice of Case Action informing her that her FA benefits would decrease from \$194 to \$16 effective October 1, 2016. The reason for the reduction was that her unearned had income increased.
5. On October 11, 2016, the petitioner requested a hearing to challenge the respondent's action.
6. At the hearing the petitioner reported shelter expenses for property tax of \$9,590 yearly, mortgage of \$4,400 monthly (not paid) and utility expenses. She also reported medical expenses for prescriptions. The petitioner reported that the MOCO from her

brother had stopped. The respondent agreed to make adjustments to the FA budget and allow the petitioner her full shelter obligation.

7. The respondent's updated the FA budget and provided the following as its updated calculations for October 2016 ongoing:

Unearned income SS(\$1,486)	\$1,486
Total household income	\$1,486
Standard deduction for a household of 2	(\$157)
Excess Medical Expenses(\$207.57-\$35)	(\$172.57)
Adjusted income after deductions	\$1,156.43
Shelter costs	\$5,122.92
Standard utility Allowance	\$338
Total rent/utility cost	\$5,460.92
Shelter standard (50% adjusted income)	\$578.21
Excess shelter deduction	\$4,882.71
Adjusted income	\$1,156.43
Excess Shelter Deduction	(\$4,882.71)
Adjusted income after shelter deduction	\$0.00
Max net monthly Income for 1 HH Member	\$990
Thrifty Food Plan for Household size 1	\$194
Benefit Reduction 30% of \$0.00	\$0.00
Monthly FAP allotment	\$194

8. After updating the petitioner's shelter expenses, the respondent found her eligible for FA benefits of \$194 monthly, the maximum amount for the household size of one. The respondent issued auxiliaries of \$178 to supplement the months of October and November 2016.

9. On November 19, 2016, the respondent sent the petitioner an updated Notice of Case Action informing her that her FA benefits would increase to \$194.

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 Department's Program Policy Manual, CFOP 165-22, at Appendix A-1. Effective October 1, 2016, the 200% Federal Poverty level (FPL) for a household size of one is \$1,980. The 100% Federal Poverty level (FPL)/Net Income Limit is \$990. The standard deduction was \$157 and the Standard Utility Allowance was \$338. The maximum allotment for one person is \$194.

13. Federal Regulations at 7 C.F.R. §273.9 defines "Income" in the Food Assistance Program. The passage reads in relevant part:

(a) *Income eligibility standards.* Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet...

(b) *Definition of income....*

(2) Unearned income shall include, but not be limited to:

(ii) Annuities; pensions; retirement, veteran's, or disability benefits;

(d) Income deductions. Deductions shall be allowed only for the following household expenses:

(1) Standard deduction...

(3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction. Allowable medical costs are:..

(iv) Health and hospitalization insurance policy premiums.

(6) Shelter costs...

(ii) Excess shelter deduction...

(iii) Standard utility allowances...

14. The above-cited regulation explains that participants in the FAP are required to meet income standards. The authority states the petitioner's Social Security retirement is included in the eligibility determination. The above regulation sets forth specific potential deductions in the FAP budget. These potential allowable deductions are limited to include only: (1) standard deduction, (2) excess medical deduction, (3) standard utility allowance, and (4) shelter expenses.

15. The above regulation explains the petitioner may be entitled to an excess medical deduction in the FA budget if the allowable monthly medical expenses is in excess of \$35. The petitioner was credited with deductions for her Medicare Part B premium and prescriptions.

16. It further states at 7 C.F.R. §273.10 (e) Calculating net income and benefit levels:

- (1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:
 - (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net losses from the self-employment income of a farmer shall be offset in accordance with §273.11(a)(2)(iii).
 - (B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions.
 - (C) Subtract the standard deduction.
 - (D) If the household is entitled to an excess medical deduction as provided in Sec. 273.9(d)(3), determine if total medical expenses exceed \$35. If so, subtract that portion which exceeds \$35.
 - (E) Subtract allowable monthly dependent care expenses, if any, up to a maximum amount as specified under Sec. 273.9(d)(4) for each dependent.
 - (F) If the State agency has chosen to treat legally obligated child support payments as a deduction rather than an exclusion in accordance with §273.9(d)(5), subtract allowable monthly child support payments in accordance with §273.9(d)(5).

(G) Subtract the homeless shelter deduction, if any, up to the maximum of \$143.

(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.

(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.

(ii) In calculating net monthly income, the State agency shall use one of the following two procedures:

(A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or...

(ii)(A)...the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income...

17. The petitioner was allowed an excess medical deduction, an excess shelter deduction (which included the standard utility allowance) and a standard deduction.

18. The undersigned reviewed the FA budget and did not find the petitioner eligible for any additional FA benefits as she was already receiving the maximum amount of FA benefits (\$194) allowed for a one member AG. The respondent issued auxiliaries of \$178 for October and for November 2016, to supplement the FA benefits to \$194. The respondent's decision is upheld.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal 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 December , 2016,

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

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

Dec 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07679

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 November 15, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED] Petitioner

For the Respondent: Fathima Leyva, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for dental services (partial lower dentures) was correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as witnesses for the respondent were Dr. Susan Hudson, Dental Consultant, and Jackeline Salcedo, Grievance Specialist, from DentaQuest, which is the petitioner's dental services review organization. Also present as a witness for the respondent was Carlene Brock, Quality Operations Nurse, from Amerigroup, which is the petitioner's managed health care plan. Amerigroup was included as a respondent in this proceeding since it is the petitioner's health plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Case Summary, Authorization Request, Denial Notice, letter from the petitioner, Dental Review Report, and Dental Criteria.

FINDINGS OF FACT

1. The petitioner is a forty-nine (49) 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, which utilizes DentaQuest for review and approval of dental services.
2. On or about July 13, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from Amerigroup and/or DentaQuest for approval of partial lower dentures. Amerigroup denied the request for partial lower dentures on July 14, 2016 as not being medically necessary.

3. Amerigroup's denial notice to the petitioner advised her of the following reason for the denial of her request for the partial lower dentures:

Our dentist looked at the information your dentist sent, and says you are not missing enough teeth to affect your chewing function. We have also told your dentist. Please talk to your dentist

4. The petitioner stated she has teeth on the right side of her mouth, but not on the left side. She has upper dentures and she will chew her food unevenly unless she gets the lower dentures. She believes this will cause the upper dentures to warp and they will need to be replaced. She also stated this has affected her smile.

5. The respondent's witness, Dr. Hudson, stated that the denial of the petitioner's request for the lower partial dentures was appropriate because she has 8 teeth in occlusion (contact between upper and lower teeth) on the right side of her mouth which should be sufficient for chewing food. She stated the criteria for dentures require the individual to have less than 8 teeth in occlusion.

6. Services under the Medicaid State Plan in Florida are provided in accordance with the Respondent's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

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

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

10. The standard of proof in an administrative hearing is a preponderance of the evidence, in accordance with Rule 65-2.060 (1), 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.).

11. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent, AHCA. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. 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.”

13. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide;

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

14. Partial dentures and full dentures are covered services for adults under the Medicaid Program.

15. The petitioner's position is that she should be approved for the lower dentures because she does not have teeth on the left side of her mouth and she cannot chew properly.

16. The respondent's witness stated the lower dentures were properly denied since the petitioner has 8 teeth in occlusion.

17. After considering the evidence and testimony presented, the undersigned concludes the respondent correctly denied the petitioner's request for the partial lower dentures. The evidence demonstrates that she does not meet the criteria for dentures since she has at least 8 teeth in occlusion.

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

FINAL ORDER (Cont.)

16F-07679

PAGE - 6

judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The Petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 30 day of December , 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
AMERIGROUP HEARINGS UNIT

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

FILED

Dec 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07707

PETITIONER,

Vs.

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 18, 2016 at 11:30 a.m.

APPEARANCES

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

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

STATEMENT OF ISSUE

At issue is whether the respondent's action to partially deny the petitioner's request for personal care service (PCS) hours for the certification period October 1, 2016 through March 29, 2016, was correct. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted the following documents as evidence for the hearing, which were marked as Petitioner exhibits: Exhibit 1 – Calendar Notes; Exhibit 2 – Doctor’s letter; Exhibit 3 – Individual Education Plan (IEP); Exhibit 4 – Photographs; Exhibit 5 – Behavior Plan; and Exhibit 6 – School Calendar.

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: Statement of Matters, Clinical Notes, Denial Notices, and Supporting Documentation.

FINDINGS OF FACT

1. The petitioner’s home health agency (hereafter referred to as “Provider”), requested the following PCS hours for the certification period at issue: 12 hours daily, and 16 hours daily on non-school days such as weekends, school vacation days, and holidays.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for home health services. The petitioner’s provider submitted the service request through an internet based system. The submission included, in part, information about the petitioner’s medical conditions; his functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions personnel had no direct contact with the petitioner, his family, or his physicians, other than a home health assessment completed with the caregiver in September, 2016. All exchange of information was through eQHealth Solutions' internet based system. The decision made by each physician at eQHealth was solely based on the information submitted by the provider and the caregiver.

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

- 11 years of age and resides with his parents and 3 year-old sibling
- [REDACTED]
- Ambulatory
- Occasionally incontinent

5. The petitioner's mother is employed and her work schedule is 10:00 a.m. to 6:00 p.m., Monday through Sunday. The petitioner's mother was previously separated from his father, but the father is now residing in the family home again. The father works from approximately 7:00 a.m. to 3:30 p.m. and usually also works on the weekends.

6. The petitioner attends school from 8:00 a.m. to 3:00 p.m., Monday to Friday. He receives behavior therapy at school. The petitioner has been approved for occupational therapy and speech therapy but he has had to discontinue those therapies due to his behavior issues. Last year, the petitioner was receiving 4 hours daily of personal care services (and 8 hours on non-school days) through Children's Medical Services.

7. The petitioner is currently approved for 5 hours per day of respite care services through the Florida Agency for Persons with Disabilities' (APD) Medicaid Waiver program. The respite care worker is the same person providing the personal care services approved by Medicaid. This individual comes to the home at 6:00 a.m. to

bathe and feed the petitioner and get him ready for school. This person also takes him to school and picks him up from school at 2:30 p.m. and then stays in the home for 4 hours.

8. A Plan of Care was also submitted by the provider. The document was signed by a physician and outlined the type of assistance to be provided by the home health aide/personal care aide. The duties include, in part:

- Provide assistance with personal care and ADLs (activities of daily living) such as bathing and grooming, oral hygiene, feedings, and toileting

9. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and partially denied the requested PCS hours, approving 2 hours per day of PCS services. A notice of this determination was sent to all parties on October 8, 2016. The notice contained the following rationale for the decision:

The patient is ambulatory and on a regular diet but requires assistance with ADLs. The mother is the only care provider and works 10a-6p daily.

Deny requested hours. The mother is available to provide ADL care in the mornings, would approve HHA 2 hrs/d to provide assistance with ADLs in the PM while the mother works. The remaining hours, for monitoring and supervision, could be provided by non HHA personnel – supervision is not a covered service.

10. The above notice stated should the parent, provider, or the petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was requested in this case.

11. A second physician at eQHealth Solutions conducted a reconsideration review and a notice of reconsideration decision was sent to all parties on October 16, 2016.

The reconsideration decision modified the initial decision as follows:

The clinical information provided supports the medical necessity of PCS for 2 hours on school days and 4 hours on non-school days to assist the patient with ADLs. The partial denial should be modified to add an additional 2 hours on non-school days and weekends.

12. The petitioner thereafter requested a fair hearing and this proceeding followed.

13. The petitioner's mother stated her son has severe [REDACTED] and behavior problems. He has tried to drink cologne and must wear a harness in the car to restrain him. He cannot dress himself or brush his teeth and he needs help with toileting. She stated her son needs more than just supervision due to his behavior issues. She also stated the 3 year old sibling has behavior issues as well, although those issues have not yet been formally diagnosed.

14. The respondent's witness, Dr. Mittal, stated that supervision is not a covered service and the purpose for personal care services is to provide assistance with ADLs (activities of daily living). He also stated that the eQHealth reviewers were not previously aware of the father's presence in the home and the approval of APD services for the petitioner. He stated if these facts had been known at the time, eQHealth would not have approved any services for the petitioner.

15. Personal Care Service (PCS) for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Home Health Services Coverage and Limitations Handbook (October 2014).

CONCLUSIONS OF LAW

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

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

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

19. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the petitioner is requesting an increase in the hours of service. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

20. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent.

21. The petitioner has requested personal care 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.

22. 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.

23. 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.

24. The service the petitioner has requested (personal care 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

¹ "You" in this manual context refers to the state Medicaid agency.

(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.

25. 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.

26. 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.

27. Based upon the information submitted by the petitioner's provider, eQHealth Solutions completed a prior authorization review to determine medical necessity for the requested personal care services.

28. In the petitioner's case, the respondent has determined that some personal care services are medically necessary, but has approved 2 hours daily and 4 hours daily on non-school days, rather than the 12 hours daily and 16 hours on non-school days requested by the petitioner.

29. 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.

30. 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.

31. The petitioner’s request for service is governed by the respondent’s Home Health Services Coverage and Limitations Handbook (October 2014). The Handbook, on page 1-2, addresses Personal Care Services as follows:

Personal care services provide medically necessary assistance with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) that enable the recipient to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability. Medicaid reimburses for these services provided to eligible recipients under the age of 21 years.

ADLs include:

- Eating (oral feedings and fluid intake);
- Bathing;
- Dressing;
- Toileting;
- Transferring; and
- Maintaining continence (examples include taking care of a catheter or colostomy bag or changing a disposable incontinence product when the recipient is unable to control his bowel or bladder functions).

IADLs (when necessary for the recipient to function independently) include:

- Personal hygiene;
- Light housework;
- Laundry;
- Meal preparation;
- Transportation;
- Grocery shopping;
- Using the telephone to take care of essential tasks (examples include paying bills and setting up medical appointments);
- Medication management; and
- Money management.

32. Page 2-24 of the Handbook addresses who can receive personal care services, as follows:

Medicaid reimburses personal care services for recipients under the age of 21 who meet all of the following criteria:

- Have a medical condition or disability that substantially limits their ability to perform their ADLs or IADLs.
- Have a physician's order for personal care services.
- Require more individual and continuous care than can be provided through a home health aide visit.
- Do not have a parent or legal guardian capable of safely providing these services.

33. Page 2-25 of the Handbook imposes a parental responsibility requirement with respect to personal care services, which is described as follows:

Personal care services can be authorized to supplement care provided by parents and legal guardians. Parents and legal guardians must participate in providing care to the fullest extent possible. Where needed, the home health service provider 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. The home health services provider must document the methods used to train a parent or legal guardian in the medical record.

Medicaid can reimburse personal care services rendered to a recipient whose parent or legal guardian is not able to provide such care.

Supporting documentation must accompany the prior authorization request in order to substantiate a parent or legal guardian's inability to participate in the care of the recipient.

34. Page 2-11 of the Handbook also addresses which services Medicaid does not provide reimbursement for under the home health services program. This list includes:

- Housekeeping (except light housekeeping), homemaker, and chore services, including any shopping except grocery shopping when provided as an IADL
- Meals-on-wheels
- Mental health and psychiatric services
- Normal newborn and postpartum services, except in the event of complications
- Respite care
- Services which can be effectively and efficiently obtained outside the recipient's place of residence without any medical contraindications
- Baby-sitting
- Services to a recipient residing in a community residential facility when those services duplicate services the facility or institution is required to provide
- Social services
- Transportation services (except when necessary to protect the health and safety of the recipient and no other transportation service is available or when provided as an IADL)
- Escort services
- Care, grooming, or feeding of pets and animals
- Yard work, gardening, or home maintenance work
- Day care or after school care
- Assistance with homework
- Companion sitting or leisure activities

35. The petitioner's physician ordered a service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states

a prescription does not automatically mean the requirements of medical necessity have been satisfied.

36. The respondent's witness, Dr. Mittal, stated that supervision is not a covered service and the currently approved hours are sufficient to provide assistance with ADLs.

37. The petitioner's mother stated her son needs more than just supervision due to his behavioral problems.

38. Although the undersigned acknowledges the petitioner may benefit from additional supervision, the scope of services to be performed by a personal care aide is limited as set forth in the Handbook provisions cited above. Services such as monitoring and supervision do not require the services of a para-professional such as a personal care aide. The role of a personal care aide is to provide medically necessary assistance with ADL needs such as bathing, grooming, feeding, and toileting, not to provide constant supervision or behavioral re-direction.

39. The undersigned concludes that the petitioner has not demonstrated that the respondent was incorrect in partially denying the requested personal care services. Taking the APD services into account, the petitioner is currently approved for 7 hours of assistance daily and 9 hours on non-school days. The 9 hours on non-school days and weekends covers the petitioner's mother's entire work schedule, so that the petitioner will be receiving constant supervision and assistance during those hours. Both parents are home in the evening; therefore there is no need for additional hours at night.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the Petitioner's responsibility.

DONE and ORDERED this 30 day of December , 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
AHCA HEARINGS UNIT

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

FILED

Dec 30, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-07809

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 [REDACTED]
UNIT: AHCA

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 9, 2016 at 10:19 a.m.

APPEARANCES

For the Petitioner: [REDACTED] mother

For the Respondent: Selwyn Gossett, healthcare analyst

STATEMENT OF ISSUE

Whether the respondent's decision terminating the petitioner's Prescribed Pediatric Extended Care (PPEC) services 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 eQ Health Solutions (eQ) to conduct prior services authorizations for certain Medicaid services, including PPEC services.

By notice dated October 21, 2016, eQ informed the petitioner that her request for continued PPEC services, for the certification period October 18, 2016 – April 15, 2017, was denied.

The petitioner timely requested a hearing to challenge the termination decision. The PPEC services have been continued at the prior level pending the hearing decision.

Present as witnesses for the petitioner: [REDACTED], maternal grandmother; [REDACTED], regional director with [REDACTED] (the PPEC facility); and [REDACTED] director of Nursing with [REDACTED]. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Composite Exhibit 1.

Present as a witness for the respondent: Dr. Darlene Calhoun, physician reviewer with eQ. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The hearing record was closed on December 9, 2016.

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 7 months) is a Florida Medicaid recipient.

2. The petitioner's diagnoses includes a history of [REDACTED]

[REDACTED]. The petitioner requires total assistance with all activities of daily living.

3. The petitioner lived with her maternal grandmother, under state appointed care, for several months while her mother attended a residential rehabilitation program. The petitioner recently returned to her mother's home. The household also includes a four year old sibling and the mother's "live-in boyfriend."

4. The petitioner began attending PPEC in April 2016. PPEC facilities provide skilled nursing care to children with complex medical conditions. The petitioner attends PPEC Monday – Friday from 8:00 a.m. to 6:00 p.m.

5. Continued eligibility for PPEC services must be reviewed every six months. The PPEC recertification process begins with the PPEC facility submitting a request form and supporting documentation to eQ, the respondent's contracted authorization agent.

6. The petitioner's PPEC submitted a recertification request packet to eQ in October 2016. The supporting documentation included an order for PPEC services from petitioner's treating physician, Florida Home Assessment Tool, Physician Plan of Care, PPEC Nursing Assessment Form and case notes, and other clinical records.

7. The Physician Plan of Care (PPOC) is dated September 28, 2016 and lists the petitioner's diagnoses as [REDACTED]

[REDACTED]

8. The PPOC addressed the petitioner's current medical condition:

Spontaneous vaginal delivery at 39 weeks...Baby positive for [REDACTED] at birth...admitted to NICU but eventually transferred from [REDACTED]. Weaned to room air...Suspected [REDACTED] activity confirmed on EEG. Followed by Neurology. During recent Neurology visit the term cerebral palsy was discussed...While there is no official diagnosis yet, clinical appearance supports the term. Child safety measure will be maintained and [REDACTED] log as well.

9. The PPOC goals were listed as: optimal nutrition and hydration status will be achieved and maintained; optimal neurological status will be maintained; optimal growth and developmental milestones will be achieved and maintained; and child safety measure will be maintained at all times.

10. PPEC facility case notes show that the petitioner was ventilator dependent and taking [REDACTED] to treat [REDACTED] at birth. The petitioner was weaned from the ventilator in April 2016. The [REDACTED] was discontinued in August 2016 with no recurrence of [REDACTED] activity.

11. PPEC facility case notes dated October 20, 2016 record monthly call with the petitioner's mother and her current concerns:

Monthly call completed with mother. She just finished OT [occupational therapy] Early Steps appointment. [Petitioner] is not rolling over and OT as concerned about lack of progress. OT feels she should be making more progress with therapy received at PPEC....Denied any recent seizure activity since completion of tapering. OT is concerned about her eye site.

12. eQ concluded that the petitioner's medical condition had improved since birth (she is no longer ventilator dependent and [REDACTED] activity has ceased) to the point that she no longer required continuous skilled nursing care.

13. eQ issued a denial notice on October 21, 2016. The notice reads in pertinent part:

Requested services are denied because the clinical information does not support the medical necessity. The patient is a 6 month old with possible [REDACTED]. The patient has been noted to have tremors but no [REDACTED] have been noted. The patient has been weaned off [REDACTED]. The patient is on no scheduled medications. The clinical information provided does not support the medical necessity of the requested services. The request is denied.

14. Dr. Darlene Calhoun, physician reviewer with eQ, appeared as a respondent witness during the hearing. Dr. Calhoun explained that PPEC services are intended for children who require mechanical devices to maintain life (i.e., G-tubes, IV for medications, ventilators, etc.,) or have complex medical conditions (severe [REDACTED] multiple times daily) that require continuous nursing care. Dr. Calhoun opined that the petitioner's care needs do not require the services of skilled nurse staff. Dr. Calhoun opined further that it is not medically necessary for the petitioner to continue to receive PPEC services.

15. The petitioner's family and PPEC care staff acknowledged that her condition has improved. She is no longer ventilator dependent and [REDACTED] activity has ceased. However, they argued that the petitioner's [REDACTED] (suspected [REDACTED] poor [REDACTED] and history of [REDACTED] activity warrant continued skilled nursing care.

16. The petitioner's witnesses argued further that her [REDACTED] where mild tremors, not noticeable to the naked eye of a lay person. They are concerned that

standard daycare providers would not recognize the symptoms if the [REDACTED] activity reoccurred.

17. The petitioner also received speech and physical therapy at the PPEC facility. Her witnesses testified that the therapies are medically necessary and should be continued.

18. Dr. Leslie Ravago, physician with UF Health Family Medicine and Pediatrics, wrote a letter recommending continued PPEC services. The letter is dated October 28, 2016 and reads:

[Petitioner] was seen in my clinic on 10/27/16. She is 6-month-old baby girl who was one full-term weighing 2.5kg with an Apgar scores of 2-2-7 and required positive pressure ventilation due to [REDACTED]. She stayed in NICU due to the following: Intrauterine drug exposure [REDACTED]. She currently has a severe [REDACTED] and is followed by the nutritionist. She continued to throw up with every feeding. She smiles, laughs, coos and babbles, but does not roll over yet. She requires PT, OT, and ST, and is waiting for a swallowing study prior to introducing solid foods. Isabel would benefit from a medical day care where a trained staff will be available to take care of her complex medical condition especially with a history of [REDACTED].

19. [REDACTED], nurse practitioner with [REDACTED] Specialty Care, wrote a letter also recommending continued PPEC services. The letter reads in pertinent part: "It is our judgement that [petitioner] would benefit from a medical daycare until she has been cleared of any swallowing issues, by her PCP [primary care physician]. Once done she will continue to need care with providers who can recognize and respond to [REDACTED] in an infant."

20. In response to the testimony of the petitioner's witnesses and the medical attestation letters, Dr. Calhoun explained that the petitioner can continue to receive physical and occupational therapies as an outpatient. Dr. Calhoun opined that the petitioner's current care needs can be met by a responsible adult and do not require the services of skilled nursing staff.

CONCLUSIONS OF LAW

21. 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.

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

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

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

25. 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.).

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

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

“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.

28. 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.

29. 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.

30. Page 1-1 of the PPEC Handbook notes that, “[t]he purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Services Program is to enable recipients under the age of 21 years with medically complex conditions to receive medical and therapeutic care at a non-residential pediatric center.”

31. On page 2-1 thru 2-2, the PPEC Handbook lists the requirements for PPEC services.

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

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

32. Fla. Admin. Code R. 59G-1.010 defines “medically complex” and “medically fragile” as follows:

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

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

33. The respondent, through its agent eQ, denied the petitioner's request for ongoing PPEC services. The respondent determined that the petitioner's medical condition had improved to the point that PPEC services were no longer medically necessary. The respondent concluded that the petitioner's care needs can be met by a responsible adult and do not require the continuous skilled nursing care.

34. The petitioner's witnesses argued that her guarded [REDACTED] activity require the services of skilled nursing staff.

35. The evidence proves that the petitioner's medical condition was not stable at birth; she required medication for seizure activity and a mechanical device (ventilator) to maintain life. The evidence proves that the petitioner's medical condition has improved over the past several months. The [REDACTED] activity has ceased and she no longer requires [REDACTED] medication. In addition, she has been weaned from the ventilator. She no longer requires a mechanical device to maintain life. While the petitioner requires monitoring and supervision, the evidence does not prove that the petitioner requires continuous skilled nursing care to ensure her health and safety.

36. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent met its burden of proof in this matter. The

respondent proved by a preponderance of the evidence that it is no longer medically necessary that the petitioner receive PPEC services.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 30 day of December, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Dec 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-07881
16F-07882
16F-07939

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 November 22, 2016, at 1:15 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED].

For the Respondent: Debbie Ellis, economic self-sufficiency supervisor.

STATEMENT OF ISSUE

Petitioner is appealing the respondent's action to impose a Child Support Enforcement (CSE) sanction terminating her Temporary Cash Assistance (TCA), reducing her Food Assistance Program (FAP) benefits level and terminating her

Medicaid benefits. Respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated October 20, 2016, respondent notified petitioner that her TCA and Medicaid benefits would stop effective October 31, 2016 on the contention that she failed to cooperate with CSE. Additionally, the notice informed her that her Food Assistance Program (FAP) benefits would decrease effective November 1, 2016 for the same reason. On October 25, 2016, petitioner timely requested a hearing challenging Respondent's action.

No representative from CSE was present for this hearing.

During the hearing, the petitioner did not submit any exhibits. Respondent submitted four exhibits, which were entered into evidence as Respondent's Exhibits "1" through "4".

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 was pregnant in her third trimester and had been receiving TCA, FAP and Medicaid benefits for herself.
2. On September 22, 2016, petitioner submitted an online application to continue her benefits. While waiting for her application to be processed, the petitioner gave birth. The case was processed, the newborn was added to the case and petitioner was referred to CSE for cooperation.

3. On October 19, 2016 Department received a data exchange alert on its Data Exchange Inquiry Child Support Sanction screen (DECS), which requests sanctions to be imposed due to failure to cooperate with CSE. The DECS screen was notated with CSE Reason code of "345", See Respondent's Exhibit 3. The Department explained that the alert required it to impose a CSE sanction due to non-cooperation with CSE. Department's policy requires it to apply a CSE sanction against the non-compliant parent in the TCA, FAP and Medicaid Programs. The Department imposed a CSE sanction against the petitioner only and the petitioner's child remained eligible for the FAP and Medicaid benefits.

4. October 20, 2016, respondent mailed a Notice of Case Action to petitioner informing her that her TCA and Medicaid benefits would stop effective October 31, 2016 and that her FAP benefits would decrease from \$357 to \$194 effective November 1, 2016 due to her failure to cooperate with Child Support Enforcement, See Respondent's Exhibit 1.

5. Respondent explained that as the petitioner was pregnant when she applied for the TCA, FAP, and Medicaid programs, she was not yet required to cooperate with CSE yet. The petitioner was required to cooperate with CSE once her child was born. She explained that petitioner had plenty of opportunities to cooperate with CSE because she contacted the Department on a few occasions and was given the telephone number to CSE. She explained that petitioner must contact CSE and find out what she needs to do to have her sanction removed before she can regain eligibility.

6. Petitioner did not dispute the facts presented by the respondent. Petitioner asserted as follows: That she has contacted CSE office and already provided them with

everything she knows about the non-custodial parent. That she believes that her family should not be denied benefits just because CSE does not do its job. Respondent advised petitioner to contact CSE and talk to a supervisor to have her sanction removed. Petitioner is requesting that all her affected benefits be reinstated from the CSE effective date of November 1, 2016.

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. Section 414.095, Florida Statutes, states:

- (6) 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.

10. 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.

11. Respondent must follow the rules. Respondent asserts its action of reducing

FAP and terminating TCA and Medicaid was due to petitioner failing to cooperate with

CSE. In this instant case, CSE requested a sanction against petitioner. However no representative from the Child Support Enforcement office was present for this hearing to give testimony on the sanction request.

12. Section 90.801, Florida Statutes addresses Hearsay and states as follows:

90.801 Hearsay; definitions; exceptions.—

(1) The following definitions apply under this chapter:

(a) A “statement” is:

1. An oral or written assertion; or
2. Nonverbal conduct of a person if it is intended by the person as an assertion.

(b) A “declarant” is a person who makes a statement.

(c) “Hearsay” is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.

(2) A statement is not hearsay if the declarant testifies at the trial or hearing and is subject to cross-examination concerning the statement and the statement is:

(a) Inconsistent with the declarant’s testimony and was given under oath subject to the penalty of perjury at a trial, hearing, or other proceeding or in a deposition;

(b) Consistent with the declarant’s testimony and is offered to rebut an express or implied charge against the declarant of improper influence, motive, or recent fabrication; or

(c) One of identification of a person made after perceiving the person.

13. Fla. Admin. Code 28-106.213 Evidence states:

(3) Hearsay evidence, whether received in evidence over objection or not, may be used to supplement or explain other evidence, but shall not be sufficient in itself to support a finding unless the evidence falls within an exception to the hearsay rule as found in Sections 90.801-.805, F.S.

14. Respondent cannot account for any actions taken by CSE leading to the sanction being requested. While respondent may use a data exchange from CSE to impose a particular sanction, without a representative from CSE, it is considered hearsay evidence in this proceeding.

15. After carefully reviewing the evidence and controlling legal authorities, the undersigned cannot conclude that the imposition of the child support sanction against petitioner was correct. Therefore, respondent's action to reduce the petitioner's FAP and terminate the petitioner's TCA and Medicaid benefits effective November 1, 2016 is reversed. The appeals are remanded to the respondent to determine ongoing eligibility beginning with the month of November 2016 and removing the CSE sanction at issue. Respondent is ordered to reinstate petitioner's TCA based on the household size of two and restore her FAP benefits at the \$357 level effective with the month of November 2016, not duplicating any benefits already received. Additionally, respondent is to restore petitioner's Medicaid benefits effective November 1, 2016. Respondent is to issue notice with appeal rights upon completion of its redetermination.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is **GRANTED**. Department's action to impose a child support sanction against petitioner in the Temporary Cash Assistance, Food Assistance Program, and Medicaid Programs is reversed. Respondent is to take corrective action and reinstate the Temporary Cash Assistance, Food Assistance Program, and Medicaid benefits as explained above.

ANY TEMPORARY CASH, FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

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 December, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Dec 22, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-08015

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 12:30 p.m. on December 2, 2016.

APPEARANCES

For the Petitioner: [REDACTED] pro se

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant 1

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

Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibit "1" through "5". The record was closed on December 2, 2016.

FINDINGS OF FACT

1. On August 15, 2016, the petitioner (age 42) submitted an application for Food Assistance and Family Medicaid for her and her 18 year old child. The application was denied on September 14, 2016, due to not receiving the required documentation to determine eligibility.
2. On September 29, 2016, the petitioner submitted the requested documentation for the August 15, 2016 application. Therefore, the Department reused the petitioner's August 15, 2016 application. Medicaid is the only issue.
3. To be eligible for Family Medicaid, the petitioner must have children, under age 18, living in the home or be pregnant.
4. Petitioner is not pregnant and her child is age 18; therefore, the petitioner is not eligible for Family Medicaid.
5. To be eligible for Adult Medicaid (SSI-Related 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 determining Medicaid Disability eligibility for the Department.
6. The petitioner last applied for disability through the SSA on or about January 2016. SSA denied the petitioner disability on June 16, 2016. Petitioner is appealing the SSA denial through an attorney; an appeal date has not been scheduled.
7. On September 30, 2016, the Department electronically sent DDD the petitioner's documentation for review. DDD denied the petitioner Medicaid Disability on October 5, 2016, due to adopting the SSA denial decision.

8. On October 6, 2016, the Department mailed the petitioner a Notice of Case Action, notifying she was denied Medicaid, due to not meeting the disability requirements.

9. Petitioner stated that the SSA is aware of all of her medical conditions and her attorney will present all of her medical records at the SSA appeal hearing.

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. 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 pregnant women, and (2) SSI-Related Medicaid for disabled adults and adults 65 or older.

13. Florida Administrative Code R.65A-1.705 Family-Related Medicaid General Eligibility Criteria states:

(1) Technical eligibility criteria of living in the home of a specified relative, age, residence, citizenship and deprivation apply to coverage groups as follows...

(7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested...

(c) 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...**For the parent to be eligible, there must be at least one child under age 18...**(emphasis added)

(e) If assistance is requested for a pregnant woman who is not living with the father of the unborn child, the woman...

(f) If assistance is requested for a pregnant woman who is living with the father of the unborn child, the woman, the unborn child, the father of the unborn child...

14. The above authority explains for a parent to be eligible for Family-Related Medicaid, there must be a least one child under age 18 in the home.

15. The evidence submitted establishes that the petitioner is not pregnant and her child is 18 years of age. Therefore, the petitioner is not eligible for Family-Related Medicaid.

16. 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..."

17. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations of Disability in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this section.

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

- (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-
- (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
 - (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
 - (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-
 - (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
 - (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility...

18. The above authority explains that the SSA determination is binding on the Department.

19. In accordance with the above authority, the Department adopted the SSA June 2016 denial decision and also denied the petitioner's Medicaid Disability.

20. Petitioner testified that the SSA is aware of all of her medical conditions and her attorney will present her medical records at the SSA hearing.

21. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof. The undersigned concludes the Department's action to deny the petitioner Medicaid Disability is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 22 day of December, 2016,

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

Dec 27, 2016

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-08046

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 01 [REDACTED]
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 12, 2016 at 11:35 a.m. Eastern and 10:35 a.m. Central.

APPEARANCES

For Petitioner: [REDACTED], Mother

For Respondent: Cindy Henline, Medical/Healthcare Program Analyst,
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent's denial of Petitioner's request for continued Prescribed Pediatric Extended Care (PPEC) services for full days (up to twelve hours), Monday through Friday for the certification period of October 22, 2016 to April 19, 2017,

was correct. Because the matter under appeal involves a termination of PPEC services, the burden of proof is assigned to Respondent.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Dr. Rakesh Mittal, Physician Consultant for eQHealth Solutions, Inc.

Respondent's Exhibits 1 and 2 were entered into evidence.

Administrative notice was taken of Florida Statutes 409.815, Florida Administrative Code Rules 59G-1.010 and 59G-4.290 and the Respondent's Prescribed Pediatric Extended Care Services Coverage and Limitations (PPEC) Handbook issued September 2013.

Petitioner has been administratively approved to continue receiving PPEC services 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 one-year-old male Medicaid recipient. He has been diagnosed with [REDACTED]

2. Petitioner no longer wears an A/B monitor 24 hours per day but wears it at nap time and during sleep. Petitioner has not had any A/B monitor alarms for the past 6 months. (Respondent's physician consultant explained an [REDACTED] (A/B) monitor measures the breathing and heart rate.)

3. Petitioner is on a regular diet. He lives with his mother and three siblings. The mother is not working at this time. Petitioner attends PPEC from 7:30 a.m. to 4:30 p.m. and receives speech therapy and occupational therapy there.

4. The Agency contracts with a Quality Improvement Organization (QIO), eQHealth Solutions, to perform medical utilization reviews for PPEC services through a prior authorization process for Medicaid State Plan beneficiaries. The prior authorization review determines the medical necessity of the 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 of service requested. A review is conducted for every new certification period, and, if necessary, a request for modification may be submitted by the provider during a certification period.

6. On October 18, 2016, a request to continue PPEC full services (up to 12 hours per day) Monday through Friday was submitted by the provider on behalf of the Petitioner for the certification period October 22, 2016 to April 19, 2017.

7. On October 21, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on October 21, 2016, which notified Petitioner that PPEC full and partial services were denied. The rationale for the denial was that the PPEC services were not medically necessary as defined in 59G-1.010 (166), Florida Administrative Code.

8. On October 21, 2016, a "Notice of Outcome-Denial" was issued to Petitioner's provider and gives the following clinical rationale:

The patient is a 1-year-old with a history of [REDACTED]. He continues to use the A/B monitor while sleeping and has had no alarms in the past 6 months. The patient uses the nebulizer four times per day. The patient is not on a complex medication regimen. The clinical information provided does not support the medical necessity of the requested PPEC services. The patient no longer appears to have a skilled need and does not meet the medical necessity requirement of PPEC services.

9. On October 26, 2016, Petitioner requested a reconsideration review.

10. Respondent completed the reconsideration review on October 28, 2016 and sent a Notice of Reconsideration to the Petitioner on November 9, 2016. The notice upheld the initial denial.

11. On November 9, 2016, a Notice of Reconsideration Determination was sent to the provider stating the following:

For the Reconsideration Review, the provider submitted a request for reconsideration and a file containing information that supported the following [REDACTED] inhalation q 4 hrs pm wheezing; [REDACTED] inhalation BID (twice a day) and [REDACTED] once daily. The mother is a single mother of 4 children who states she is not working at this time. The submitted documentation does not support the medical necessity for PPEC services. The child's medication regimen is uncomplicated and no apnea events have been reported in 6 months. Recommend upholding the initial PR's denial of PPEC services from 10/22/16 through and including 4/19/16. Medical necessity for PPEC has not been demonstrated.

12. On October 31, 2016, Petitioner filed a timely request for a fair hearing.

13. Respondent's physician reviewer witness reviewed Petitioner's medical status as reflected in paragraph 1 above. He reviewed the supporting documentation submitted by Petitioner in support of the request for continued PPEC services. He observed that Petitioner was previously being monitored 24 hours for his heart rate and respiration

and PPEC services were appropriate. Petitioner now only needs to be monitored at nap time and when sleeping. Mother is available to monitor Petitioner since she is not working. Respondent's witness observed the documentation did not provide any information indicating Petitioner needs skilled nursing services and, therefore, he agrees with the denial of PPEC services for Petitioner.

14. Petitioner's mother stated her son still needs to get his therapy at PPEC.

15. Respondent's physician reviewer witness explained therapy services can be provided outside of PPEC.

16. Petitioner's mother did not know what skilled nursing services, if any, her son is receiving at PPEC.

CONCLUSIONS OF LAW

17. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

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

19. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

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

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

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.”

22. Rule 59G-1.010 (164), Florida Administrative Code defines “medically complex” as: a person who “has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.”

23. Rule 59G-1.010 (165), Florida Administrative Code defines "medically fragile" as:

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

24. Because Petitioner is under twenty-one-years-old, the requirements of Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) must be considered.

Section 409.905, Florida Statutes, Mandatory Medicaid services, provides that Medicaid services for children must include:

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

25. In reviewing the appeal for compliance with EPSDT requirements, PPEC services are part of Florida's Medicaid State Plan of services. The agency has administratively approved ongoing PPEC services pending the outcome of this appeal. Therefore, Respondent would need to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

26. The Florida Medicaid Prescribed Pediatrics Extended Care Services Coverage and Limitations Handbook- September 2013 (PPEC Handbook) is promulgated by Rule 59G-4.260, Florida Administrative Code, and provides the following purpose and definition of PPEC on page 1-1:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

27. On page 2-1, the PPEC Handbook provides the following requirements for those who can receive PPEC services:

To receive reimbursement for PPEC services, a recipient must meet **all** of the following criteria [emphasis added]:

- Be Medicaid eligible.

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

28. On page 2-5, the PPEC Handbook provides a list of excluded services:

The Medicaid PPEC rate does not reimburse for the following services:

- Baby food or formulas.
- Total parenteral and enteral nutrition.
- Mental health and psychiatric services.
- Supportive or contracted services which include speech therapy, occupational therapy, physical therapy, social work, developmental evaluations, and child life.

29. Respondent's physician reviewer witness explained Petitioner was previously monitored 24 hours a day for his breathing and heart rate, but now only needs to be monitored at nap time and when he sleeps. The mother is available to provide this monitoring.

30. Petitioner's mother stated her son needed to continue to receive his therapy services.

31. Respondent's witness responded the therapy services can be provided outside of the PPEC setting.

32. After reviewing the evidence and testimony, as well as the above cited authorities, including the EPSDT requirements, the undersigned finds Petitioner does not have a current need for skilled nursing services. PPEC services, therefore, are not medically necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If Petitioner disagrees with this decision, Petitioner may seek a judicial review. To begin the judicial review, Petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. Petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. Petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 27 day of December, 2016,
in Tallahassee, Florida.



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

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

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

FILED

Dec 22, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-08077

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 [REDACTED]
UNIT: 88313

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 14, 2016 at 10:03 a.m. (Eastern Time).

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Pat Hernandez, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 5, 2016 denying his application for Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was scheduled as a face-to-face hearing in [REDACTED], Florida on December 12, 2016. The petitioner called morning of the hearing to advise he was

unable to appear in person and requested reschedule to a telephonic hearing. The undersigned rescheduled the hearing for December 14, 2016.

The Department provided evidence to the undersigned on December 9, 2016. The petitioner did not have the evidence prior to the hearing. He requested the hearing proceed without him having a copy of the evidence.

The undersigned left the record open through December 19, 2016 for the petitioner to have opportunity to receive and review the documents. The petitioner was to contact the undersigned if he needed a reconvene of the hearing no later than December 19, 2016 to receive more clarification.

The petitioner did not contact the undersigned as of December 19, 2016. The record closed on December 19, 2016.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on November 4, 2016. The petitioner was 45 years old at the time of his application. The petitioner reports no minor children in his household.

2. The petitioner filed an application for Supplemental Security Income (SSI) and Disability with Social Security Administration (SSA) on May 13, 2016.

3. The Department issued a Notice of Case Action on November 9, 2016 informing the petitioner of a need for a telephone interview on November 28, 2016 to complete an interview. The letter noted the interview would discuss the petitioner's SSA status, disabling condition, and medical treatment.

4. The Department recorded in case notes on November 28, 2016 that an intake interview was completed with the customer.

5. The Department issued a Notice of Case Action on December 5, 2016 denying the petitioner's application for Medicaid due to "You or a member(s) of your household do not meet the disability requirement".

6. SSA denied the petitioner's application for SSI and disability on July 13, 2016. The reason given for the denial was "N32" which means "Non-pay – Capacity for substantial gainful activity – other work, no visual impairment."

7. The petitioner stated his conditions include [REDACTED] symptoms, [REDACTED]. The petitioner is also concerned he may have the Zika virus, but has not been diagnosed with it as of the hearing.

8. The petitioner appealed the July 2016 SSA decision on August 25, 2016.

9. The petitioner stated his condition has not changed since the July 2016 denial.

10. The petitioner has reported all conditions to the SSA for review.

11. The petitioner is concerned that he is unable to obtain the prescriptions to treat his conditions.

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 undersigned explored eligibility first under Family-Related Medicaid groups as the petitioner's application was marked for "Family-Related Medicaid". The petitioner does not have a minor child in the home according to his November 4, 2016 application. The Family-Related Medicaid Program benefit rules are set forth in the Florida Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid program; the petitioner must be pregnant or have a dependent minor child residing in the home. The undersigned concludes the petitioner does not meet the criteria for Family-Related Medicaid Program benefits.

15. The definition of Med-AD Demonstration Waiver is found in Fla. Admin. Code R. 65A-1.701 (20) and states:

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

16. Fla. Admin. Code R. 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), 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).

17. 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.)

18. 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.

19. The undersigned explored potential eligibility for Medicaid for the petitioner under the SSI-Related Medicaid program. The petitioner was 45 years old at the time of application. He has not been established as disabled. As he is under age 65, a disability determination is required for eligibility determination in the SSI-Related Medicaid program.

20. The findings show the petitioner applied for disability with the Social Security on May 13, 2016. The findings show the petitioner applied for Medicaid with the Department on November 4, 2016. The findings also show SSA determined the petitioner was not disabled on July 13, 2016 and that decision was appealed on August 25, 2016. According to the above controlling authorities, a decision made by SSA within

12 months of the Medicaid application is controlling and binding on the state agency **unless** the applicant reports a disabling condition not previously reviewed by SSA. In this case, the petitioner reported there were no new disabling conditions.

21. Based on the evidence and testimony presented, the above-cited rules and regulations, the undersigned concludes with the SSA binding decision on the agency, the denial of SSI-Related Medicaid remains appropriate.

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 22 day of December, 2016,

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

FINAL ORDER (Cont.)

16F-08077

PAGE - 8

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

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

FILED

Dec 22, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-08097

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 [REDACTED]
UNIT: 88007

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:30 p.m. on December 8, 2016.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit exhibits. The respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on December 8, 2016.

FINDINGS OF FACT

1. On May 26, 2016, the petitioner (age 43) submitted a web application for SSI-Related Medicaid for himself.
2. To be eligible for SSI-Related Medicaid, the petitioner must be age 65 or older, or considered blind/disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD determines Medicaid Disability eligibility for the Department.
3. Petitioner is not age 65 or older and has not been considered blind or disabled by the SSA or DDD.
4. Petitioner applied for disability through the SSA on May 16, 2016. SSA denied the petitioner disability on October 17, 2016. Petitioner is appealing the SSA denial through an attorney.
5. In 2011 the petitioner suffered from a [REDACTED] and was [REDACTED] for two weeks. As a result, the petitioner now suffers from [REDACTED]
[REDACTED]
6. The petitioner does not have new or worsened medical conditions that the SSA is not aware of.
7. Due to the Department's backlog on applications, the Department electronically sent the petitioner's documents to DDD on July 28, 2016 for review.

8. On October 17, 2016, DDD denied the petitioner disability, due to adopting the SSA denial decision.

9. On October 19, 2016, the Department mailed the petitioner a Notice of Case Action, notifying Medicaid was denied, due to not meeting the disability requirements.

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 Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations of Disability in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this

section.

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

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

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

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility...

13. The above authority explains that the SSA determination is binding on the Department.

14. In accordance with the above authority, the Department denied the petitioner's Medicaid, due to adopting the SSA denial decision.

15. Petitioner testified that he is appealing the October 2016 SSA denial through an attorney. And he does not have new or worsened medical conditions that the SSA is not aware of.

16. In careful review of the cited authority and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes the Department's action to deny the petitioner Medicaid Disability is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 22 day of December, 2016,

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

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

Dec 21, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-08110
APPEAL NO. 16F-09027

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 [REDACTED]
UNIT: 88322

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on November 30, 2016 at 9:36 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent Barbara Dean, supervisor

STATEMENT OF ISSUE

1. The petitioner is appealing the respondent's action to deny her September 26, 2016 application for Food Assistance Program (FAP) benefits. The petitioner carries the burden of proof by preponderance of evidence.

2. The petitioner is appealing the termination of Medicaid benefits. The respondent carries the burden of proof by preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented four exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 4. The petitioner did not present any exhibits. The record was held open until December 5, 2016, for the respondent to provide the authority on sponsorship. The information was received, entered into evidence and marked as Respondent's Exhibit 5. The record was closed on December 5, 2016.

FINDINGS OF FACT

1. The respondent approved pregnancy Medicaid for the petitioner based on an application dated August 29, 2016.
2. On September 26, 2016, the petitioner submitted an application for FAP benefits. She is the only assistance group member. She is employed and is paid weekly. Her expenses are rent of \$500 and telephone of \$50.
3. On September 29, 2016, the respondent mailed a Notice of Case Action to the petitioner requesting proof of all gross income for the last four weeks and income/assets for her Immigration and Naturalization Service (INS) sponsor (JD). It was due by October 10, 2016.
4. On October 27, 2016, the respondent reviewed the petitioner's recertification application and found she did not provide her sponsor's income/assets as requested. The respondent denied the application for FAP benefits for failure to provide her sponsor's income/assets. The pregnancy Medicaid was terminated as the sponsor's income/assets was not verified when the initial Medicaid application was approved. A notice was sent on October 27, 2016, notifying the petitioner of the denial.

5. On November 1, 2016, the petitioner requested a hearing to challenge the respondent's action.
6. The petitioner asserted she does not know her sponsor as it was her father who arranged her sponsorship. She no longer lives with her father.
7. The respondent advised the petitioner that she can complete an indigent form which will exempt her from providing her sponsor's income and assets. The respondent asserted that according to its policy her sponsor's information is needed until she meets an exemption. The respondent asserted that the case worker attempt to contact her to complete the indigent paperwork.

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.

The FAP issue will be addressed first

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

(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility...**(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification,**

or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. **For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later...If the applicant does not provide required verifications or information by the deadline date the application will be denied...**

11. The above authority sets the requirement for the Department to verify certain information and to give the applicant written notice with a deadline for its return. If the required verification is not provided within the ten days or by the due date, the application will be denied the application. The petitioner's sponsor's income was needed to determined eligibility. The Department provided the petitioner with a written request and gave her ten days to provide.

12. The Code of Federal Regulations at 7 C.F.R. section 273.4 sets forth the authority on sponsorship. It states:

(c) Households containing sponsored alien members—(1) Definition. A sponsored alien is an alien for whom a person (the sponsor) has executed an affidavit of support (INS Form I-864 or I-864A) on behalf of the alien pursuant to section 213A of the INA.

(2) Deeming of sponsor's income and resource. For purposes of this paragraph (c)(2), only in the event a sponsored alien is an eligible alien in accordance with paragraph (a) of this section will the **State agency consider available to the household the income and resources of the sponsor and spouse. For purposes of determining the eligibility and benefit level of a household of which an eligible sponsored alien is a member, the State agency must deem the income and resources of sponsor and the sponsor's spouse, if he or she has executed INS Form I-864 or I-864A, as the unearned income and resources of the sponsored alien. The State agency must deem the sponsor's income and resources until the alien gains U. S. citizenship, has worked or can receive credit for 40 qualifying quarters of work as described in paragraph (a)(6)(ii)(A) of this section, or the sponsor dies.**

...

(iii) The State agency must consider as income to the alien any money the sponsor or the sponsor's spouse pays to the eligible sponsored alien, but only to

the extent that the money exceeds the amount deemed to the eligible sponsored alien in accordance with paragraph (c)(2)(i) of this section.

(3) Exempt aliens. The provisions of paragraph (c)(2) of this section do not apply to:

(i) An alien who is a member of his or her sponsor's food stamp household;

(ii) An alien who is sponsored by an organization or group as opposed to an individual;

(iii) An alien who is not required to have a sponsor under the Immigration and Nationality Act, such as a refugee, a parolee, an asylee, or a Cuban or Haitian entrant;

(iv) An indigent alien that the State agency has determined is unable to obtain food and shelter taking into account the alien's own income plus any cash, food, housing, or other assistance provided by other individuals, including the sponsor(s). Prior to determining whether an alien is indigent, the has signed an affidavit of support...

(5) Awaiting verification. **Until the alien provides information or verification necessary to carry out the provisions of paragraph (c)(2) of this section, the sponsored alien is ineligible...** (emphasis added)

13. The above authority states that a sponsor's income and resources is required before the eligibility of the alien can be determined. It also gives the authority to deny the application if the information is not provided.

Medicaid benefits will now be addressed.

14. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at passage 2630.0202.01, addresses Noncitizens Sponsored On or After 12/19/97 (MFAM). It states:

Noncitizens whose sponsor signed an Affidavit of Support, USCIS Form I-864, on or after December 19, 1997, will have all of the income and assets of the sponsor and the sponsor's legal spouse considered in the eligibility determination for Medicaid. The income and assets of the sponsor and the sponsor's spouse will continue to be counted until the noncitizen:

1. becomes a naturalized citizen,
2. leaves the country,
3. dies,
4. can be credited with 40 qualifying work quarters (refer to Chapter 1430)
5. the sponsor dies and there is no joint sponsor.

Note: The income and assets of the sponsor's spouse will not be counted when the spouse does not reside in the home of the sponsor. Exceptions to this policy are found in listed below.

15. The policy Manual passage 2630.0202.02 addresses Exemptions From Sponsored Deeming (MFAM). It states:

Noncitizens whose sponsor signed an Affidavit of Support, USCIS Form I-864, on or after December 19, 1997, are exempt from having the income or assets of the sponsor or the sponsor's spouse included in their eligibility determination in the following situations:

1. a noncitizen sponsored by an organization or group rather than an individual;
2. a noncitizen sponsored prior to December 19, 1997;
3. a noncitizen not required to have a sponsor under the Immigration and Nationality Act (INA), such as a refugee, a parolee, one granted asylum, a Cuban/Haitian entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980, or resident noncitizen who previously held a refugee status;
4. a noncitizen who meets battered noncitizen criteria (see Chapter 1430) may be exempt for periods of up to 12 months total from the date of the battered noncitizen determination which is renewable annually for 12 months at the time;
5. a noncitizen who meets indigent criteria (see passage below) may be exempt for periods of up to 12 months total from the date of the indigent determination which is renewable annually for 12 months at the time; and
6. The individual is applying for Emergency Medicaid for Aliens (EMA).

16. The above authority informs that the applicant is required to provide her sponsor's income and assets in order to determine her Medicaid benefits. The respondent requested written verification of the sponsor's income and assets but it was not returned. The petitioner claimed she does not know her sponsor and does not live with her father anymore. The respondent informed the petitioner she could complete indigent paperwork and be exempted from providing her sponsor's information. The petitioner has not completed the paperwork as of the

date of this hearing. Ultimately, it is the petitioner's responsibility to provide the requested information to the respondent.

17. The undersigned concludes there was no evidence presented to prove the petitioner attempted to get the requested sponsor information. The petitioner was provided with written notification that her sponsor's information was required. Initially, the respondent erred when it approved the petitioner's Medicaid benefits without counting the sponsors income and assets; however, the Department is bound to follow the authorities when determining eligibility and to take corrective action. The respondent's action to terminate Medicaid benefits is correct and holds until the sponsor's income and assets are provided.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal for FAP benefits is denied. The respondent's decision is upheld.

The petitioner's appeal for Medicaid benefits 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.

DONE and ORDERED this 21 day of December, 2016,
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

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

Dec 20, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-08186

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 [REDACTED]
UNIT: 883DT

RESPONDENT.

/

FINAL ORDER

The undersigned convened an administrative hearing by phone in the above-referenced matter on November 29, 2016 at 3:00 p.m.

APPEARANCES

For Petitioner: [REDACTED] pro se

For Respondent: Mary Lou Dahmer, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's October 26, 2016 application for Family-Related Medicaid benefits is correct. The burden of proof is assigned to the petitioner by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner submitted no exhibits at the hearing. Respondent was represented by Mary Lou Dahmer with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). Respondent

submitted five exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" – "5".

FINDINGS OF FACT

1. On June 10, 2016, the petitioner indicated to the respondent that she did not wish to cooperate with the Department of Revenue Child Support Enforcement Unit (CSE) in regards to her child's father. Petitioner's Family-Related Medicaid benefits were denied effective June 1, 2016.
2. On October 26, 2016, the petitioner submitted a recertification application for Food Assistance (FA) and Family-Related Medicaid benefits. FA benefits are not an issue under appeal. The application listed the petitioner and her child as the only household members; the petitioner not claiming to be disabled; and the petitioner requesting Medicaid benefits for herself due to some health issues.
3. On October 26, 2016, the petitioner stated to the respondent she did not wish to cooperate with CSE in regards to her child's father.
4. On October 27, 2016, the respondent mailed the petitioner a Notice of Case Action indicating her October 26, 2016 Medicaid application was denied as "You or a member(s) of your household is not eligible due to failure to cooperate with child support enforcement. No household members are eligible for this program". The notice also indicated the petitioner's child remained eligible for Medicaid benefits.
5. Petitioner explained that if she cooperates with CSE she would receive less money from her child's father or her child's father would no longer pay the bills.

6. Petitioner explained she requested Medicaid for herself as she has health issues that need medical attention. Furthermore, the petitioner would like her health issues addressed so she can find employment.

7. Respondent explained that in order for the petitioner to receive Family-Related Medicaid benefits, she would have to cooperate with CSE in regards to child's father.

8. Respondent explained a few technical requirements to receive Family-Related Medicaid benefits are having minor children living in the home or being pregnant.

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-1.705(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...

12. 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 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.

13. 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...

14. 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...

15. 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. Petitioner has never claimed good cause and is not currently pregnant; therefore, she is required to cooperate with CSE to receive Family-Related Medicaid benefits.

16. On June 10, 2016 and on October 26, 2016, the petitioner explained to the respondent she did not wish to cooperate with CSE in regards to her child's father; therefore, the respondent was correct to deny the petitioner's October 26, 2016 application for Family-Related Medicaid benefits.

17. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof in establishing the respondent incorrectly denied her October 26, 2016 application for Family-Related Medicaid benefits for herself.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 20 day of December , 2016,

in Tallahassee, Florida.

Mary Jane Stafford

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

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

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

FILED

Nov 14, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06639

PETITIONER,

Vs.

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

And

MAGELLAN COMPLETE CARE,

RESPONDENTS.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 10, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's partial denial of the petitioner's request for dental services (deep dental cleaning) was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as a witness for the respondent was Michelle Rigler, Compliance Officer, from Magellan Complete Care, which is the petitioner's managed health care plan. Also present as witnesses for the respondent were Omeisha Smith, Complaints and Grievance Specialist, and Dr. Frank Mantega, Dental Consultant, from DentaQuest, which reviews dental claims on behalf of Magellan. Magellan was included as an additional respondent in this proceeding since it is the petitioner's health plan.

The respondent, Magellan, submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Case Summary, Authorization Request, Denial Notice, Dental Criteria, and Dental Plan Provisions.

FINDINGS OF FACT

1. The petitioner is a fifty (50) 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 from Magellan Complete Care, which utilizes DentaQuest for review of requests for dental services.
2. On or about August 12, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Magellan to perform deep dental cleaning of the upper and lower portions of his mouth (upper right, upper left, lower right, lower left quadrants). On or about August 16, 2016, Magellan

and/or DentaQuest denied the request based on medical necessity considerations. The notice specified the following reasons for the denial:

Your teeth must have noticeable bone loss or show on an x-ray that there is a hard substance built up on the root of the tooth. Your x-rays do not show that you have these issues.

3. The petitioner stated he needs the deep dental cleaning because he has [REDACTED]. He stated he has lost molars on the lower right side of his mouth and another tooth in his upper arch and he can only chew on one side of his mouth.

4. The respondent's witness, Dr. Mantega, stated that the requested procedure code (4341) is applicable only when there are 4 teeth per quadrant. Another procedure code for deep cleaning (4342) is applicable when there are 1-3 teeth per quadrant, and Dr. Mantega stated this procedure code would probably be approved for the petitioner.

5. Dental services under the Medicaid State Plan in Florida are provided in accordance with the respondent AHCA's Florida Medicaid Provider General Handbook ("Medicaid Handbook"), effective July 2012 and the Dental Services Coverage Policy ("Dental Policy"), effective May 2016.

CONCLUSIONS OF LAW

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

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. The Medicaid Handbook and the Dental Policy are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

11. 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.

12. 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.

13. Managed care plans, such as Magellan, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Policy.

14. Although the initial denial notice indicated the requested services were denied due to medical necessity considerations, the testimony at the hearing indicated the services would probably be approved if a different procedure code was requested by the provider. Accordingly, the undersigned concludes the petitioner has not demonstrated the requested services should have been approved by DentaQuest. The petitioner should work with his provider to re-submit the request for services with the applicable procedure codes.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

FINAL ORDER (Cont.)

16F-06639

PAGE - 6

the court fees required by law or seek an order of indigence to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 14 day of November , 2016,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
MAGELLAN HEARINGS UNIT

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

FILED

Nov 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16N-00084

PETITIONER,

VS.

ADMINISTRATOR

[REDACTED]
[REDACTED]
[REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on October 11, 2016 at 9:33 a.m., at [REDACTED], in [REDACTED], Florida.

APPEARANCES

For the Petitioner: [REDACTED], sister and legal guardian.

For the Respondent: Sid Roberts, Administrator

ISSUE

At issue is whether the respondent's intent to discharge the petitioner from the facility because her health has improved sufficiently so that she no longer needs the services provided by the nursing facility 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. § 483.12.

PRELIMINARY STATEMENT

Present as witness for the petitioner was [REDACTED], Long-term Care, Ombudsman Program.

Present as witnesses for the respondent were Sharon Montgomery, business office manager, Arilea Fenty, social services director, Rocky Vincente, assistant director of nursing, and Darlene Thompson, director of nursing.

At the request of the undersigned, the Agency for Health Care Administration (AHCA) conducted an on-site inspection of the facility and found no violations.

The petitioner presented one exhibit which was accepted, entered into evidence and marked as Petitioner's Composite Exhibit 1. The respondent presented one exhibit, which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The AHCA survey letter was entered as Hearing Officer's Exhibit 1.

FINDINGS OF FACT

1. The petitioner (age 63) entered the nursing facility on May 20, 2016. She came from a facility that was being renovated. She entered the facility as a long-term skilled care resident. She was approved for Medicaid and had a patient responsibility of \$222.
2. On July 20, 2016, the petitioner was seen by Dr [REDACTED], her attending physician. After visiting, he updated the resident's progress notes with the following: "No complaints; She wants to go to an ALF. Wc ridden; However; she is able to take care ADL VSS; BP 125/75. PE no exam, CT scan Chest done at JMC; results are pending. ASSESSMENT& PLAN: Tobacco; Hypertension, Await CT results; D/w CM resident is appropriate for ALF."

3. On August 17, 2016, the respondent issued a Nursing Home Transfer and Discharge Notice to the petitioner informing her that she was to be discharged from the nursing facility effective September 17, 2016. This action was being taken because her health had improved sufficiently that she no longer needed the services of the facility. In the support notes section of the Nursing Home Transfer and Discharge Notice was the comment, "the petitioner has supervision with ADL's, transfers independently from bed to chair, able to walk 50 feet or more and moves wheelchair." The same notice was delivered to the petitioner's legal guardian's address by FedEx on August 21, 2016. The petitioner's representative received the notice after August 21, 2016, as she was not in Florida at the time of delivery. However, she was informed of this before that date via telephone by the petitioner.
4. On August 18, 2016, the petitioner's representative requested a hearing to challenge the Nursing Home's Transfer and Discharge action.
5. No medical records were submitted into evidence to support the respondent's contention that the petitioner's health had improved sufficiently so that she no longer need skilled services.
6. The facility's representative asserts that the petitioner can walk 200 feet and would be more social in an ALF.
7. The petitioner's representative believes the petitioner is unable to function in an ALF. She asserts that the petitioner's health is at risk as she is having blinding headaches and has a history of [REDACTED]. She is awaiting the result of a CT scan and further evaluation. The petitioner's representative argued that the Nursing Home

Discharge Notice was an improper notice as it was given to the petitioner who signed it prior to giving it to the petitioner's legal guardian.

CONCLUSIONS OF LAW

8. 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.

9. Federal Regulations appearing at 42 C.F.R. § 483.12, Admission, transfer and discharge rights, sets forth the limited reasons a Medicaid or Medicare certified nursing facility may involuntarily discharge a resident and states in part:

(a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) 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

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) 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. 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

(vi) The facility ceases to operate.

10. The above-cited authorities set forth the conditions which must exist for a nursing home to involuntarily discharge a resident.

11. In this case, the petitioner was given the notice on August 17, 2016, indicating that her health had improved sufficiently enough that she no longer needed the services provided by the facility and she would be discharged on September 17, 2016. Upon receiving the notice, the petitioner signed it. The same notice was delivered to the petitioner's representative's address by FedEx on August 21, 2016. At the hearing, the petitioner's representative argued that the notice was improperly issued as she was the legal guardian but a copy of the notice was given to the petitioner, who signed it. The petitioner's representative argued that the petitioner had no authority to sign any legal documents. On August 18, 2016, the petitioner's representative requested a hearing. As the hearing was timely requested, the petitioner was not harmed by the by FedEx delivery date.

12. Section 400.0255 (7) (a), Florida Statutes, states, "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..."

13. 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.

14. The above regulations stipulate that before the facility discharges a resident under any of the circumstances referenced above, the resident's medical records must be documented by the resident's physician showing the reason for the discharge/transfer. In this case, the Nursing Home Transfer and Discharge Notice was issued on August 17, 2016, with the discharge to be effective September 17, 2016; however, the only documentation pertaining to the petitioner's readiness for an ALF was the progress notes dated July 20, 2016 which was input by her attending physician. The notes stated, "she is able to take care ADL" and it also states "await CT results" but it did not address how they relate to the petitioner's readiness to be discharged from a medical standpoint. No medical records to support the decision to discharge the petitioner were submitted, nor was any testimony from the physician given at the hearing. The respondent did not present medical evidence demonstrating that the petitioner had improved sufficiently so that she no longer required the services of a long-term skilled facility. The physician's statement to support the discharge was inconclusive as the petitioner's CT scan was still pending.

15. The hearing officer concludes that the reason for the discharge was provided in federal regulation (42 C.F.R. § 483.12), however, the facility failed to provide adequate documentation in the medical record by the physician, as required by the regulations. The facility has not met its burden of proof and the action to discharge the petitioner is not upheld at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the petitioner's appeal is GRANTED. The facility may not proceed with the discharge of the petitioner at this time.

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 November, 2016,
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
[REDACTED], Respondent
Ms. Arlene Mayo-Davis
Agency for Health Care Administration
[REDACTED]
[REDACTED]

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

FILED

Nov 28, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16N-00088

PETITIONER,

Vs.
ADMINISTRATOR

[REDACTED]
[REDACTED]
[REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on October 11, 2016, at 2:00 p.m. a [REDACTED], Florida.

APPEARANCES

For the Petitioner: [REDACTED] father

For the Respondent: Michael Garcia, Director of Nursing

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. § 483.12.

PRELIMINARY STATEMENT

At the hearing, the respondent presented one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any exhibits. A letter dated September 12, 2016, 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] on September 6, 2016 and found no violations. This was entered into evidence and marked as Hearing Officer Exhibit 1.

Present for the petitioner was [REDACTED], mother of the petitioner, [REDACTED] from the Ombudsman Program and [REDACTED], Sunshine care coordinator.

Present for the respondent were Keslerme Thelemaque, administrator, Stacy Valdivia, regional vice president, Amiler Coile, social services director, Ashley Simpson, assistant administrator, Jeanetta Watts, nursing unit manager and Sherrian Daley, assistant director of nurses. The record was closed October 11, 2016.

After review of the evidence the undersigned found that the Nursing Home Transfer and Discharge Notice and the AHCA survey letter was not entered into evidence. An interim order to reopen the record and admit those exhibits into evidence was issued on November 9, 2016, without the attachment. An amended interim order was issued on November 16, 2016, with the attachment. Seven days were allowed for any objections. No objections were received. The record was reopened and the Nursing Home Transfer and Discharge Notice was entered into evidence and marked as Petitioner's Exhibit 1. The AHCA survey letter was entered into evidence marked as Hearing Officer's Exhibit 1. The record was closed on November 23, 2016.

FINDINGS OF FACT

1. The petitioner (age 37) was admitted to the respondent's nursing facility on February 20, 2008.
2. In 2014, the nursing facility updated its smoking policy and held monthly meetings to educate the residents about its smoking policy. The petitioner was given a copy of the facility's smoking policy. The facility's smoking policy stated that staff must maintain all smoking materials (e.g. cigarettes, pipes, lighters etc.) for residents who smoke. Residents are prohibited from possessing cigarettes, e-cigarettes and lighters on their person or in their rooms. Residents are only allowed to smoke during designated times and in designated areas (outside on the patio). A staff member must be present during smoking periods. The petitioner's representative acknowledged being aware of the smoking policy.
3. On July 21, 2016, the respondent held a smoking meeting with the petitioner. She was an unsafe smoker and was required to be supervised and wear a smoking apron while smoking.
4. On July 29, 2016, the respondent held another smoking meeting with the petitioner.
5. On August 8, 2016, the petitioner's roommate reported to the nursing unit manager that the petitioner was smoking e-cigarettes in her room.
6. On August 9, 2016, the petitioner's room was searched and two e-cigarettes was found in her room. When questioned by the nursing staff, she admitted to smoking in her room unsupervised. The respondent presented two statements from the nursing

unit manager attesting to the petitioner admitting to smoking and the discovery of the e-cigarettes.

7. On August 9, 2016, the facility informed the petitioner's mother that the petitioner was in noncompliance with the facility's smoking policy as she was found with two e-cigarettes.

8. On August 26, 2016, 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 "Patient non compliant with smoking policy by hiding smoking supplies and smoking in room."

9. The respondent believes the petitioner's unsupervised smoking is a danger to others and is fearful she will continue to smoke while unsupervised which may cause a fire.

10. On August 29, 2016, the petitioner's representative requested a hearing to challenge the respondent's intent to discharge the petitioner.

11. The petitioner wishes to remain in the facility as she has been at the facility for eight years. The petitioner's representative asserted that this was her first violation since the facility revised its smoking policy. He argued that according to the facility's smoking policy page 1-22 a discharge notice is only warranted if continued noncompliance is determined and quoted the following policy on smoking, non-compliance.

Non –Compliance to Smoking Policy:

a). Upon identification of resident non-compliance to smoking policy, a new smoking assessment will be completed and the resident's physician, family or responsible party will be notified.

b). Upon the findings of the smoking assessment, the resident's smoking care plan will be updated as necessary with individual approaches to promote smoking compliance.

c). In the event the resident continues to be non-compliant with smoking policies, the facility will notify the resident, family and/or responsible party of potential discharge, due to resident creating potential for harm of self and/or others.

12. At the hearing the petitioner's mother alleged that the respondent was retaliating for the petitioner's past history of being burnt at the facility.

13. The respondent asserted that the petitioner had violated its smoking policy previously. She had used nicotine gum without a prescription. The respondent only allows the use of nicotine gum when prescribed by a physician.

CONCLUSION OF LAW

14. 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.

15. A nursing facility must inform the residents of all rules and regulations. That information must be done both orally and in writing. In accordance with 42 C.F.R. § 483.10.

(b) Notice of rights and services.

(1) 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. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the

resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

16. The petitioner was given the facility's smoking policy and attended monthly smoking meetings.

17. The Code of Federal Regulation at 42 C.F.R. § 483.12, limits the reasons a nursing facility may discharge a Medicaid or Medicare patient.

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;...

(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or

discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

18. In this case, the petitioner was given a notice on August 26, 2016, indicating that she would be discharged from the facility citing 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.

19. 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.

20. The respondent's reason for discharge is the safety of other individuals being endangered. This is one of the reasons given in the above federal and state law to permit discharge from a facility.

21. The respondent's sole reason for the discharge was the petitioner's violation of their smoking policy, which included smoking unsupervised at non-designated times and having smoking materials in her room or on herself. During weekly safe smoking committee meetings, the dangers of smoking and the facility's smoking policy were explained.

22. The petitioner's representative argued that this is the petitioner's first smoking incident therefore she should at least be given a second chance before any discharge actions are taken. He argued that according to the nursing facility's smoking policy on non-compliance, if non-compliance continues then potential discharge may occur.

23. The respondent argued that the incident on August 8, 2016, was not the petitioner's first violation of the facility's smoking policy. The petitioner had violated it previously when she used nicotine gum without a prescription.

24. 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. § 483.12) for which a nursing facility may involuntarily discharge a resident.

25. 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 28 day of November , 2016,

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]
[REDACTED], Respondent
Ms. Arlene Mayo-Davis
Agency for Health Care Administration
[REDACTED]

Nov 21, 2016

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 16N-00090

PETITIONER,

Vs.

CASE NO.

Administrator

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned at 9:07 a.m. on October 28, 2016, at [REDACTED] & Nursing Center (Facility).

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Malkia Walden, Facility Administrator

STATEMENT OF ISSUE

At issue is whether the respondent's action to discharge the petitioner to the hospital is proper. The respondent carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

Jeanette James, Facility Director of Nursing, appeared as a witness for the respondent. [REDACTED], R.N. Certified Ombudsman, appeared as a witness for the

petitioner. Petitioner submitted one exhibit, entered as Petitioner Exhibit "1".

Respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7".

The record was closed on October 28, 2016.

FINDINGS OF FACT

1. Petitioner, age 56, was admitted to the Facility in November 2012 from the hospital, after suffering a [REDACTED]. The Facility Baker Acted the petitioner to [REDACTED] on August 30, 2016 and refused to readmit the petitioner when she was released from the hospital.

2. On April 26, 2016, an incident occurred with the petitioner and her roommate (BA) that required involvement from the Agency for Health Care Administration (AHCA).

AHCA completed a Nursing Home Federal Report. The report states in part:

Description of Incident

[BA] stated she is afraid of the man in her room, her roommate [petitioner] has been mean and cruel and has poked her.

Facility's Immediate Response

[BA] was immediately moved to a new room. [BA] was assessed for injury, none was found. [BA] denied injury. [Petitioner] was placed on 1 on 1 supervision.

Investigative Findings

[BA] is a 93 year old Caucasian female, alert with confusion with diagnosis of [REDACTED] without behavioral disturbance, [REDACTED] major [REDACTED]

[Petitioner] is a 55 year old African American female, alert and oriented x4 diagnosis of [REDACTED]

[BA] stated the "man" in her room is loud and is mean. [BA] reported roommate threw something at her and it hit her in two places. When asked when this occurred [BA] could not recall. When asked how else her roommate has been mean, [BA] stated, "she's just loud and mean and she always wears that hat or sunglasses.

[Petitioner] was interviewed and denied any physical interaction with [BA]. [Petitioner] stated her roommate gets confused and yells out, sometimes

at the staff or just because. [Petitioner] states she calls for the staff to come assist her roommate when she gets agitated and her roommate sometimes yells at her.

Staff that care for the roommates were interviewed and stated [petitioner] who is in the B bed always keeps the privacy curtain pulled because the light from [BA] lights hurts her eyes and they have never seen [petitioner] enter onto her roommate's side of the room. The staff further stated [petitioner] will call for the staff when she thinks her roommate needs care.

Allegation Substantiated?

No

3. Petitioner claims BA's allegation is incorrect. Petitioner alleges BA is prejudiced against people of color and hallucinates. Petitioner alleges that the Facility is retaliating against her because she contacted the Department of Children and Families, at least three times, to report that the Facility was neglecting BA.

4. On August 16, 2016, an incident occurred with the petitioner and a different roommate (Bed A). Social Service Progress Notes, dated August 16, 2016, written by DG about the petitioner states:

This writer met with resident to discuss concern voiced by her roommate. This writer requested resident turn off music on computer while away from computer, in the shower. The resident refused, referring to roommate's TV on while out of room. This writer asked if roommate's TV is turned off while out of the room, would resident turn off music while in the shower. Resident replied no, stating the music prevented demonic forces from permeating her area of the room. Resident was referred to psych services for evaluation, who attempted to evaluate resident the same day. Resident refused to cooperate with psych evaluation and stated the demonic forces were coming from her roommate's TV show. This writer and DON met with the resident to discuss psych evaluation, resident was not receptive to need of services to ensure psychosocial well-being.

5. Also on August 16, 2016, Doctor Deshmukh (Psychiatrist) prescribed the petitioner psychosis [REDACTED] mg in the morning and [REDACTED] mg at night.

6. Social Service Progress Notes, dated August 19, 2016, written by DG about the petitioner states:

Staff reports resident continues to refuse [REDACTED] continues to play music loudly in room. Resident was evaluated by the Medical Director, who determined the resident can possibly pose a danger to staff and other residents and initiated a Baker Act. NHA and DON made aware. Possible receiving facilities were contacted for bed availability. 1:1 supervision continues on resident.

7. Social Service Progress Notes, dated August 29, 2016, written by DG about the petitioner states:

Staff reports resident continues to refuse [REDACTED], continues to play music loudly which she states keeps the demonic forces away. Staff reported resident physically blocked staff from providing care to roommate by wheeling and wedging wheelchair against roommate's bed. When asked by staff to return to her side of the room and allow them to provide care to roommate, resident refused to move and would not respond to the requests. Law enforcement was notified, who came out and spoke with resident regarding behavior and presence at facility. Resident was seen by Psychiatrist again today who concluded that resident's continued refusal of [REDACTED] and becoming more psychotic and obsessed with her roommate, becoming a possible threat. Psychiatrist initiated a Baker Act. 1:1 supervision continues on resident.

8. On August 30, 2016, the Facility Baker Acted the petitioner to [REDACTED] and issued a Nursing Home Transfer and Discharge Notice; Reason for Discharge or Transfer are, "Your needs cannot be met in this facility." and "The safety of other individuals in this facility is endangered."

9. Certificate of Professional Initiating Involuntary Examination, included with the Nursing Home Transfer and Discharge Notice, identifies criteria as "Psychosis NOS" and has checkbox "B" checked that reads, "There is substantial likelihood that without care or treatment the person will cause serious bodily harm to others." Section II; Supporting Evidence, the Psychiatrist wrote:

Patient allegedly hurt previous roommate. Now has a belief that “no one should provide care to current roommate”. Patient is opposing when caregivers try to give care to roommate. Patient refusing psych. Meds. Possible religious delusions maintenance. Patient is agitated, is likely that this changes will escalate and harm roommate.

10. Petitioner alleges that the last roommate was irritated with her because the petitioner reported the roommate’s husband to his employer. Petitioner alleges that the roommate’s husband visited the roommate at the Facility while working as a bus driver, driving medical patients. Allegedly, the medical patients waited in the bus while he visited with his wife.

11. Respondent’s representative contends that the Facility cannot meet the petitioner’s needs, due to her refusal to take her [REDACTED], which is required in accordance with the Psychiatrist.

12. Petitioner agreed that she was not taking [REDACTED] because “she does not have psychological problems”.

13. Respondent’s representative contends “the safety of other individuals in this facility is endangered”, “due to issues with the roommates”. And the petitioner’s roommates believe that the petitioner is a threat and are “afraid that the petitioner will harm them”.

14. Respondent’s representative alleges that the last roommate and her husband are in the process of getting a restraining order on the petitioner.

15. Petitioner alleges that the Facility Baker Acted her due to the grievances she has filed against the Facility.

16. Respondent’s representative provided the last three grievances filed by the petitioner in August 2016. The grievances state in part:

August 9, 2016

Concerns: The last few weeks I have been trying to retrieve clothing that has been lost by the laundry...When bed A bed pan is emptied by CNA there has been urine & bile left on sink, toilet, mirror and in shower areas...

Follow-Up with Person Voicing Concern:

Resident was informed that the bathroom is being checked every hour and housekeeping informed if any further cleaning is needed to be done.

August 13, 2016

Concerns: Resident upset because curtain for "A" bed not pulled during an X-ray for "A" bed.

Follow-Up with Person Voicing Concern:

Spoke with resident about A bed curtain. Resident stated "she did not want to deal with this anymore". "Anyone writing statements saying resident was covered so they won't get in trouble."

August 24, 2016

Concerns: Resident voiced frustration about Aide speaking with roommate. Stating things like "we need to make sure to turn T.V. down when you leave for therapy" and "I got the bathroom all cleaned up & picked up". Resident [petitioner] feels those statements are digs on her. She complains her roommate keeps lights on and T.V. to loud. She complained roommate's spouse comes in and they are "Kissy face" when he leaves people out in the bus he drives. She knows this because she can see it through the window. Also complains that the Aide in the hallway doesn't offer to help and should, even if she has one on one care.

Follow-Up with Person Voicing Concern:

Resident continues to refuse medication; psych services will continue to attempt to reassess and treat resident.

17. Respondent's representative said each of the grievances were investigated by the Facility and resolved.

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 400.0255(15), Florida Statutes. In accordance with that section this order is the final administrative decision of the Department of Children and Families.

19. Federal Regulations 42 C.F.R. § 483.12 Admission, transfer and discharge rights in part states:

(a)(2) Transfer and discharge requirements. **The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--**

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (emphasis added)

(ii) 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;

(iii) The safety of individuals in the facility is endangered; (emphasis added)

(iv) The health of individuals in the facility would otherwise be endangered;

(v) 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. 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

(vi) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; (emphasis added)

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, (emphasis added) the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section; (emphasis added)

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section;

(emphasis added) or

(E) A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

20. The Facility's reasons for discharging the petitioner are: 1) needs cannot be met in the facility and 2) the safety of individuals in the facility is endangered. These are two reasons permitted for discharge from a Facility in accordance with the above Federal Regulation.

21. In accordance with the above Federal Regulation, the Facility included a "Certificate of Professional Initiating Involuntary Examination" completed by the Facility Psychiatrist with the Nursing Home Transfer and Discharge Notice.

22. The evidence submitted establishes that the Psychiatrist's evaluation of the petitioner determined "there is substantial likelihood that without care or treatment the person will cause serious bodily harm to others."

23. Section 400.0255, Florida Statutes, Resident transfer or discharge; requirements and procedures; hearings in part states:

(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 circumstances, 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 health or safety of 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... (emphasis added)

(10) (b) If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing...

(11) Notwithstanding paragraph (10)(b), an emergency discharge or transfer may be implemented as necessary pursuant to state or federal law during the time after the notice is given and before the time a hearing decision is rendered... (emphasis added)

24. The evidence submitted establishes that the Facility cannot meet the petitioner's needs, due to the petitioner's refusal to take Risperdal prescribed by the Psychiatrist.

25. The evidence submitted establishes that two of the petitioner's roommates were in fear of the petitioner.

26. Establishing that the reason(s) for a discharge is lawful is just one step in the discharge process. The Facility must also identifying an appropriate transfer or discharge location and 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 was for a lawful reason(s) and that requirements of the controlling authorities have been met.

27. Discharge by the Facility must comply with all applicable Federal Regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the petitioner have concerns about the appropriateness of the discharge location or the discharge process, she may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

28. In accordance with the above authorities, the Facility involuntarily discharged the petitioner to [REDACTED] on August 30, 2016, due "needs cannot be met in the facility" and "the safety of other individuals in the facility is endangered".

29. The Hearing Officer's jurisdiction is to determine whether the Facility's discharge was lawful. The Hearing Officer does not have jurisdiction on readmission to the Facility in accordance with Section 400.0255(10)(a), Florida Statutes, which states "a resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge".

30. After careful review of the evidence and testimonies, the undersigned concludes that the respondent met its burden of proof. The undersigned concludes that the respondent's discharge of the petitioner to [REDACTED] was proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the petitioner's appeal is denied. The Facility's action to discharge the petitioner to [REDACTED] is in accordance with Federal 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 21 day of November , 2016,
in Tallahassee, Florida.

Priscilla Peterson

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

[REDACTED]
Ms. Kriste Mennella,
Agency for Health Care Administration
[REDACTED]

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

FILED

Dec 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16N-00091

PETITIONER,

Vs.

ADMINISTRATOR

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

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 1, 2016 at 2:26 p.m., at the Heartland Health Care Center in [REDACTED], Florida.

APPEARANCES

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

For the Respondent: Kim Ridinger, Administrator for [REDACTED] Center.

ISSUE

At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations at 42 C. F. R. § 483.15. The nursing home is seeking to discharge the petitioner because the

petitioner's "bill for services at this facility has not been paid after reasonable and appropriate notice to pay."

The respondent will have the burden to prove 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(a) and Section 400.0255, Florida Statutes (2009).

PRELIMINARY STATEMENT

By notice dated August 29, 2016, the respondent informed the petitioner that the facility was seeking to discharge/transfer him due to nonpayment. On September 7, 2016, the petitioner timely requested a hearing to challenge the discharge/transfer.

Appearing as witnesses for the petitioner were [REDACTED] and [REDACTED], sons to the petitioner.

Appearing as witnesses for the respondent was Wylene Edmondson, Business Office Manager.

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

A letter dated October 11, 2016 from the Agency for Health Care Administration (AHCA) was sent to the undersigned and it stated 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 held open until 5:00 p.m. on November 8, 2016 to allow the petitioner to submit additional evidence.

On November 8, 2016, the petitioner's son contacted the undersigned to request an extension to November 15, 2016 to allow additional time to submit evidence. His request was granted.

On November 15, 2016, the petitioner's son contacted the undersigned, who was unavailable. On November 16, 2016, the undersigned returned the petitioner's son's telephone. The petitioner's son was advised to submit correspondence, in writing, regarding the status of his father's application for Medicaid to the undersigned's email address.

On November 17, 2016, the petitioner's son submitted an email to the undersigned. This was entered as the Petitioner's Exhibit 2.

The record was closed on November 17, 2016.

FINDINGS OF FACT

1. The petitioner, age 71, was admitted to the facility for rehabilitation under Medicare after suffering a [REDACTED].

2. The respondent explained that it has a case manager who works with managed care companies. The facility's goal is to provide to its patients the therapy and nursing care to assist its residents in reaching optimal health. The facility explained that it does not have full decision making when it comes to the decisions made by the insurance companies. The facility explained that they provide weekly updates on the patient's progress to the insurance company. The insurance company determines when the insurance discharge will take place.

3. The facility contends that it provided the requested documentation to support further coverage for the petitioner's care in the facility, however, Wellcare denied additional coverage under the benefit plan. The petitioner was no longer covered under Wellcare; therefore, the facility sought after a secondary source, which was either private pay or Medicaid. The current facility's administrator was not employed by the facility at the time the insurance discharge took place.

4. On or around July 6, 2016, the petitioner's insurance provider, Wellcare, notified the respondent that the petitioner would no longer be covered to receive therapy under its insurance plan. On or around July 8, 2016, the petitioner became a private pay resident. The facility contacted the petitioner to inquire how he would pay for his care. The petitioner informed the business office manager to contact his son.

5. On July 27, 2016, the facility issued a billing statement to inform of the balance owed for private pay. The business office manager contends that she spoke with the petitioner's son regarding the balance owed for the private pay and also submitted to him the billing statement.

6. The respondent contends that the petitioner's son informed the business office manager that he would bring the matter of the Wellcare's denial of extending the petitioner's coverage before an administrative law judge (ALJ).

7. The facility's records also show that a billing statement was given to the petitioner on August 1, 2016, September 1, 2016, and October 1, 2016 (*Respondent's Exhibit 2*).

8. The petitioner applied for Institutional Care Program (ICP) Medicaid on September 27, 2016. The application for ICP Medicaid was denied on October 28, 2016 due to failure to provide requested verifications according to the Notice of Case Action (*Respondent's Exhibit 2*).

9. As of the date of the hearing, the petitioner's balance owed is \$33570.09.

10. The petitioner's son argues that he returned calls from the facility multiple times and left messages but did not receive a call back; these returned calls were not included in the activity reports provided by the facility. The petitioner's son explained that the petitioner has a spouse who is living in the community.

11. The petitioner's son argues that the petitioner received follow-up care at [REDACTED] on July 20, 2016, when his medical records were notated by medical staff that it was recommended that he continue receiving occupational, physical, and speech therapies. The petitioner's son contends that the petitioner's primary care physician reviewed all of the medical records from [REDACTED] and requested a referral for him to be transferred to another facility in order to continue receiving therapy. The petitioner's son argues that he spoke with the facility's former administrator regarding the referral for a transfer and was informed that the request was denied due to the petitioner's medical documentation at [REDACTED] showing that he had reached a plateau.

12. The petitioner's son believes that the petitioner would not owe the facility if its administrator, at the time of the insurance discharge, had not provided medical documentation to Wellcare that the petitioner had reached a plateau. The petitioner's

son believes that if the medical documentation from [REDACTED] showed that the petitioner needed continued therapies, Wellcare would have provided the coverage needed to continue his therapy and there would not be a billing issue.

13. The respondent contends that up to 100 days of coverage is provided as long as the facility can provide supporting documents to justify that there is a clinical need for skilled services in a nursing home setting. The respondent contends that the administrator or the business office manager cannot inform Wellcare to cut or extend insurance coverage; they can only facilitate submitting documentation to the insurance companies.

14. The respondent contends that most insurance companies do not provide 100 days of coverage. The respondent contends that an average length of stay is 20 days, while most providers would like to keep the stay at 17 days before moving the resident to a home-like environment; it is difficult to extend a stay. The respondent contends that even if the petitioner's coverage was extended, he would not be covered under Wellcare for his entire stay at the facility.

15. The respondent contends that since the former administrator was not a skilled provider, her opinion would not have had a bearing on the denial decision made by Wellcare. The insurance provider only reviews medical documentation provided by skilled providers, such as doctors, nurses, and therapists. The respondent contends that the facility does not attempt to cut short a resident's stay, as it wants to ensure that the resident is well enough to be discharged to the community. The respondent contends that hospitals have different criteria as to how long one can be treated with

physical and occupational therapies and are reimbursed differently than a skilled nursing facility. The respondent contends that it does not discharge prematurely and that Wellcare made the decision to deny additional coverage.

16. The petitioner's son contends that the family is working on the petitioner's application for Medicaid. The petitioner's son explained that the application is currently pending and that the family needs to provide the power-of-attorney and other legal documentation to the Department of Children of Families (DCF).

17. The Petitioner's Exhibit 2 includes an email dated November 17, 2016 which states, "...they advised that the Level of Care document had not yet been reviewed by their processing department yet....They also confirmed for me that was the only thing pending for the application review."

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 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

19. Federal Regulations appearing 42 C.F.R. § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows:

(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;

...

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

20. 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 federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

21. 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.

22. The facility has attempted to collect the money owed to them since July 27, 2016. On August 29, 2016, the respondent mailed to the petitioner the notice of its intent to discharge him from the facility. The findings show that the petitioner applied for Medicaid on September 27, 2016 and was denied on October 28, 2016. The son

explained that the petitioner's application is currently pending; however, the evidence provided does not include a Notice of Case Action to show that the case is pending for additional information. Therefore, the undersigned cannot conclude that the petitioner's application is currently in pending status. Based on the above findings of fact and conclusions of law, the hearing officer concludes that the facility has given the petitioner reasonable and appropriate notice to pay for her stay at the facility. Based on the cited authorities, the hearing officer concludes that the facility's action to discharge the petitioner is in accordance with Federal Regulations.

23. 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

FINAL ORDER (Cont.)

16N-00091

PAGE -10

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 December , 2016,

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
[REDACTED],
Respondent
Mr. Robert Dickson,
Agency for Health Care Administration
[REDACTED]

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

FILED

Dec 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16N-00095

PETITIONER,

vs.

ADMINISTRATOR

[REDACTED]
[REDACTED]
[REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, an administrative hearing in the above-referenced matter convened on November 3, 2016, at approximately 2:47 p.m. in [REDACTED], Florida.

APPEARANCES

For Petitioner: [REDACTED], Petitioner's Nephew

For Respondent: Roselyn Brecher, Administrator, Williston Care Center/
Williston Rehabilitation & Nursing Center

STATEMENT OF ISSUE

Respondent seeks to discharge Petitioner from its nursing home facility (NHF), alleging that "the safety of other individuals in this facility is endangered" by Petitioner's presence. Respondent bears the burden of proof to show, by clear and convincing evidence, that this discharge is appropriate per federal regulations (42 C.F.R. § 483.15).

PRELIMINARY STATEMENT

Via Nursing Home Transfer and Discharge Notice dated September 13, 2016, the Respondent notified the Petitioner that he was to be discharged from its NHF effective October 13, 2016, due to an asserted safety risk. On September 14, 2016, the Petitioner's nephew requested a hearing to challenge Respondent's proposed action.

Roselyn Brecher, Administrator, represented the Respondent, and provided one, additional witness on behalf of the facility: Theresa Jarvis, Social Services Director. The Petitioner was represented by his nephew, [REDACTED], who presented three other witnesses: [REDACTED], Petitioner's niece, and [REDACTED], RN and [REDACTED], both from the Ombudsman Program. Respondent's Exhibits 1 and 2, and Petitioner's Exhibits 1 through 4, inclusive, were 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 has been a resident of Respondent's facility since December 11, 2015. He was admitted as a Medicaid patient, with diagnoses including [REDACTED], [REDACTED].
2. Petitioner is a 75-year old male, born in 1941. He is a military veteran who has spent his life in service to others. He is visited by his nephew and niece on a regular basis.
3. Due to exit-seeking behavior and the potential for elopement, the Petitioner currently resides in the secure/locked Memory Care Unit within Respondent's facility, which is specifically geared towards the needs of patients with [REDACTED]. His room is

near the non-exit end of this wing, where there may be a slightly higher focus of regular activity. He remains physically strong, and is able to ambulate independently, but he suffers from [REDACTED] and is sometimes disturbed by the chaotic and noisy environment of the Memory Care Unit, especially the area closest to his room. He has seen Dr. [REDACTED], the facility's contracted psychiatrist, since December 18, 2015, and currently takes daily [REDACTED] and as-needed [REDACTED] to assist in controlling his agitation.

4. On or about July 9, 2016, Petitioner was involved in an incident in which he allegedly threatened to punch his (then current) roommate. Respondent did not present any witnesses who observed this event, and the witnesses present at hearing did not know whether the threat was heard by the staff member who documented Petitioner's file, or reported to her by another party. It is unknown whether this threat was unprovoked, or whether it was in response to a statement or action on the part of the roommate. There is no evidence that Petitioner attempted to follow through on the threat, or that he otherwise engaged in any physical altercation.

5. Following this incident, Petitioner's roommate was moved to a different room. Since that date, the Petitioner has remained in a double room, but the facility has not attempted to pair him with another roommate. As such, his room is essentially a private one, and he frequently chooses to close his door to maintain a quieter, more isolated atmosphere, where he can rest.

6. Sometime in August of 2016, Petitioner was walking through the hall of his unit when a fellow resident began screaming for help. Per Respondent, this resident often yells loudly and requests help when she does not require same; however, Petitioner responded to her distress and attempted to lift the resident out of her wheelchair. Per

staff notes entered shortly after the incident, it took staff one to one and a half minutes to redirect Petitioner from his efforts, so as to safely place the resident back in her chair. The Petitioner was then taken back to his room and given [REDACTED], without further incident.

7. Respondent initially testified that following this event, Petitioner was placed on one-to-one care; however, the facility later clarified that there is not one staff member assigned specifically to Petitioner, nor does anyone follow him around the facility or sit with him while he is in his room. Instead, there is a hall monitor present in the Memory Care Unit, who keeps watch over everyone who passes through that wing. Respondent also testified that the hall monitor was *not* placed in response to Petitioner's actions, but has always been part of that unit's staffing protocol.

8. A Physician's progress note from August 18, 2016 indicates that Petitioner was assessed as "not aggressive" but occasionally agitated. This note appears to institute [REDACTED] PRN, and suggests a psych consult in conjunction with [REDACTED] unit supportive care."

9. An August 26, 2016 encounter note from Dr [REDACTED] reflects that Petitioner had "remained aggressive" towards other residents without provocation, but does not give any details. The note states, "will add an afternoon dose of [REDACTED] in hopes of decreasing his aggression." At the time of this note, Petitioner was thus prescribed [REDACTED] 0.5 mg twice per day, as needed, 25 mg o [REDACTED] in the morning, and 50 mg of [REDACTED] at bedtime.

10. On August 27, 2016, Petitioner met with the facility's Licensed Clinical Social Worker (LCSW) for a 20-minute, individual therapy session to address [REDACTED],

restlessness, nervousness, and isolation. The therapist engaged Petitioner in supportive listening, noting that he was cooperative and moderately active in his participation. She noted improved move/affect and the development of strategies to reduce worry as benefits of the session, stated that they worked on positive self-image and deep breathing, and checked a box to indicate her recommendation to "Continue with frequency/length of sessions. Without such care, client at risk of decompensation and needing higher levels of intervention."

11. Via the above-referenced 30-day notice, dated September 13, 2016, Respondent informed Petitioner and his family of its intent to pursue discharge, checking a box to indicate that "the safety of other individuals in this facility is endangered," and noting, by way of explanation: "[Petitioner] attempted to help another resident by picking her up; staff assisted that resident back into her chair." The discharge notice was signed by Dr. [REDACTED], the facility's attending physician.

12. On September 14, 2016, Petitioner's family requested a hearing to challenge the discharge. Since this request was timely filed, Petitioner has remained in the NHF pending disposition of his appeal.

13. Physician's progress notes from September 13 and 20, 2016 reflect that no further incidents were noted, that Petitioner was calm and cooperative, that his agitation had improved, and that "no further episode of aggressive outburst[s] has been] noted." However, the note on September 20, 2016 also reflects: "Continue current Rx regimen. Planed for discharge to ALF."

14. Dr. [REDACTED] encounter note dated September 30, 2016 reflects a medication regimen of 0.25 mg of [REDACTED] at 12:00 p.m. and 4:00 p.m., and every 12 hours as

needed, along with 25 mg of [REDACTED] every 8 hours, as needed. Petitioner is noted to be fairly calmer without overt psychosis. Dr. [REDACTED] writes: "Patient's overall behavior has significantly improved. He is a lot calmer and not as agitated, but nonetheless the facility has given him a 30 day notice because of his behavior problems that the family has appealed."

15. An additional therapy visit note from October 6, 2016 reflects that Petitioner had pacing and nervousness, expressed worry about his family, and participated in therapy with cooperation and moderate activity. The LCSW again noted that Petitioner demonstrated an improved mood/affect and developed strategies to reduce worry. She recommended continuation of therapy at the same frequency.

16. At hearing, Respondent indicated that the NHF seeks to discharge Petitioner after the incident in August because they are concerned about their liability regarding, and responsibility to other residents. They do not feel that they can continue to keep Petitioner in a private room, and do not believe he has a high quality of life living in the Memory Care Unit with residents who are less physically active, but more vocal/noisier than he is. Respondent feels that an Assisted Living Facility (ALF) would be appropriate to meet Petitioner's needs. They have attempted to coordinate transfer with multiple other facilities, but have not found a residence that is willing to accept Petitioner, of which Petitioner's family also approves. Social Service progress notes document these attempts, and a notation from October 28, 2016 states:

Recent psych note reflects resident was calmer. In preparation for resident to transfer to another facility (which will hopefully be an ALF), resident's medications were adjusted, per nursing. This change, combined with

[Petitioner's] remaining on 1:1 with nursing, has likely contributed to his calmer demeanor [*sic*] seen by LCSW on her short visits with the resident.¹

17. Petitioner argues that an ALF would not suffice to meet Petitioner's needs, which include nursing and medication administration, and a higher level of care. Petitioner's family contends that Petitioner has received quality care in a properly controlled environment within Respondent's facility, and they wish for him to remain in the NHF. Petitioner's nephew has proposed switching Petitioner's room from the end of the Memory Care Unit closest to the rest of the facility to a room more towards the center of that wing, so as to minimize the level activity to which he is exposed and limit over-stimulation.

18. The Ombudsmen emphasize that Petitioner was only administered his as-needed [REDACTED] six times in the month of October, that he has benefitted from and engaged in six therapy sessions, and that he has not had any incident since August of 2016. They feel that Respondent has addressed Petitioner's agitation, testified that Respondent's Memory Care Unit is one of the more peaceful ones they have visited, and believe that the facility can continue to meet Petitioner's needs. They are also concerned that Petitioner will not be accepted into any other NHF, since Respondent has notated his file to indicate that he is a behavioral concern. They feel that any proposed transfer would require a phone call to the receiving facility, so as to explain that Petitioner is not violent and that his anxiety is under control.

19. Respondent contends that the Memory Care Unit is busy and noisy in all parts of the wing, and that residents do yell out to request help, and will likely continue to do so.

¹ Again, the 1:1 care referenced here is supervision by a hall monitor, as opposed to 1:1 staffing.

As such, they don't think transferring Petitioner to another room within the unit would alleviate his exposure to stimulation. They do not believe that Petitioner intends to hurt anyone, but they suspect that he will continue to try to provide help, whether or not it is needed. Nonetheless, Respondents acknowledge that Petitioner is currently doing very well, and that he has had no other incidents, nor "close calls" since August, 2016.

20. Respondent has not attempted behavior therapy, nor targeted behavior modification to teach Petitioner that he is not to aid other residents, even if they request his assistance. The NHF has not attempted to utilize a bed or room alarm to ensure someone, other than the general hall monitor, is alerted when Petitioner decides to ambulate in the hallway. The facility did not consult with Dr. [REDACTED], Petitioner's psychiatrist, nor involve him in the decision to discharge. The facility is willing to continue attempts at coordinating a transfer to a different NHF, which would offer a similar environment and range of services, but Respondent remains concerned that Petitioner is a threat to the safety of other residents within their NHF.

CONCLUSIONS OF LAW

21. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla. Stat. § 400.0255(15). In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

22. The burden of proof (clear and convincing evidence) is assigned to the Respondent.

23. Federal Regulations appearing at 42 C.F.R. § 483.15 set forth the reasons a facility may involuntarily discharge a resident as follows:

(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....

(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.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(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).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) 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...(emphasis added).²

24. While the facility's attending physician did sign Petitioner's discharge notice, Petitioner's medical record was *not* documented by his physician to reflect the doctor's agreement with same. In contrast, physician progress notes reflect *improved* behavior and mood, and only make reference to a "planned discharge to ALF" on September 20, 2016 – i.e., one week after Respondent's issuance of the 30-day discharge notice, and at least one month after the last incident recorded. Notably, Petitioner's treating psychiatrist was not consulted on the discharge, noting after the fact on September 30, 2016 that "[Petitioner] is a lot calmer and not as agitated, but nonetheless the facility has given him a 30 day notice..." (emphasis added).

25. Per documentation and testimony offered, Petitioner was admitted to Respondent's facility as a dementia patient who needs nursing care and a secure

² Provisions regarding transfer rights, documentation of the resident's record, and notice requirements were previously found at 42 C.F.R. § 483.12.

environment to prevent eloping. While it is understandable that Respondent wishes to maintain the safety of all residents, it does not appear that Petitioner has been instructed or trained on appropriate interaction, or that any additional measures have been taken to ensure he does not continue attempting to provide assistance when staff do not respond to other residents' pleas for same. Indeed, it appears that the facility's approach of implementing therapy has currently avoided the need for any further intervention.

26. It is noted that some of Respondent's testimony regarding Petitioner's alleged behaviors constitutes uncorroborated hearsay; however, even given that Petitioner *has* engaged in some inappropriate behavior, Respondent bears the burden to prove that as a result of said behavior, the safety of other residents is in jeopardy. There is no indication that Petitioner has made any attempts to intervene with other residents since August of 2016.

27. It is understandable that the facility may not be able to provide 24-hour, 1:1 *direct* supervision for Petitioner. However, Respondent's facility does house patients with dementia, and accepted Petitioner as a [REDACTED] patient who exhibits [REDACTED]. Respondent has a duty to attempt provision of appropriate services, and to exhaust all reasonable attempts at addressing their concerns regarding others' safety, *before* pursuing a discharge. To this end, there is no evidence that measures such as bed/room alarms or behavior modification were attempted, failed, and ruled out. Notably, there is also no documentation or testimony from the facility's psychologist related to Petitioner's potential to benefit from these interventions.

28. Should Petitioner return to and continue engaging in behaviors that threaten the safety of others, despite ongoing and exhaustive attempts to deter same, Respondent may wish to consult with their physicians and determine whether discharge is proper, at some future date. However, after considering the entire record, the undersigned concludes that Respondent has not met its burden to prove, by clear and convincing evidence, that Petitioner presents a continued and ongoing danger to the safety of his fellow residents.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the Petitioner's appeal is GRANTED. The facility has not established that discharge is permissible under federal 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.

FINAL ORDER (Cont.)

16N-00095

Page 13 of 13

DONE and ORDERED this 13 day of December, 2016,

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:

██████████, Petitioner

██
Ms. Kriste Mennella, Agency for Health Care Administration

██████████