

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

FILED

Sep 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

██████████
██████████
████████████████████

APPEAL NO. 16F-03543

PETITIONER,

Vs.

CASE NO. ██████████

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 26, 2016, at 8:52 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: ██████████

For the Respondent: Gail Stewart, economic self-sufficiency supervisor.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny full Medicaid benefits for her and her 18 year-old son and their enrollment in the Medically Needy Program each with an estimated share of cost (SOC). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On May 10, 2016, the petitioner requested an appeal challenging the Department's actions of denying full Medicaid benefits for her and her son and their individual enrollment in the Medically Needy Program each with an estimate SOC of \$291.

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The respondent submitted six exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 6. The record was left open through August 9, 2016 for the Department to explore transitional Medicaid eligibility for the household and for the petitioner to respond with a statement. The Department's evidence was received and marked as Respondent's Exhibit 7. The petitioner's response was received and marked as Petitioner's Exhibit 1. The record was closed on August 10, 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, petitioner has been receiving full Medicaid benefits for her household. The household's last month of full Medicaid eligibility was May 2016.
2. On March 15, 2016, the petitioner submitted an application to continue Food Assistance and Medicaid benefits for her family. Her household consists of herself (age 45), her son (age 18) and her two daughters, ages 11 & 15. On that application, the petitioner reported that she was a tax filer.

3. Petitioner reported that she was the only one employed earning \$32 a week and provided the respondent with income verification. Based on the information listed on the application, petitioner was approved for FAP and Medically Needy benefits.

4. On April 21, 2016, the respondent sent the petitioner a Notice of Case Action informing her she was approved for the Medically Needy Medicaid for her and her son. They were enrolled separately with a \$291 share of cost. Petitioner's daughters were approved for full Medicaid.

5. On May 10, 2016, the petitioner requested a hearing challenging the respondent's action. The petitioner was seeking full Medicaid for all members of her household. Only the enrollment in the Medically Needy Program is under challenge.

6. Petitioner's son is employed and gets paid biweekly. He received \$390.59 on March 23, 2016 and \$339.37 on March 9, 2016. To determine eligibility for Medicaid for the petitioner, her weekly income was converted to a monthly amount by adding four weeks together to equal \$146.92. The son's biweekly income was converted to a monthly amount by adding four weeks together to equal \$730.06. The two incomes were added together to arrive at \$876.98 in total household income. This amount is called modified adjusted gross income (MAGI). The respondent counted four 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 four, \$364. As her income exceeded the maximum limit, she was found ineligible for full Medicaid benefits.

7. As of the date of application, the son had turned 18 years old and was no longer eligible for AFDC-Related Medicaid. As the petitioner and her son were determined ineligible for full Medicaid, the respondent enrolled them in the Medically Needy

Program. Initially, to determine the estimated SOC for the petitioner, the respondent determined the household's MAGI to be \$876.98. The Medically Needy Income Level (MNIL) of \$585 for a standard filing unit size of four was subtracted resulting to the petitioner estimated SOC of \$291. The respondent used the same methodology to determine the estimated SOC for the son. His estimated SOC was \$291.

8. Respondent's representative explained that the petitioner and her 18-year old son were no longer eligible for full Medicaid due excess income. In addition, she explained that the son was no longer eligible for the 1931 Medicaid due to his age. The respondent did not explore transitional Medicaid eligibility for the petitioner.

9. 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 son is currently employed and will be filing his own taxes. Petitioner argued she cannot afford to be responsible for \$291 each month for out-of-pocket to get coverage.

10. After a case review, the respondent excluded the son's income and counted three members in the petitioner's standard filing unit. Her income was then compared to the income limit for an adult with a household size of three, \$303. As her income was below the maximum limit, she was found eligible for full Medicaid benefits.

11. The respondent determined the son was not eligibility for the 1931 Medicaid benefits due to his age. However, he remains eligible for the Medically Needy Program with a \$291 SOC. On August 8, 2016, the undersigned received verification that the petitioner was approved for full Medicaid, See Respondent's Exhibit 7. Petitioner maintains that her son should be eligible for full Medicaid, See Petitioner's Exhibit 1.

CONCLUSIONS OF LAW

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

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

14. The petitioner was seeking full Medicaid for herself and her 18 year-old son. After a case review she was approved for full Medicaid. Her son, however, remains in the Medically Needy Program.

15. Federal regulation at 42 C.F.R §435.118 addresses Family-Related Medicaid income criteria for infants and children under age 19 and states in part:

(a) *Basis.* This section implements sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) and (d) of the Act.

(b) *Scope.* The agency must provide Medicaid to children under age 19 whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) *Income standard.* (1) The minimum income standard is the higher of—

(i) 133 percent FPL for the applicable family size; or

(ii) For infants under age 1, such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for infants, or, as of July 1, 1989 had authorizing legislation to do so.

(2) The maximum income standard for each of the age groups of infants under age 1, children age 1 through age 5, and children age 6 through age 18 is the higher of—

(i) 133 percent FPL;

(ii) The highest effective income level for each age group in effect under the Medicaid State plan for coverage under the applicable sections of the Act listed at paragraph (a) of this section or waiver of the State plan covering such age group as of March 23, 2010 or December 31, 2013, if

higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or..

16. 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.

17. Federal regulation 42 C.F.R. § 435.603 Application of modified gross

income (MAGI) (f) defines a Household for Medicaid. It states:

(f) Household—(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent.

...

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and

natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

...

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

18. The Department's Program Policy Manual CFOP 165-22 (The Policy Manual) at section 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

19. In accordance with the above controlling authorities, when the son is being tested, the Medicaid household group is the son, his mother and his two siblings (four members). The findings show the Department determined the son's eligibility with a household size of four for Medicaid. A more favorable outcome could not be found.

20. Federal regulation at 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (d) defines Household Income:

(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as

defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

21. 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.

22. 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.

23. The above allows for the use of the conversion factor of 2 if income is received biweekly for Medicaid eligibility determination.

24. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. The undersigned concludes the son is ineligible for 1931 Medicaid group due to his age. The respondent proceeded to explore the Medically Needy Program. The undersigned recognizes the petitioner's concerns about her son and the family's other needs. However, the controlling legal authorities do not allow for any more favorable outcome.

25. The Policy Manual at passage 0830.0600 EX PARTE DETERMINATIONS (MFAM) states in part:

An ex parte determination assesses whether a Medicaid AG member that is no longer eligible under one coverage group is eligible under a different coverage group. Continue Medicaid until the ex parte process has been completed.

Perform ex partes when:

1. An increase in income or assets causes ineligibility.

2. A child turns age 18 and is a member of a 1931 or transitional Medicaid AG.

26. The Policy Manual at passage 2030.0902 Children Under Age 19 (MFAM)

When a child who meets the technical criteria for residency, age, identity and citizenship/noncitizen and the tax household's income is at or below the income limit for the coverage group, the child is eligible for Medicaid. If

the income is higher than the income limit, the child may be enrolled in Medically Needy and/or referred to the Children's Health Insurance Program (CHIP) or the Federally Facilitated Marketplace (FFM).

27. In this instant case, petitioner's son turned 18 is was no longer eligible for coverage under the 1931 Medicaid group. Additionally, he is not eligible for transitional Medicaid due to turning 18. No ex-parte was necessary, as the respondent was processing an active application.

28. The Policy Manual at passage 2630.0502 Enrollment (MFAM) sets forth:

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.

29. 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.

30. Effective April 2016, Appendix A-7 indicates that the MNIL for a household of four is \$585.

31. To determine the estimated SOC for the son, household monthly income of \$876.98 was deducted by the MNIL of \$585 for a standard filing unit size of four, resulting in their estimated SOC of \$291. No computational errors were found. The hearing officer found that no exception to this calculation. It is concluded that a no more favorable share of cost could be determined.

32. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner's son full Medicaid under the 1931 Medicaid coverage group and his 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.

FINAL ORDER (Cont.)
16F-03543
PAGE -12

DONE and ORDERED this 13 day of September, 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

Sep 08, 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-03640
16F-06529

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 9, 2016 at approximately 1:38 p.m. CDT. The proceeding was reconvened on August 18, 2016 at approximately 2:29 p.m. CDT. Appearances for both hearings were the same.

APPEARANCES

For the Petitioner: [REDACTED] [REDACTED]

For the Respondent: Stacy Ann Mills, economic self-sufficiency specialist supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of May 3, 2016 enrolling her in the Medically Needy Program (MN) with a Share of Cost (SOC) rather than in full Medicaid coverage, and not receiving coverage from the Qualified Medicare Beneficiary

(QMB) program for the three months prior to her application (retro coverage). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted a packet of information that was submitted into evidence and marked as Petitioner's Exhibit 1.

The Department submitted a packet of information that was submitted into evidence and marked as Respondent's Exhibits 1 through 9.

FINDINGS OF FACT

1. On April 25, 2016, the petitioner submitted an application to the Department for Food Assistance (FA), SSI-Related Medicaid and the Medicare Savings Plan.
2. In response to the application, the Department approved QMB, enrollment in the MN Program with a \$540 SOC, and FA effective April 2016. Petitioner's ineligibility for full Medicaid was at issue because she believes that Social Security Administration (SSA) benefits should not be considered income when determining Medicaid eligibility. The respondent determined the petitioner ineligible for full Medicaid which causes the eligibility determination system to consider eligibility or enrollment in the Medically Needy Program. The respondent deducted \$20 unearned income, \$180 MNIL and \$187 medical deductions from the petitioner's \$927 income to arrive at a \$540 SOC. Medical bills were tracked and the SOC met making the petitioner full Medicaid eligible effective March 20, 2016 through March 31, 2016.
3. The petitioner's earned income has ended; however, she continues to receive \$927 in Social Security benefits. The petitioner argued that this income should not be

counted in the eligibility determination as this is money she had previously earned which is being paid back to her through the Social Security Administration (SSA).

4. The petitioner listed medical expenses on her application which were computed by the respondent and deducted in the eligibility determination in the amount of \$187.

This deduction was not questioned by the petitioner.

5. The \$927 income from SSA is less than the \$990 income limit for QMB. The petitioner was approved for QMB coverage effective the month of application, April 2016.

6. The petitioner is ill and is concerned that with her limited income she will not be able to afford any medical care that is not covered by Medicare or Medicaid. She worries that in months she does not meet her SOC, she will not be able to live.

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.

MEDICAID AND MEDICALLY NEEDY WITH SHARE OF COST

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

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically

Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services...

11. The petitioner is not institutionalized and is a Medicare recipient; therefore, according to the above cited authority, she is not eligible for full Medicaid.

12. 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:

...

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

(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost" shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility.

13. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income.

14. Federal Regulation at 20 C.F.R. §416.1121 Types of unearned income states in part:

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example,

private pensions, **social security benefits**, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits. [emphasis added]

15. The above authority explains that income received from the Social Security Administration is counted unearned income.

16. 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 of any unearned income in a month...”

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

18. Federal Regulation at 42 C.F.R. § 436.831 explains allowable deductions in the Medically Needy Program and in part states:

(d) Deduction of incurred medical expenses. If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f) and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

(e) Determination of deductible incurred expenses: Required deductions based on kinds of services. Subject to the provisions of paragraph (g) of this section, in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under §447.52, §447.53, or §447.54 of this chapter;

(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration or scope of services...

(g) Determination of deductible incurred medical expenses: Optional deductions. In determining incurred medical expenses to be deducted from income, the agency—

(1) May include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate;

(2) May, to the extent determined by the agency and specified in its approved plan, include expenses incurred earlier than the third month before the month of application; and

(3) May set reasonable limits on the amount to be deducted for expenses specified in paragraphs (e)(1), (e)(2), and (g)(2) of this section.

19. The respondent included deductions in the eligibility determination amounting to \$187. The amount of deductions included in budget computations were not in dispute.

20. In accordance with the above authorities, the respondent deducted \$20 unearned income, \$180 MNIL and \$187 medical deductions from the petitioner's \$927 income to arrive at a \$540 SOC.

21. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet her burden of proof to show she is eligible for full Medicaid benefits. The respondent's action to deny full Medicaid and enroll the petitioner in the MN Program with a \$540 SOC is proper.

QUALIFIED MEDICAID BENEFICIARY (QMB)

22. Also at issue is the effective date of eligibility for QMB. The respondent approved coverage in the QMB Program effective the month of application, April 2016.

23. The Department's Program Policy Manual CFOP 165-22, Passage 0640-0509, Retroactive Medicaid (MSSI) states:

This policy does not apply to QMB.

Medicaid is available for any one or more of the three calendar months preceding the application month, provided:

1. at least one member of the SFU has received Medicaid reimbursable services during the retroactive period, and

2. the individual meets all factors of eligibility during the month(s) he requests retroactive Medicaid.” [emphasis added]

24. The above authority explains that eligibility for QMB coverage cannot be determined for the three month period prior to the month of application as other types of Medicaid may.

25. The undersigned concludes that the respondent’s action approving QMB beginning with the effective date of April 2016, the month of application, is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department’s action 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 08 day of September, 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

Sep 09, 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-03759

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 Hillsborough
UNIT: 883DT

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on July 29, 2016 at 1:01p.m. One continuance was granted for the petitioner.

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Nicole Nurridin, Economic Self Sufficiency Specialist II

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. Petitioner submitted no exhibits at the hearing. Respondent was represented by Nicole Nurridin with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). Ms. Nurridin testified. Respondent submitted eight exhibits, which were entered and marked as Respondent’s Exhibits “1” through “8”.

FINDINGS OF FACT

1. On January 22, 2016, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). On March 14, 2016, SSA denied the petitioner’s SSI application using the code N32. N32 means “Non-pay-Capacity for substantial gainful activity – other work, no visual impairment”. On April 25, 2016, the petitioner appealed the denial of his SSI application and that appeal is currently pending.
2. On February 22, 2016, the petitioner submitted an application for SSI-Related Medicaid benefits. On the application, the petitioner claimed to be disabled; to have his SSI application denied within the last 90 days; and to have unpaid medical bills. Petitioner did not claim to have health conditions that had changed since the SSI denial.
3. On March 8, 2016, the respondent submitted both the Disability Determination and Transmittal form (Respondent’s Exhibit 5) 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.

4. On March 14, 2016, DDD determined the petitioner not disabled using the denial code N32. The Disability Determination and Transmittal form had "Hank 03-14-16" handwritten on it. The document also listed the petitioner's age as 47 years old.

5. On March 14, 2016, the respondent denied the petitioner's application for Medicaid benefits as DDD determined him not to be disabled.

6. On March 15, 2016, the respondent mailed the petitioner a Notice of Case Action indicating his Medicaid application dated February 22, 2016 was denied as, "You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program".

7. Several years ago, the petitioner suffered severe trauma that caused many of his ongoing medical conditions. Petitioner requests Medicaid benefits as he requires physician visits and medications. He cannot go to the doctor or take his medications without Medicaid as he cannot afford them.

8. Respondent determined the petitioner was not eligible for Family-Related Medicaid benefits as he had no children under the age of eighteen living with him; and was not eligible for SSI-Related Medicaid benefits as he was under the age of 65 and had not been determined disabled by SSA.

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

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

11. Fla. Admin. Code R. 65A-1.705(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, 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...

16. Petitioner applied for SSI benefits on January 22, 2016 and was denied SSI benefits on March 14, 2016 pursuant to code N32. On February 22, 2016, the petitioner applied for Medicaid benefits with the respondent. On April 25, 2016, the petitioner appealed his SSI denial with SSA. On March 14, 2016, DDD determined the petitioner not disabled by adopting the March 14, 2016 SSI denial. On March 14, 2016, the

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. Furthermore, the petitioner does not claim any new or worsening medical conditions since his March 2016 SSI denial. 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 does not claim any new or worsening medical conditions.

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 February 22, 2016 application for SSI-Related Medicaid benefits.

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 09 day of September, 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]
Office of Economic Self Sufficiency

FILED

Sep 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-03799

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Sumter
UNIT: 88999

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:05 p.m. on July 27, 2016.

APPEARANCES

For the Petitioner:

[REDACTED]
[REDACTED]

For the Respondent:

Stefanie Camfield, Esq.
Department of Children and Families

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's Medicaid Institutional Care (ICP) Medicaid for the month of March 2016 is proper. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By notice dated April 22, 2016, the respondent (Department) notified the petitioner his March 22, 2016 Medicaid application was denied. Petitioner timely requested a hearing to challenge the denial.

Petitioner is deceased and was represented by legal counsel. [REDACTED]

[REDACTED]
designated representative, appeared as a witness for the petitioner. Appearing as witnesses for the respondent from the Department of Children and Families were, Stan Jones, Economic Self-Sufficiency Specialist II and Kane Lamberty (KL), Senior Human Services Program Specialist.

Petitioner did not submit exhibits. Respondent submitted 10 exhibits. Entered as Respondent Exhibits "1" through "10". The record remained open until August 10, 2016, for both parties to submit Proposed Orders. The Proposed Orders were received timely and entered as Petitioner Exhibit "1" and Respondent Exhibit "11". The record was closed on August 10, 2016.

FINDINGS OF FACT

1. Petitioner was admitted to [REDACTED] on February 25, 2016. He remained at the Nursing Center until his death on [REDACTED].
2. On February 5, 2016, petitioner signed a Durable Power of Attorney appointing petitioner's stepson, (BFK, III) as his agent.
3. Also on February 5, 2016, petitioner's agent (BFK, III) signed a Support and Maintenance Service Agreement (SMSA), which lists BFK, III as petitioner's Caregiver.

The petitioner is listed as the Grantor on the SMSA; however, B.F.K, III signed the SMSA as Attorney-in-fact for the Grantor.

4. The SMSA defines the value of “services” to be provided by the Caregiver for “personal care, support and maintenance” to the petitioner. Schedule “A”, part of the SMSA, specifies payment of the Caregiver services at the rate of \$40 per hour, 20 hours per week; for a total of \$41,600 yearly.

5. Also on February 5, 2016, petitioner’s agent/Caregiver (BFK, III) signed “The [petitioner’s] Irrevocable Personal Care Trust” (Trust). The Trust states in part:

Article I - Purpose

The purpose of this Trust is (1) to assure that the personal services to be provided to [petitioner] under the terms of the Support and Maintenance Services Agreement...

Article III - Irrevocable Provision

The Grantor declares that neither he/she nor any other person shall have the right to alter, amend, modify, or revoke this Trust.

Article IV – Administration of Trust

The Trustee shall hold and administer the Trust Estate as follows:

1...a lump sum payment of \$235,040.00 for the personal services to be provided by BFK, III, as Caregiver under the terms of the Personal Service Agreement...The Trustee shall pay to BFK, III, for so long as he or she provides the personal services to [petitioner], required by the Personal Service Agreement, a sum not to exceed \$3,466.66 per month.

2... [petitioner] shall have (a) no interest in the income or principals of this Trust...

3...[petitioner] shall have no right to sell, assign, transfer or encumber his or her right to receive any payments form this Trust...

4...The Trustee and any successor trustee shall have no right or discretion to use the income or principal of this Trust for any purpose other than to pay the person(s) who provide the personal care services required by the Personal Service Agreement...

Article IX - Granting Trust Powers

The Grantor intends that he or she be treated as the owner of the Trust Estate (both income and principal) for the income tax purposes...Accordingly, at any time, the Grantor may borrow the income

or corpus of the Trust without adequate interest or security...The Grantor shall have a substitution power or right to reacquire any assets of the Trust by substitution of other assets of equivalent value.

6. The petitioner is listed as the Grantor of the Trust; however, B.F.K, III signed the Trust as Attorney-in-fact for the Grantor. Petitioner's witness (DT) is the Trustee of the Trust.

7. Petitioner's BB&T bank statements indicate that in February 2016, the petitioner's assets were in excess of \$185,418.49. On February 24, 2016, a \$166,771.44 check was paid to the petitioner's Trust. On February 29, 2016, a \$10,000 check was paid to the petitioner's Trust.

8. Petitioner's BB&T bank statement, dated March 14, 2016, indicates that \$185,422.39 in checks were written out of petitioner's account between February 17, 2016, and March 10, 2016. And indicates petitioner's bank balance of \$780.53.

9. DT stated that the purpose of the Trust was to assist the Caregiver in avoiding a large tax liability to the Internal Revenue Service, as a lump sum payment. And it was to pay the Caregiver for services already rendered as well as future services to be provided to the petitioner by the Caregiver.

10. On March 22, 2016, an ICP application was submitted on behalf of the petitioner.

11. The ICP asset limit for the petitioner to be eligible for ICP benefits is \$2,000.

12. Petitioner's counsel claims that petitioner's \$780.53 bank balance is under the asset limit; therefore, he is eligible for ICP benefits.

13. Petitioner's counsel stated that in accordance with the Department policy 1640.0312.01, 1640.0312.02, 1640.0576.07 and 1640.0308 petitioner's assets in the Trust are not available to him.

14. KL, respondent's witness, reviews all Trusts for the Department. KL reviewed petitioner's Trust and determined that the Trustee has the "ability and responsibility" to use the money in the Trust to pay for support and maintenance services "for the benefit of the petitioner".

15. KL explained that the petitioner benefits from the Trust, because the Trust requires the Trustee to pay for personal care, support and maintenance that can only be delivered to the petitioner.

16. Petitioner's counsel contends that the contractual rights that were received from the creation and execution of the Trust are that the funds only to be used for providing for the petitioner; "not for the benefit of the petitioner".

17. KL said that that although the petitioner was denied ICP benefits due to being over the asset limit, he would also be denied due to transfer of assets within the exclusion period, which is the transferring of the petitioner's money from his bank account to the Trust.

18. On April 22, 2016, the Department mailed the petitioner a Notice of Case Action, notifying the March 22, 2016, Medicaid application was denied: "Reason: The value of your assets is too high for this program."

CONCLUSIONS OF LAW

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

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

21. Fla. Admin. Code R. 65A-1.712 and 65A-1.716 addresses SSI-Related Medicaid asset criteria and in part state:

65A-1.712

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

65A-1.716

(5) SSI-Related Program Standards.

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

1. \$2000 per individual.

22. The above authorities explain \$2,000 as the resource (asset) limit for an individual to be eligible for ICP Medicaid.

23. Petitioner's counsel argued that in accordance with the Department Policies, 1640.0312.01, 1640.0312.02, 1640.0576.07 and 1640.0308, petitioner's Trust should not count as an asset. Petitioner's counsel further argued that the petitioner's \$780.53 bank balance (after \$185,418.89 was used to fund the Trust), is within the \$2000 ICP asset limit.

24. Respondent's witness testified that in accordance with the same Department Policies (#23) petitioner's counsel referenced, the Trustee has the ability and responsibility to use the money in the Trust to pay for support and maintenance services; which benefits the petitioner.

25. The Department's Program Policy Manual, CFOP 165-22, passages 1640.0308, 1640.0576.07, 1640-0312.01 and 1640-0312.02 state:

1640.0308 General Availability (MSSI, SFP)

Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility on the factor of assets.

Assets are considered available to an individual when the individual has unrestricted access to the funds.

Accessibility depends on the legal structure of the account or property. An asset is countable if the asset is available to a representative possessing the legal ability to make the asset available for the individual's support and maintenance, even though the individual may not choose to do so.

Assets not available due to legal restrictions or factors beyond an individual's control are not considered in determining total available assets. The only exception to this rule occurs when the legal restrictions were caused or requested by the individual.

1640.0312.01 Availability of Trusts (MSSI, SFP)

The availability of funds held in a trust depends on the conditions (wording) of the trust and whether the individual is the trustee or beneficiary of the trust.

1640.0312.02 Trust Availability to Trustee (MSSI, SFP)

The trust is not an asset to the trustee if the trustee cannot use any of the funds in the trust for his own benefit.

The trust is an asset to the trustee if the individual is the trustee and has the legal ability to revoke the trust and use the money for his own benefit, regardless of whose funds were originally deposited in the trust.

The trust is an asset to the individual if the individual or the individual's spouse created the trust and has the right to dissolve it and use the funds for his own benefit.

One type of revocable trust commonly established is a "totten trust". A totten trust is created with an individual's own funds and the individual is named as trustee for another person (the beneficiary). The trustee of a totten trust can revoke the trust at any time during the trustee's lifetime. If the trustee dies without revoking the trust, the trust principal reverts to the beneficiary. These trusts are usually set up in the form of savings accounts and are not legally recognized in most states. Regardless of whether the totten trust is legally recognized or not, the trust principal is an asset of the trustee.

1640.0576.07 Trusts Established On or After 10/1/93 (MSSI, SFP)

The following policy applies to trusts established by an individual on or after 10/1/93.

An individual will be considered to have established the trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established the trust (other than by will):

1. the individual;
2. the individual's spouse;
3. a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
4. a person, including a court or administrative body, acting at the direction or upon request of the individual or individual's spouse.

If the trust was not established by one of the above individuals, refer to passage 1640.0576.03.

If the trust is revocable:

1. Consider the entire principal as an available asset to the individual.
2. Consider any payments which can be made as countable income to the individual.
3. Consider any other payments from the trust as assets disposed of by the individual without fair compensation.

If the trust is irrevocable and there are any circumstances under which payment from the trust could be made to or for the benefit of the individual:

1. Consider that portion of the principal that could be available, as an asset to the individual.
2. Consider payments from that portion of the principal which could be available as income to the individual.
3. Consider any other payment from the trust as a transfer of assets.

If the trust is irrevocable and no payment could be made from the trust under any circumstances:

1. Apply the transfer of assets policy to the individual's assets and income used to establish the trust. The transfer policy applies only to applicants or recipients of nursing facility services and HCBS.
2. The trust is not counted as an available asset.

The above policies apply without regard to:

1. the purpose of the trust;
2. whether the trustees have or exercise any discretion under the trust;
3. any restrictions on when or whether distributions may be made from the trust; or
4. any restrictions on the use of distributions from the trust.

26. Fla. Admin. Code R. 65A-1.702 Special Provisions, in part states:

(15) Trusts.

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

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

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

27. Also in accordance with the above authority, funds in a Trust may be disbursed for the benefits of the individual. In this case, the petitioner benefits for the payment of his ONE month stay at the nursing facility.

28. Additionally, the Social Security Program Operations Manual System (POMS) SI 1730.048 Medicaid Trust in part states:

C. Policy — effect on Medicaid...

2. October 1993...

Irrevocable Trusts

If there are any circumstances under which payment from an irrevocable trust could be made to or for the benefit of the individual, the portion of the principal from which (or income on that principal) payment to the individual could be made is considered resources. (emphasis added) Payments from the trust or income on the trust for the benefit of the individual are income. Payments for any other purpose are considered a transfer of assets by the individual. Any portion of the trust or income on the trust from which no payment could be made under any circumstances to the individual is considered to be transferred assets on the date the trust was/is established. If, however, the access by the individual was "blocked" later, the date of the transferred assets will be the date that access was "blocked" (foreclosed)...

Exception from this rule is possible under one of several specific statutory provisions and also may occur when an individual establishes, pursuant to procedures developed by the State, that application of the provision on Medicaid trusts would work an undue hardship on the individual as determined on the basis of criteria established by CMS.

29. Further, 42 U.S. Code § 1396p - Liens, adjustments and recoveries, and transfers of assets in part states:

(d)(3)(B) In the case of an irrevocable trust—
(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—
(I) to or for the benefit of the individual, shall be considered income of the individual, and
(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c) of this section...

30. Respondent's counsel argued that the Trust requires the Trustee pay for personal care, support and maintenance of the petitioner, which benefits the petitioner.

31. Petitioner's counsel argued that the funds in the Trust are to be used for providing for the petitioner, not for the benefit of the petitioner.

32. Fla. Admin. Code R. 65A-1.303 Assets in part states:

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. **An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf...**
(emphasis added)

33. In accordance with the above authority an asset is countable, if available for support or maintenance, even though the representative chooses not to do so. And assets that are not available due to legal restrictions are not considered.

34. Petitioner's counsel argued the assets in the Trust have legal restrictions and are unavailable.

35. Respondent's counsel argued that Article IX of the Trust lists the petitioner as the owner of the income and principal of the Trust. And allows the petitioner to reacquire assets of the Trust.

36. Section 409.910, Florida Statutes(1) Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable, in part states, "It is the intent of the Legislature that **Medicaid be the payor of last resort** (emphasis added) for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid."

37. The evidence submitted establishes that prior to the creation of the SMSA and the Trust, the petitioner had resources to pay for his ONE month stay at Osprey Point Nursing Center.

38. The evidence submitted also establishes that the petitioner is the owner of the income and principal of the Trust; which allows the petitioner to reacquire assets of the Trust. Therefore, the petitioner still has resources to pay for his ONE month stay at Osprey Point Nursing Center.

39. Additionally, the evidence submitted establishes that the Trustee shall use funds from the Trust to provide "personal care, support and maintenance" for the petitioner. Therefore, the petitioner has resources to pay for his ONE month stay at Osprey Point Nursing Center, through the Trustee.

40. In careful review of the authorities, evidence and testimonies, the undersigned concludes that the petitioner did not meet its burden of proof. The undersigned

concludes that the respondent's action to deny the petitioner ICP benefits for the month of March 2016, is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 14 day of September, 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
Stefanie Camfield, Esq.
Garland & Padelford Attorneys, LLC

FILED

Sep 12, 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]
[REDACTED]

APPEAL NO. 16F-03949

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 01 Escambia
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on August 4, 2016 at approximately 10:51 a.m., Central Standard Time (CST). All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent: Dianne Soderlind, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA), through its contracted peer review organization, eQHealth Solutions, Inc., to terminate Petitioner's Prescribed Pediatric Extended Care (PPEC) services.

Respondent bears the burden of proving, by a preponderance of the evidence, that said termination is proper.

PRELIMINARY STATEMENT

At hearing, the minor Petitioner was not present, but was represented by her mother, who also presented a witness from Petitioner's PPEC facility: [REDACTED] RN, Administrator/Director of Nursing. Respondent was represented by Dianne Soderlind, RN, on behalf of AHCA. Respondent presented one additional witnesses: Darlene Calhoun, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 9, inclusive, and Petitioner's Exhibits 1 through 4, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

FINDINGS OF FACT

1. The Petitioner is a 4-year-old male, born in 2012. He is diagnosed with

[REDACTED]
He suffers one to two seizures per month, but is not currently taking seizure medication due to side effects from same.

2. The Petitioner requires assistance with all activities of daily living (ADLs), is unable to walk independently, uses leg braces, and has an unsteady gait. He has low muscle tone and frequently falls, both while attempting to ambulate and during seizure

activity. He uses a walker and/or wheelchair to mobilize over long distances. Petitioner is unable to verbalize his needs and is incontinent.

3. The Petitioner resides at home with his single, working mother, who adopted both the Petitioner and his twin brother (who also has special needs). He receives Occupational, Physical, and Speech Therapies. Petitioner attends school during the day, but seeks PPEC services for school breaks and holidays. His mother has contacted various day care centers in the community, but has been unable to locate one equipped to provide care to or willing to enroll the two boys. The mother notes that she is concerned about the possibility of Petitioner having a seizure while in the care of someone who does not know how to respond.

4. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

5. On or about May 17, 2016, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue his previously authorized PPEC services of 180 full days and 180 partial days into the new certification period, spanning May 21, 2016 through November 16, 2016.

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

7. On May 20, 2016, the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated May 20, 2016, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

Clinical Rationale for Decision: The patient is a 4 year old with [REDACTED], [REDACTED], [REDACTED] and seizures. The patient seizures appear to be staring spells and have occurred about once per month. The seizures have not required [REDACTED]. The patient has not required respiratory interventions per provider. The patient wears AFOs and has an unsteady gait. The patient attends preschool where an aide is present; there is no nurse at the preschool. The clinical information provided does not support the medical necessity of the requested services. There no longer appears to be skilled interventions and the patient does not appear to meet the medical complexity requirement for PPEC services. The request is denied.

8. The May 20, 2016 letter, which eQHealth sent to Petitioner, notes only:

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

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

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

9. In response to this notice, on or about May 20, 2016, Petitioner's requested a hearing to challenge termination of PPEC. As this was a timely request, Petitioner's services have continued, pending outcome of his appeal.

10. At hearing, Dr. Calhoun testified based upon her review of Petitioner's request for services, in conjunction with his Plan of Care, assessments, care coordination and progress notes, and testimony from Petitioner's caregivers. Dr. Calhoun noted that while the Petitioner clearly requires precautions/monitoring, the only interventions indicated on the Plan are the administration of as-needed medications/nebulizer and ADL care.

11. Per Dr. Calhoun, Petitioner's assessments and notes reflect that Petitioner is not dependent upon mechanical devices, and does not have multiple seizures per day.

While Dr. Calhoun agrees that Petitioner requires adjustments to his seizure medication, continued therapeutic services, and assistance with ambulation and ADL development, she does not feel these needs indicate a medical necessity for continuation of PPEC.

12. Petitioner's PPEC provider noted that eQHealth's reviews as to who qualifies for PPEC services are becoming increasingly stringent. In her experience, PPEC used to be authorized for any child who had a seizure disorder and was taking seizure medication. At some point, the criteria became whether the child had a seizure within the year; then whether he/she had a seizure within the certification period; then whether the seizures required [REDACTED] then whether more than one of the seizures required [REDACTED]

[REDACTED] She does not feel that this is fair to Petitioner, and doesn't think his seizure disorder can be properly monitored in a regular day care setting.

13. The provider is also concerned that Petitioner's overall condition was not considered, as in addition to seizures, he is a fall risk, is incontinent, cannot express himself verbally, and is developmentally delayed. She emphasized that the nursing staff at PPEC assess Petitioner twice per day and closely monitor him. They are trained to notice subtle differences in his appearance and behavior, which may signify a change in his neurological status. If the Petitioner does have a seizure, staff respond to keep him stabilized, keep his airway open, and prevent him from falling/injuring himself, all while preparing to administer [REDACTED], if needed.

14. Petitioner's mother testified that Petitioner *does*, in fact, have an on-duty nurse (two nurses, who rotate schedules) at his school. She stated that she specifically sought a school setting where a nurse would be on staff, such that Petitioner would have immediate care in the event of an emergency, and be able to receive routine medication during the school day. She also testified that Petitioner sustained a seizure lasting more than 5 minutes in July of 2016, for which she had to administer [REDACTED]. She clarified that the Petitioner is not currently on seizure medication, as the [REDACTED] he was taking caused significant loss of muscle tone, for which he was hospitalized. He is currently taking [REDACTED] to assist in regaining muscle control, and his doctors are awaiting further progress in that regard before reinstating a seizure medicine.

15. Medical records from June and July of 2016 document the more recent history provided by Petitioner's mother. A narrative from his physician, dated July 8, 2016, states, in part:

[Petitioner] is under my care for spastic quadriparesis, strabismus, epilepsy and [REDACTED]. He has developmental delay. He was recently in emergency department at Sacred Heart Hospital for seizure exacerbation. He was seen today as an emergency visit for increased gait difficulties. He also has a chromosomal abnormality.

...

I hope you will maintain his current benefits.

16. It is Dr. Calhoun's opinion that at this time, Petitioner does not require skilled nursing interventions on a regular basis. Even though he is currently undergoing medication changes, and even though his seizures may have increased since stopping [REDACTED], said seizures still do not require regular intervention. The PPEC facility monitors Petitioner for seizures, and provides ADL care; however, Dr. Calhoun opined that this type of care and supervision can be provided by any trained adult. Per Dr.

Calhoun, if Petitioner were to experience a seizure while at a regular day care facility, the staff would call 9-1-1 and either be instructed as to administration of Diastat, or advised as to how to manage Petitioner until paramedics arrived.

17. Dr. Calhoun did testify that Petitioner might qualify for home health services/personal care, to assist in meeting his ADL needs. She opined that Petitioner's ambulation issues should continue to be addressed through PT, and his communication issues should be addressed through ST, both of which, along with OT, Petitioner can request as distinct services, outside of the PPEC setting.

18. AHCA agreed to assist Petitioner's mother in seeking additional and/or alternate supports within her community, and also suggested that she contact the Department of Children and Families (DCF) to explore their child care resources.

CONCLUSIONS OF LAW

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

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

21. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

22. This is a Final Order, pursuant to § 120.569 and § 120.57, Fla. Stat.

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

24. The burden of proof in the instant case is assigned to Respondent, who seeks to terminate Petitioner's PPEC services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

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

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

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

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

27. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

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

- Be Medicaid eligible.

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

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

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

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

(emphasis added)

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

30. Fla. Admin. Code Rule 59G-1.010(166) defines medical necessity, as follows:

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

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

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

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

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

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

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

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

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

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

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

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

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

34. In the instant case, PPEC is requested to treat and ameliorate the supervisory, monitoring, and continuous therapy needs which Petitioner’s health conditions require.

As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-

1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

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

36. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life-sustaining medical intervention or equipment. While he is currently undergoing medication changes that may result in increased/breakthrough seizures, these seizures do not consistently require "short, long-term, or intermittent *continuous* therapeutic interventions or skilled nursing care." They require monitoring and, on one occasion, required administration of Diastat. However, Dr. Calhoun testified that an adult caregiver can be taught to look for seizure activity and to respond, as necessary, when seizures occur.

37. Similarly, although Petitioner clearly requires continued therapy services and ADL care, these services can be provided outside of the PPEC setting. Therapy can be offered on an out-patient basis, and Petitioner may request personal care assistance visits for days when he is unable to attend school. As such, the provision of PPEC is currently in excess of Petitioner's medical needs.

38. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Respondent has met its burden of proof to terminate PPEC.

39. Petitioner's mother is to be commended for her dedication to her adopted sons, and her concern for their welfare is duly noted. Should Petitioner's health decline, such that he regularly requires medical or nursing interventions, his mother is encouraged to reapply for PPEC services. Additionally, she is encouraged to coordinate with AHCA and to contact the Department of Children and Families to seek assistance with locating an appropriate day care facility, and obtaining any other services which may be appropriate to meet Petitioner's needs. If any subsequent requests for services are denied, she will retain the right to appeal that/those, specific denial(s).

DECISION

Based upon the foregoing, Petitioner's appeal is hereby DENIED.

NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)

16F-03949

Page 14 of 14

DONE and ORDERED this 12 day of September, 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
AHCA, Medicaid Fair Hearings Unit

██████████

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

FILED

Sep 22, 2016

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-04174

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 PALM BEACH
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 2, 2016 at 8:30 a.m.

APPEARANCES

For the Petitioner:



For the Respondent:

Cindy Henline, Medical Program Analyst
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for an overnight hospital stay 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 Elvis Galvez, Government Contracts Specialist for Molina Healthcare, which is the petitioner's managed health care plan.

The respondent submitted a case summary, medical records, and medical criteria information, which were marked as Respondent composite Exhibit 1.

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 Molina Healthcare.
2. The petitioner's mother stated her daughter suffered a panic attack while participating in a chorus performance at her school and she was advised by paramedics to go to the hospital since she had a history of [REDACTED]. The petitioner had tests performed at the hospital and received I.V. fluids for dehydration. She remained in the hospital overnight and was released at noon the next day.
3. The petitioner's mother also stated she has not received any bills related to the hospital stay.
4. The Molina representative stated the overnight hospital stay was denied because the health plan believed the hospital services could have been provided at a different

level of care. He also stated the petitioner has no financial responsibility for any hospital bills for the services received.

CONCLUSIONS OF LAW

5. 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. Statutes.

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

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

8. 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.).

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

10. The undersigned concludes that there is no relief which can be afforded to the petitioner as part of the Medicaid fair hearing process since she received the services at issue and has no financial responsibility for any hospital bills.

Accordingly, the case is now moot.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 22 day of September, 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

FILED

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

Sep 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04197

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 PALM BEACH
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 5, 2016 at 8:30 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Lisa Sanchez, 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 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 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: Fair Hearing Summary, Clinical Notes, and Denial Notice.

FINDINGS OF FACT

1. The petitioner is a sixty (60) year-old Medicaid recipient. He is an undocumented, non-citizen alien. On January 2, 2016, he sought emergency room treatment due to severe chest pain. He underwent emergency heart surgery and was hospitalized until January 15, 2016
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for certain Medicaid services.
3. On May 5, 2016, eQ Health sent a notice to the petitioner entitled "Notice of Denial – Emergency Coverage: Undocumented Non-Citizen." This notice stated the following:

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

... Recommend approval from 1/2 to 1/5.

Awake, saturating well, on nasal canula [*sic*] and while need further post op medical care he was not in emergency on 1/6 to 1/14.

4. The petitioner's son stated his father can no longer work due to his medical conditions and he was hospitalized again for one week in May, 2016. He is not certain if his father was billed by the hospital for the services rendered in January, 2016.

5. The AHCA representative stated that emergency Medicaid coverage for aliens only covers the duration of the emergency.

6. The respondent's witness, Dr. Mittal, stated it would be appropriate to approve the hospital stay until January 9 rather than January 5 since the petitioner's condition did not become stable until January 10, 2016.

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. Statutes.

9. This is a final order pursuant to Fla. Statute Sections 120.569 120.57.

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. After considering the evidence and testimony presented, the undersigned concludes that the petitioner was entitled to emergency Medicaid coverage until January 9, 2016. After that date, his condition became stable and services rendered afterward cannot be considered emergency services. The respondent correctly denied the hospital stay from January 10 through 14, 2016.

DECISION

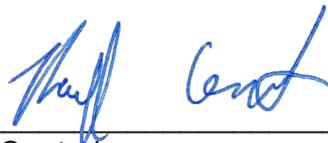
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, in part, and the petitioner is entitled to emergency Medicaid coverage from January 2 through January 9, 2016

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 27 day of September, 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

[REDACTED]

APPEAL NO. 16F-04284

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88264

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 26, 2016 at 1:30 p.m.

APPEARANCES

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

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

ISSUE

At issue is the Department's termination on July 19, 2016 for the Qualifying Individual 1 (QI1) program due to not meeting the income guidelines for a couple.

The petitioner is also disputing her continued enrollment in the Medically Needy program with a corrected share of cost in the amount of \$1353.

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

PRELIMINARY STATEMENT

The respondent submitted evidence that was entered as the Respondent's Exhibits 1 through 2. The petitioner did not submit evidence.

The record was held open until 5:00 on July 29, 2016 to allow the respondent to submit additional evidence. Evidence was submitted and entered as the Respondent's Exhibit 3.

The record was closed on July 29, 2016 at 5:00 p.m.

FINDINGS OF FACT

1. On or around April 1, 2016, the petitioner's husband completed a manual application to recertify for the Medically Needy (MN) and apply for the QI1 programs for herself (age 49) and her husband (age 53). The petitioner's husband included on the application his Social Security income in the amount of \$856 and his retirement income in the amount of \$470.20. The petitioner's husband also included on the application the petitioner's Social Security income in the amount of \$494.

2. The Respondent's Exhibit 2, page 11, includes the QI1 budget to include only the income for the petitioner's husband. The countable income for the petitioner's husband was \$1310.20 and the income standard for an individual was \$1337 for an individual. Therefore, the Department approved the QI1 program for the petitioner's husband. However, the petitioner was not included as part of the assistance group for the QI1 program (*Respondent's Exhibit 1, page 3*). The Department was unable to

explain the reason for the petitioner not being included as part of the assistance group for the QI1 program.

3. On or around July 19, 2016, the Department made corrections to the petitioner's case. The Department explained that corrections were made because the petitioner and her income were not included in its calculations for the months prior to July 2016.

4. The Department corrected the QI1 budget by including gross Social Security income in the amount of \$493 for the petitioner, the petitioner's husband's Social Security income in the amount of \$861 in Social Security income, and his retirement income in the amount of \$470.20. The total income included was in the amount of \$1824.20. The \$20 unearned income disregard was subtracted from the total gross income, which resulted in a countable unearned income of \$1804.20.

5. The Department determined that the petitioner and her husband were ineligible for the QI1 program as the income exceeded the QI1 income standard for a couple in the amount of \$1803. On July 19, 2016, the Department mailed to the petitioner the Notice of Case Action to inform her that she and her husband were not eligible for the QI1 program.

6. The Department calculated the MN budget by including the petitioner's gross monthly Social Security income in the amount of \$493 and the petitioner's husband's retirement income of \$470.20 and Social Security income of \$861, for a total unearned income in the amount of \$1824.20. The total gross income was subtracted by the unearned income disregard in the amount of \$20 to result in \$1804.20 total countable

income. The total countable income was subtracted by the Medically Needy Income Limit (MNIL) in the amount of \$241 to result in a monthly SOC in the amount of \$1563.20. The monthly SOC amount of \$1563.20 was further reduced by the Medicare insurance premiums paid by the petitioner's husband in the amount of \$104.90, to result in a remaining SOC in the amount of \$1458.

7. The Department completed a corrected MN budget (September 2016) after receiving testimony during the hearing that the petitioner would be paying the Medicare premium in the amount of \$104.90. The Department included the petitioner's gross monthly Social Security income in the amount of \$493 and the petitioner's husband's retirement income of \$470.20 and Social Security income of \$861, for a total unearned income in the amount of \$1824.20. The total gross income was subtracted by the unearned income disregard in the amount of \$20 to result in \$1804.20 total countable income. The total countable income was subtracted by the MNIL in the amount of \$241 to result in a monthly SOC in the amount of \$1563.20. The monthly SOC amount of \$1563.20 was further reduced by the Medicare insurance premiums paid by the petitioner and her husband in the amount of \$209.80, to result in a remaining SOC in the amount of \$1353 (*Respondent's Exhibit 3, page 7*).

8. The petitioner argues that her income will be reduced to \$342 beginning in August 2016 due to her Medicare premium in the amount of \$104.90 and the amount being taken out to repay a Social Security Administration (SSA) overpayment claim. The petitioner explained that she did what was required of her and reported to the SSA that she got married. The petitioner believes the overpayment occurred through no fault

of her own. The petitioner argues that she needs Medicaid so that she can receive treatment for her asthma and lung issues; she needs to receive treatment from a lung specialist. The petitioner and her husband do not receive any institutional care services (ICP), hospice services, or community based waiver services at this time.

9. The respondent explained that all of the petitioner's income must be included in its calculations and that there are no exceptions to allow her Medicare premiums and amount deducted to repay overpayment to be excluded as income. The respondent's records show that the petitioner has been enrolled in the MN program since May 2015 (*Respondent's Exhibit 3, page 8*). There was no evidence to show that the petitioner was recently receiving full-coverage Medicaid.

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-1.709 SSI-Related Medicaid Coverage states, "SSI-related Medicaid provides medical assistance to eligible individuals who are aged, blind or disabled in accordance with Titles XVI and XIX of the Social Security Act and Chapter 409, F.S."

13. Federal Regulations at 20 CFR § 416.1121 Types of unearned income

states:

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

14. Federal Regulations at 20 CFR § 416.1123, How we count unearned income.

(a) *When we count unearned income.*

We count unearned income at the earliest of the following points: When you receive it or when it is credited to your account or set aside for your use. We determine your unearned income for each month. We describe an exception to the rule on how we count unearned income in paragraph (d) of this section.

(b) *Amount considered as income.* We may include more or less of your unearned income than you actually receive.

(1) **We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see § 416.1121) has been reduced to recover a previous overpayment.** You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. *Exception:* We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums (**emphasis added**).

15. The above authorities explain that unearned income, such as Social Security income and retirement benefits, are included as income in determining eligibility for the Medicaid programs. Also included as income are amounts withheld to recover an

overpayment and to pay Medicare premiums. The findings show that the petitioner and her husband are receiving Social Security income and retirement benefits. The petitioner's income is reduced by amounts withheld to pay an overpayment of Social Security income and to pay her Medicare premium. Therefore, the undersigned concludes that the Department was correct to include the Social Security income and retirement benefits, along with including as income the amounts withheld to pay the overpayment and Medicare premiums, in its calculations.

The termination of the QI1 will be addressed first:

16. Fla. Admin. Code R. 65A-1.702 Special Provisions 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.)

17. Fla. Admin. Code § 65A-1.713 SSI-Related Medicaid Income Eligibility

Criteria 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.

(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.

18. The above authority explains that an individual must have income that is within the income limits established by the federal and state law as well as the Medicaid State plan. An individual may qualify for the QMB program if his income is less than or equal to the federal poverty level after applying exclusions to the income. The SLMB program requires income to be greater than 100% of the federal poverty level but equal to or less than 120% of the federal poverty level. An individual must have income greater than 120% of the poverty level but equal to or less than 135% of the federal poverty level to be eligible for QI-1. QI-1 only allows payment of the Part B Medicare premium through Medicaid.

19. The Department's Program Policy Manual, CFOP 165-22, passage 2440.0322 Standard Disregard (MSSI) states in part,

This policy applies to MEDS-AD, MN, QMB, SLMB, QI-1, Working Disabled, Protected Medicaid and EMA. A \$20 per month standard disregard applies to any type (earned or unearned) of income other than income which is provided on the basis of need. The amount of the disregard is not increased for a couple, regardless of whether one or both individuals have income.

20. The above authority states that for the QI-1 program, a \$20 per month standard disregard is allowed to reduce the amount in unearned income in determining eligibility for the program. An eligible couple only gets one \$20 disregard.

21. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the income standards for a couple, effective July 2016, as \$1335 for the QMB program, \$1602 for the SLMB program, and \$1803 for the QI 1 program. The income standards are a percentage of the Federal Poverty Level as explained above.

22. Based on the above findings of facts and conclusions of law, the undersigned concludes that the petitioner and her husband do not meet the income requirements to be eligible for the QI1 program.

The petitioner's continued enrollment in the Medically Needy Program will now be addressed:

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

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

24. The above controlling authorities explain that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related program is for individuals who are not receiving Medicare, or if receiving Medicare, are eligible for Medicaid covered institutional care services (ICP), hospice services, or community-based services. The findings also show that the petitioner is receiving Medicare but is not receiving ICP, hospice, or community based services. Therefore, the undersigned concludes that the petitioner does not qualify for full-coverage Medicaid.

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 01 day of September, 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

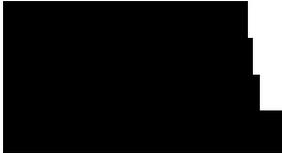
Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Sep 06, 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-04300

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on August 11, 2016, at 11:00 a.m.

APPEARANCES

For the Petitioner:



For the Respondent:

Stephanie Lang, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the respondent prove by a preponderance of the evidence that the Agency for Health Care Administration correctly denied the petitioner's request for Prescribed Pediatric Extended Care ("PPEC") Services?

PRELIMINARY STATEMENT

Pamela Smith, the petitioner's mother, appeared on behalf of the petitioner, [REDACTED] (petitioner"), who was not present. [REDACTED] may sometimes hereinafter be referred to as the petitioner's "representative".

Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Coordinator with the Agency for Health Care Administration ("AHCA" or "Agency"), appeared on behalf of the Agency for Health Care Administration. Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions, appeared as a witness on behalf of the Agency.

The respondent introduced Exhibits "1" through "6", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly. The petitioner did not introduce any exhibits.

At the request of the respondent, the hearing officer took administrative notice of the following:

- Section 409.905, Florida Statutes.
- Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.260.
- The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013.

FINDINGS OF FACT

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

1. The petitioner is a 13-year-old male diagnosed with [REDACTED] [REDACTED]
2. The petitioner was eligible to receive Medicaid at all times relevant to this proceeding.

3. The petitioner has limited verbal ability.
4. The petitioner is ambulatory.
5. The petitioner is [REDACTED].
6. The petitioner is on a regular, age-appropriate diet but requires assistance with meal preparation and feeding.
7. The petitioner has no documented respiratory issues.
8. The petitioner had two seizures in the prior certification period (December 10, 2015 through June 6, 2016) which required the administration of [REDACTED] [REDACTED] is an anti-seizure medication that is administered rectally by a parent or skilled nursing professional during prolonged seizure activity. One of the seizures occurred on January 4, 2016 and lasted five minutes and the other occurred on January 29, 2016 and lasted four minutes.
9. The petitioner had a [REDACTED] neurological consultation on April 11, 2016 at which time [REDACTED] was discontinued and [REDACTED] was added twice daily and as needed during prolonged seizures. The petitioner's mother reported one seizure which lasted two minutes and did not require the administration of medication since the medication change.
10. The petitioner is not on a complex medication regimen. His medications may be administered at home in the morning and in the evening.
11. The petitioner does not have a gastrostomy tube ("G-tube") or any other feeding tube.
12. The petitioner does not use a ventilator for assistance with breathing nor is he connected to any other medical equipment.

13. The petitioner attends school Monday through Friday. The school bus picks him up at 7:45 a.m. and drops him off at 3:30 p.m.

14. The petitioner lives in the family home with his mother, a single parent, and three siblings – ages 14, nine, and six. The petitioner's siblings do not have special needs.

15. The petitioner's mother works Monday through Friday from 7:00 a.m. to 3:00 p.m. and alternating weekends. On the weeks where the petitioner's mother works on the weekend, she gets corresponding days off during the week.

16. 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.

17. The petitioner was approved to receive 616 partial-day units and 154 full-day units of Prescribed Pediatric Extended Care Services in the previous certification period which ran from December 10, 2015 through June 6, 2016. This equates to care up to and including 12-hours per day, Monday through Saturday.

18. On or about May 25, 2016, the petitioner's provider submitted a request to eQHealth Solutions for 624 partial-day units and 156 full-day units of Prescribed Pediatric Extended Care Services for the current certification period which runs from June 7, 2016 through December 3, 2016. This, too, equates to care up to and including 12-hours per day, Monday through Saturday.

19. 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.

20. 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.

21. 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.

22. Prescribed Pediatric Extended Care Services are normally requested and approved in six month increments.

23. The petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on May 31, 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."

24. The Physician Reviewer provided the following clinical rationale for the decision:

The patient is a 13 year old with autism and seizures. The patient has had one seizure since his medication changes. The patient is not on a complex medication regimen. The patient is on an age-appropriate diet. The clinical information provided does not support the medical necessity of the requested

services. The patient does not appear to require skilled nursing. The request is denied.

25. The petitioner did not request an internal reconsideration of the eQHealth decision.

26. The petitioner requested an administrative fair hearing and this proceeding ensued.

27. 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.

28. The respondent's witness testified that Prescribed Pediatric Extended Care is designed for children that are medically complex and who require skilled nursing care. He testified PPEC services are generally for children who require ventilators for breathing assistance, gastrostomy tubes ("G-tubes"), or are dependent on the use of medical equipment to which they are attached. 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 potential seizure activity, nor may they be approved for monitoring and supervision. He explained any care provider may be trained to monitor a patient for seizures.

CONCLUSIONS OF LAW

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

30. 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.

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

32. 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.

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

34. 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...

35. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in 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.

36. 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.

37. 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).

38. 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.

39. 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.

40. 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.

41. 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.

42. 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.

43. 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.

44. 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 he require the provision of skilled nursing services. The petitioner’s level of illness does not reach the level of “medically complex” or “medically fragile,” as defined in the Florida Administrative Code.

45. After carefully reviewing the EPSDT and medical necessity requirements set forth above, the hearing officer concludes the respondent has demonstrated by a preponderance of the evidence that it correctly denied the petitioner’s PPEC Services.

DECISION

Based upon the foregoing, the petitioner's appeal is DENIED and the decision of the Agency for Health Care Administration is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 06 day of September, 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

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

FILED

Oct 05, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-04330

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on August 18, 2016 at 1:00 p.m.

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: Sylma Dekony, ACCESS Economic Self-Sufficiency
Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to deny his application for Medicaid disability benefits on the basis that he did not meet the disability Program requirement. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Donald Burtick, Unit Supervisor with the Division of Disability Determination (DDD), appeared telephonically, as a witness for the respondent.

Petitioner did not present any exhibits. Respondent submitted 1 exhibit, entered as Respondent's Composite Exhibit "1".

FINDINGS OF FACT

1. On February 29, 2016, the petitioner (22) applied for Medicaid disability benefits for himself. Petitioner also applied for disability benefits through the Social Security Administration (SSA) and was denied on April 22, 2016 due to an incomplete application. Petitioner is not over age 65 or blind and does not have any minor children. On December 23, 2015, the petitioner was involved in a motorcycle accident. The petitioner sustained a fracture and developed [REDACTED] on his right shoulder which required a transhumeral amputation on January 16, 2016.
2. Petitioner graduated from high school. Prior to the motorcycle accident, the petitioner was employed at [REDACTED] as a sales executive for the last eight months. Petitioner is no longer employed at [REDACTED] since December 23, 2015.
3. The respondent reviewed the petitioner's eligibility for SSI-Related Medicaid for the blind, aged or disabled. The respondent sent the petitioner's medical information to DDD on March 30, 2016 for a disability determination.
4. The respondent's witness explained DDD completed an independent medical evaluation of disability and determined that the petitioner did not meet the criteria of aged, blind or disabled to be eligible for Medicaid disability benefits.

5. On May 6, 2016, DDD completed a disability review, which resulted in an unfavorable (N35) decision. DDD lists the petitioner's primary diagnosis as [REDACTED] and his secondary diagnosis as [REDACTED]. Decision code N35 signifies "Non-pay- Impairment is severe at time of adjudication but not expected to last twelve months, no visual impairment."
6. DDD Case Analysis Form, SSA-416, dated May 4, 2016 states in part:
 1. Is claimant engaging in SGA? DDD did not address
 2. Is impairment severe? YES, however not expected to last
 3. N/A
 4. N/A
 5. N/A
7. DDD determined the petitioner not disabled at step 2. DDD determined that the petitioner's impairments were severe; however, did not meet or medically equal a listing according to Vocational Rule 202.13. The petitioner was determined not to be disabled and capable of light work such as a ticket taker, flagman, or usher.
8. On May 9, 2016, the respondent sent the petitioner a Notice of Case Action denying his February 29, 2016 application for Medicaid disability benefits. The reason stated was that he did not meet the disability requirement.
9. Petitioner explained the amputation of his right arm has been a devastating and life-changing experience. He requires assistance from his family for his personal care.
10. Petitioner is not able to perform his personal care independently, but he is able to prepare simple meals. He is able to stand/walk.
11. On February 26, 2016, the petitioner had a follow-up visit with [REDACTED], M.D. During the visit, the petitioner reported he was doing well and some soreness of

the right upper extremity. Staples were removed, no drainage or redness was observed on the RUE. Petitioner was prescribed [REDACTED], and [REDACTED].

CONCLUSIONS OF LAW

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

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

14. Federal Regulation 42 C.F.R. § 435.541 sets standards for when it is appropriate for the state Medicaid agency to make a determination of disability for individuals who apply for Medicaid. The regulation states in relevant part:

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

(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.

15. 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. § 1396 a(m).

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

§ 416.905. The regulation states in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(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. 42 C.F.R. § 435.541 indicates that a state Medicaid agency's determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

17. 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.
(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.)

18. 20 C.F.R. § 404.1567 “Physical exertion requirements” states:

To determine the physical exertion requirements of work in the national economy, we classify jobs as sedentary, light, medium, heavy, and very heavy...In making disability determinations under this subpart, we use the following definitions:

(a) Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

19. In evaluating the first step, the petitioner is not engaging in substantial gainful activity. Therefore, the first step is met.

20. In evaluating the second step, the impairments must last or be expected to last for a continuous period of at least 12 months to meet durational requirements. The petitioner has a diagnosis of [REDACTED], which are not expected to last for a period of at least 12 months. The second step is not met. DDD stopped on step

two. Based on the petitioner's age, educational grade level, employment history and his impairments, DDD determined the petitioner would be capable of light work. According to DDD's analysis and the objective medical evidence, the petitioner should be capable of performing light and sedentary duty jobs in the national economy.

21. Based on the evidence submitted, the hearing officer must conclude that the petitioner does have the ability to perform work in the national economy. The petitioner does not meet the disability criteria and does not meet the definition of disability as set forth in the Social Security Act. It is concluded that the respondent's denial of the petitioner's Medicaid disability application is correct.

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 05 day of October, 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

Sep 06, 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-04357
16F-05105

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:55 a.m. on July 1, 2016.

APPEARANCES

For the Petitioner: [REDACTED]

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

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate the petitioner's Medicaid Qualified Medicare Beneficiary (QMB) is proper. And whether the respondent's calculation of the petitioner's Medically Needy (MN) Share of Cost (SOC) amount is correct. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated June 1, 2016, the respondent (or the Department) notified the petitioner QMB benefits would end on June 30, 2016; due to household income. Also by notice dated June 6, 2016, the Department notified the petitioner MN was approved with a \$1,495 SOC. Petitioner timely requested a hearing to challenge the QMB termination and the MN SOC amount.

Petitioner did not submit exhibits. Respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record was held open through end of business day on July 1, 2016, for the respondent to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "8". The record was closed on July 1, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received QMB benefits and her MN SOC was \$686. Also prior to the action under appeal, the Department was only counting the petitioner's income in her benefit eligibility.
2. On May 26, 2016, the petitioner submitted a recertification application for Food Assistance and Medicaid benefits for her and her husband. The application lists income from Social Security for the petitioner and her husband; \$914 for petitioner's husband and \$947 for petitioner. Medicaid QMB and MN for the petitioner are the only issues.
3. To determine the petitioner's QMB eligibility the Department first verified that the petitioner receives \$947 Social Security Disability Income (SSDI) and her husband receives \$914 SSDI.

4. The QMB calculation is as follows:

\$ 914.00	petitioner's husband's SSDI
+\$ 947.00	petitioner's SSDI
<hr/>	
\$1,861.00	total household income
-\$ 20.00	unearned income deduction
<hr/>	
\$1,841.00	total household income

5. For petitioner to be eligible for QMB benefits her household income cannot exceed the QMB income limit for a couple of \$1,335 (effective July 2016). Petitioner's \$1,841 household income exceeds the \$1,335 QMB income limit.

6. Medicaid offers two other Medicare Savings Plan (MSP) besides the QMB; which have a different income limit. Special Low-Income Medicare Beneficiary (SLMB) has a \$1,602 income limit (effective July 2016) for a couple and Part B Medicare Only Beneficiary (Q11) has a \$1,803 income limit (effective July 2016) for a couple. Petitioner's \$1,841 household income exceeds the SLMB and Q11 income limits.

7. On June 1, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA) notifying QMB would end on June 30, 2016.

8. The petitioner's MN SOC calculation is as follows:

\$ 914.00	petitioner's husband SSDI
+\$ 947.00	petitioner's SSDI
<hr/>	
\$1,861.00	total household income
-\$ 20.00	unearned income deduction
-\$ 241.00	MN income limit for household size of two
-\$ 104.00	Medicare premium
<hr/>	
\$1,495.00	SOC

9. On June 6, 2016, the Department mailed the petitioner a NOCA notifying she was approved MN with a \$1,495 SOC.

10. Petitioner was upset that there was "no grace period" when QMB was terminated. And stated that MN with the SOC "does not work in the real world".

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.

QMB ISSUE

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

(12) Limits of Coverage.

(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...

(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)...

14. 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...

15. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9 (July 2016), identifies the following MSP Program income limits for couples:

QMB	\$1,335
SLMB	\$1,602
QI1	\$1,803

16. Federal regulations at 20 C.F.R. § 416.1121 defines unearned income.

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits...

17. In accordance with the above authority, respondent included petitioner's \$947 SSDI and her husband's \$914 SSDI to arrive at \$1,861 combined income.

18. 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". Respondent deducted \$20 from petitioner and her husband's \$1,861 combined income to arrive at \$1,841 countable income.

MEDICALLY NEEDY ISSUE

19. 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...

20. The above authority explains to be eligible for full Medicaid; income cannot exceed 88 percent of the federal poverty level (FPL). And Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income.

21. Policy Manual, CFOP 165-22, Appendix A-9 (July 2016), identifies \$1,175 as 88 percent of the FPL for a couple.

22. Petitioner's \$1,861 SSDI household income exceeds the \$1,175 income limit to be eligible for full Medicaid. Therefore, petitioner is not eligible for full Medicaid.

23. 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..."

24. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$241 for a family size of two.

25. In accordance with the authorities, respondent deducted \$20 unearned income and \$241 MNIL from \$1,861, petitioner's household income, to arrive at \$1,495 SOC.

HEARING OFFICER CONCLUSION

26. In careful review of the cited authorities and evidence, the undersigned concludes the Department met its burden of proof. The undersigned agrees with the Department's action to terminate QMB benefits and approve MN with a \$1,495 SOC.

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 06 day of September, 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

Sep 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-04379

PETITIONER,

Vs.

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

RESPONDENT.
_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 23 2016 at 1:10 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to continue to receive Prescribed Pediatric Extended Care (PPEC) services. 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 perform prior services authorizations for certain Medicaid services, including PPEC services.

The matter was previously scheduled to be heard on August 5, 2016. The petitioner did not appear. The petitioner contacted the hearing officer later and requested that the hearing be rescheduled because she misunderstood the telephone hearing calling instructions. The hearing was rescheduled for August 23, 2016.

By notice dated June 1, 2016, eQ informed the petitioner that his request for continued PPEC services for the certification period May 23, 2016 – November 17, 2016 was denied. The notice reads in part: “the services are not medically necessary.”

The petitioner requested reconsideration.

By notice dated June 11, 2016, eQ informed the petitioner that the original decision was upheld.

The petitioner timely requested a hearing to challenge the denial decision. The petitioner’s PPEC services have been continued pending the outcome of the hearing.

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

Present as a witness for the respondent from eQ: Dr. Rakesh Mittal, physician consultant. The respondent submitted documentary evidence which was admitted into

the record as Respondent's Composite Exhibit 1. The hearing record was closed on August 23, 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 14 months) is a Florida Medicaid recipient.

2. The petitioner was born prematurely, at 24 weeks. His birth weight was extremely low (he weighed less than 2 pounds); he also suffered from [REDACTED], [REDACTED].

3. In late 2015, the petitioner was approved for seven hours (9am to 4pm) of PPEC services (specialized medical daycare for children with complex medical needs) daily, Monday – Friday for six months (November 2015 – May 2016) due to his coexisting conditions.

4. Continued eligibility for PPEC service must be reviewed every six months. In May 2016, the petitioner's treating physician submitted a request for continued PPEC services to eQ (AHCA's contracted review agent) for another six month certification.

The request form reads as follows:

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

[REDACTED]
[REDACTED]
[REDACTED] He is also at

risk for aspirations. For all the above reasons, he needs to be monitored closely in a specialized daycare. I strongly recommend that he continue to attend Fletcher's Tendercare.

5. All Medicaid services must be medically necessary as determined through a prior service authorization process. eQ reviews the authorization request form and all supporting documentation during the review process. eQ has no direct contact with the child or child's family.

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

7. The Plan of Care describes the petitioner as a child with serious coexisting medical conditions, who requires administration of medication as needed, monitoring and supervision.

8. The clinical notes from the petitioner's PPEC record monitoring of his diet and feeding schedule, administration of [REDACTED] medications and breathing treatments as needed, speech and physical therapies.

9. The petitioner lives in the family home with mother and one sibling (age 6). The mother has no known medical issues. The sibling has also been diagnosed with [REDACTED]. The mother is the only source of natural support. The mother is employed outside of the home 30 hours weekly.

10. eQ concluded that the petitioner's medical condition has stabilized since birth and while he has substantial medical needs, he no longer requires continuous

skilled nursing care. The clinical rationale section of eQ's evaluation explains the denial decision:

[Patient] is noted to be an 11 month old male with a history of [REDACTED] and [REDACTED]. The patient no longer has apnea and bradycardia and is on room air. The patient is on an age-appropriate diet. The patient requires respiratory treatments. His clinical information provided does not support the medical necessity of the requested services. The patient does not appear to require skilled nursing interventions and does not meet the medical complexity requirements.

11. The petitioner requested reconsideration. The reconsideration clinical rationale section of eQ's evaluation reads: "None of the information supported the medical necessity for skilled nursing services or interventions and does not meet the medical complexity for PPEC services."

12. Dr. Rakesh Mittal, physician reviewer with eQ, appeared as a respondent witness during the hearing. Dr. Mittal opined that the petitioner's needs can be met by a capable and responsible adult. Dr. Mittal concluded that the petitioner's care needs do not require the services of skilled nurse staff because he does not suffer from seizures nor does he require mechanical devices (G-tube for feedings, ventilator, or IV for medications) to maintain life. He no longer suffers from [REDACTED]. His speech and physical therapy services can be continued on an outpatient basis. Dr. Mittal opined that it is not medically necessary that the petitioner continue to receive PPEC services.

13. The petitioner's mother asserted that his needs cannot be met at a standard daycare center. His lungs have "collapsed twice", requiring emergency medical attention; the most recent occurrence was in July 2016, the petitioner was hospitalized

for two days. His asthma requires close monitoring and breathing treatments as needed. The mother acknowledged that the petitioner no longer suffers with [REDACTED]; however, he continues to have digestive issues which requires monitoring. The mother asserts that the petitioner's needs are beyond those of a standard daycare center.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

- “Medical necessary” or “medical necessity” means that medical or allied care, goods, or services furnished or ordered must:
- (a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
 3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
 4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider. . .
-
- (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

21. As the petitioner is under 21, a broader definition of medically necessary applies to include the EPSDT requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, defines Medicaid services for children to include:

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

therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

22. The above citation explains that the respondent must provide treatment and services to Medicaid recipients under 21 years of age, but only to the extent such services are medically necessary. The state is authorized to establish the amount, duration, and scope of such services.

23. 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.”

24. 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.

25. 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.

26. The respondent, through its agent eQ, denied the petitioner's request for ongoing PPEC services. The respondent determined that the services were not medically necessary because the petitioner did not meet the eligibility requirements.

27. The petitioner's medical condition was not stable at birth. Skilled nursing care was required at that time. The evidence proves that the petitioner's medical condition has improved significantly. He is no longer jaundice and no longer suffers from [REDACTED] or [REDACTED]. The petitioner has serious coexisting conditions that require monitoring and supervision; however, the evidence does not prove that he requires continuous therapeutic interventions or skilled nursing care. The petitioner does not require G-tube feedings; he is not ventilator dependent nor does he require a medical apparatus to maintain life. The petitioner's mother argued that his needs cannot be met at a standard daycare and the respondent did not make the argument that a standard daycare was appropriate for the petitioner. The respondent argued that his care needs can be met by a responsible adult, i.e., an in-home caregiver/baby sitter. The undersigned concurs with the respondent's conclusion.

28. 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 19 day of September, 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

Sep 13, 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-04443

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 08 Levy
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, administrative hearing in the above-styled matter convened on July 26, 2016 at approximately 3:04 p.m. All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED]

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

STATEMENT OF ISSUE

At issue is a decision by Respondent, the Agency for Health Care Administration (AHCA or "the Agency), to deny Petitioner's request to change Managed Care Organizations (MCOs). Petitioner bears the burden of proving, by a preponderance of the evidence, that this denial was improper.

PRELIMINARY STATEMENT

The Agency for Health Care Administration is responsible for administering Florida's Medicaid Program. In the instant case, AHCA had contracted with the MCO/Health Maintenance Organization (HMO), Sunshine Health ("Sunshine"), to provide services to Petitioner; however, Petitioner seeks to change MCOs

At hearing, Petitioner appeared as her own representative. Respondent was represented by Selwyn Gossett, AHCA Medical Health Care/Program Analyst, who also presented three witnesses from co-Respondent, Sunshine Health: Joerosa Davis, Manager of Grievances and Appeals; Tracy Thomas, Appeals Coordinator 2; and Kizzy Alleyne, Paralegal.

Although Sunshine's 'Medicaid Fair Hearing Summary' was referenced during hearing, it was not officially moved into the record. As such, said summary (three pages, dated June 20, 2016) is hereby entered as Respondent's Exhibit 1.

Respondents were unable to properly outline the progress of Petitioner's case, nor were they able to give a clear justification for denying her request to disenroll from Sunshine and enroll with a different MCO (United Healthcare). The parties were advised that the testimony secured at hearing would be taken under advisement, and that they would be notified of the need for any additional information.

Upon review of the record, the undersigned has determined that she has sufficient information to render a decision. This Final Order follows.

FINDINGS OF FACT

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

1. Petitioner is an adult female, over the age of 21. At all times relevant to this appeal, she has been eligible for Medicaid, as administered through a Managed Care Plan model.

2. On or about March 5, 2016, Petitioner was notified that her annual open enrollment period would run from March through May 31, 2016.

3. Petitioner has a cataract in her left eye, which requires surgery. At least as early as May 10, 2016, Petitioner contacted her current MCO, Sunshine Health, to request assistance locating an ophthalmologist provider.

4. Per Sunshine's case summary, Petitioner spoke to the MCO on May 10, 17, and 23, 2016. It is Sunshine's position that they assisted in locating several providers, and left voicemails for Petitioner with additional options, when they were unable to reach her via telephone.

5. Petitioner testified that she contacted 23 of the providers suggested by Sunshine (or listed as participating providers on Sunshine's website). Almost all of these providers indicated that they no longer participate in Sunshine's network. Petitioner was able to find one provider who still accepts Sunshine patients; however, the facility at which said provider performs surgeries does *not* participate with Sunshine. As such, the Petitioner was told she would have to pay out-of-pocket for the surgical portion of her eye care.

6. During the dates that Petitioner was corresponding with Sunshine to find an ophthalmologist, she was still well within her open enrollment period. As such, she also contacted Med Options/Choice Counseling, AHCA's contractor for MCO enrollment, and

AHS, AHCA's enrollment broker, to discuss the possibility of changing to an MCO that participated with a larger network of eye care providers.

7. Petitioner was advised by Choice Counseling that she should first attempt to have Sunshine authorize provision of care by an out-of-network provider. She was also informed that even if her open enrollment period expired, she would still be able to change MCOs, albeit with some "red tape," if she could not locate a provider through Sunshine Health.

8. Petitioner did contact Sunshine Health, but did not hear back from them regarding out-of-network care. On or about June 6, 2016, she again contacted AHCA, to formally request changing to a new MCO.

9. Although the AHCA representative present at hearing was not certain what transpired during this call, it appears that the AHCA representative who fielded Petitioner's call in June of 2016 attempted to enter into AHCA's system a "good cause" reason for changing plans. This request was rejected under a generic code, and AHCA upheld the resultant denial.

10. Via notice dated June 6, 2016 (not proffered as part of Respondent's evidence), Petitioner was notified that her request was denied because she did not meet a State-accepted good cause reason for switching MCOs. There is no evidence that AHCA, nor any of its contracted agents, ever spoke to Petitioner to clarify what she was alleging as good cause, or to determine whether additional information was necessary to process her request.

11. When the Petitioner called the AHCA number provided on her denial notice, she was told to file a grievance with Sunshine Health.

12. Per Sunshine's case summary, on June 6, 2016, Petitioner "contacted Sunshine Health Customer service representative in reference to disenrollment...[and] was advised to call Choice Counselling about disenrollment issues." Petitioner states that following this call, she was given grievance number CAS-5173-911-P8R4Q6.

13. On or about June 9, 2016, after receiving no response from Sunshine, Petitioner again contacted AHCA, and was told to request a hearing to challenge AHCA's denial. She then called the Office of Appeal Hearings to file her hearing request.

14. At hearing, Sunshine stated that the plan does not have authority to change a member's MCO. Sunshine further contended that, although Petitioner did have a "complaint" on file regarding disenrollment, she had not filed a "grievance." Sunshine testified that its policy is to respond to complaints via telephone, and noted that they were unable to reach Petitioner, but had left several voice messages requesting that she return their calls. When these calls were not returned, the complaint was closed out as unresolved, and forwarded to Sunshine's grievance and appeals department.

15. It is not clear why Sunshine did not treat the disenrollment request as a grievance, nor is it clear what their procedure is for assisting members who express desire to switch to a different health plan.

16. In response to Sunshine's testimony, Petitioner noted that she has never received a voicemail from the MCO. She asked what phone number Sunshine has been calling, and Sunshine read into the record a number that does not belong to Petitioner. The Petitioner provided her correct number, but Sunshine stated they were unable to change same in her file, noting she would have to contact customer service to make this correction.

17. When asked why Sunshine did not follow their unanswered phone calls with a written Notice of Inability to Contact, Sunshine testified that it is not their policy to follow up in writing.

18. The parties were advised that the undersigned would take all testimony into consideration and under advisement, and notify them of any decisions with regard to this appeal.

CONCLUSIONS OF LAW

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

20. This is a Final Order, pursuant to Fla. Stat. § 120.569 and § 120.57.

21. This hearing was held as a *de novo* proceeding, pursuant to Fla. Admin. Code R. 65-2.056. The burden of proof was assigned to the Petitioner, per Fla. Admin. Code R. 65-2.060(1).

22. The standard of proof in a Medicaid hearing is “preponderance of the evidence,” as provided by Fla. Admin. Code R. 65-2.060(1).

23. Per Section 409.912, Florida Statutes, AHCA is required to purchase goods and services for Medicaid recipients in the most cost-effective manner possible, consistent with the delivery of quality medical care.

24. The Florida Medicaid Provider General Handbook (Provider Handbook) – July 2012 is incorporated by reference in the Medicaid Services Rules found in Fla. Admin. Code R. 59G-5. In accordance with the Florida law, the Handbook discusses HMO Coverage, stating 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.

25. Federal regulations at 42 C.F.R. § 438.56(d) govern HMO/MCO disenrollment procedures. These procedures are summarized in Section 409.969(2),

Florida Statutes, which notes:

DISENROLLMENT; GRIEVANCES.—After a recipient has enrolled in a managed care plan, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause. For purposes of this section, the term “good cause” includes, but is not limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency must make a determination as to whether good cause exists. The agency may require a recipient to use the plan’s grievance process before the agency’s determination of good cause, except in cases in which immediate risk of permanent damage to the recipient’s health is alleged.

(a) The managed care plan internal grievance process, when used, must be completed in time to permit the recipient to disenroll by the first day of the second month after the month the disenrollment request was made. If the result of the grievance process is approval of an enrollee’s request to disenroll, the agency is not required to make a determination in the case.

(b) The agency must make a determination and take final action on a recipient’s request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient’s request to disenroll is deemed to be approved as of the date agency action was required.

Recipients who disagree with the agency’s finding that good cause does not

exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

26. 42 C.F.R. § 438.56(d)(4) governs what the state agency (AHCA) must review in order to determine the presence or absence of good cause, stating:

State agency action on request. For a request received directly from the beneficiary, or one referred by the MCO, PIHP, PAHP, PCCM, or PCCM entity, the State agency must take action to approve or disapprove the request based on the following:

- (i) Reasons cited in the request.
- (ii) Information provided by the MCO, PIHP, PAHP, PCCM, or PCCM entity at the agency's request.
- (iii) Any of the reasons specified in paragraph (d)(2) of this section.

27. Review of the evidence reflects that Petitioner has presented good cause for disenrollment, related to lack of access to necessary specialty services and an unreasonable delay in obtaining same.

28. In trying to resolve these issues, Petitioner was continually directed from AHCA to the MCO, and back again. There is little evidence to suggest that AHCA considered the reasons cited in Petitioner's request -- indeed, it is not clear that AHCA even knew why Petitioner was requesting a plan change at the time AHCA issued its notice denying same. Petitioner attempted to file a grievance with Sunshine, but this process, too, resulted in confusing responses, and lack of follow through to ensure Petitioner's concerns were met.

29. Petitioner has met her burden of proof to demonstrate good cause, thus proving that AHCA's denial of her request to switch to United Healthcare was improper.

DECISION

Petitioner's appeal is hereby GRANTED. Respondent AHCA is directed to comply with all governing authority while assisting Petitioner in her transition to United Healthcare. AHCA is further charged with ensuring that no loss of Medicaid eligibility or benefits occurs as a result of said transfer.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 13 day of September, 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
Sunshine Hearings Unit

FILED

Oct 25, 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]
[REDACTED]

APPEAL NO. 16F-04449

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 19, 2016 at 3:15 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Selwyn Gossett, Healthcare analyst

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to continue to receive Prescribed Pediatric Extended Care (PPEC) services through Medicaid. 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 several Medicaid services, including PPEC services.

The hearing was initially scheduled to convene telephonically on August 5, 2016 at 3:00 p.m. The petitioner did not appear. The petitioner later contacted the undersigned hearing officer and requested that the hearing be rescheduled. The petitioner's motion was granted. The hearing was held on September 19, 2016.

By notice dated June 1, 2016, eQ informed the petitioner that his request for continued PPEC services for the certification period May 21, 2016 – November 16, 2016 was denied. The notice reads in part: "the services are not medically necessary."

The petitioner timely requested a hearing to challenge the denial decision on June 10, 2016. The petitioner's PPEC services have been continued pending the outcome of the hearing.

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

Present as a witness for the respondent from eQ: Dr. Rakesh Mittal, physician reviewer. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1. The record was closed on September 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. The petitioner (age 8) is a Florida Medicaid recipient.

2. The petitioner's diagnoses includes [REDACTED]

[REDACTED].

3. The petitioner has been receiving PPEC services (specialized medical daycare for children with complex medical needs) for four years. The petitioner attends elementary school Monday – Friday from 7:30 am – 3:00 pm. The petitioner only attends PPEC during school holidays and summer break.

4. Continued eligibility for PPEC service must be reviewed every six months.

5. On May 26 2016, the petitioner's treating physician submitted a request for continued PPEC services to eQ (AHCA's contracted review agent).

6. All Medicaid services must be medically necessary as determined through a prior service authorization process. eQ reviews the authorization request form and supporting documentation during the review process. eQ has no direct contact with the child or child's family.

7. In the instant case, eQ reviewed the request form and petitioner's Plan of Care (a document which defines the patient's need for Medicaid services and the service goals), Home Health Assessment (a document which describes household composition, member's medical condition, and functioning level) and PPEC facility notes to make the eligibility decision.

8. The Plan of Care is dated May 27, 2015 and describes the petitioner as follows:

Premature at 26 weeks, weighing 3 pounds, 1 ounce. Went from the NICU to home. Mom noticed that he was not crawling and took him to the pediatrician where he was diagnosed with [REDACTED]. Currently unstable in his walk. Wears a helmet for safety at all times. Non-verbal. Not able to communicate needs. History of problems swallowing and tolerating foods. Attends Pinedale Elementary in special needs class. Currently receives PT.

...
Monitored closely for reflux and fall precautions....He will need diagnostic testing for vomiting...He is not potty trained.

...
He will attend the PPEC on non-school days and summer break.

9. The clinical notes from the petitioner's PPEC facility record delay in ambulating, unsteady gait, helmet worn for safety, able to communicate in simple sentences, and follow simple commands. Notes go on to record history of issues with swallowing and intolerance of certain foods.

10. The petitioner lives in the family home his mother, step-father, and five siblings. The other family members have no disabling conditions. The mother works outside the home as an on-call nursing assistant. The step-father does not work outside the home. The family is the only source of natural support.

11. eQ concluded that the petitioner's medical condition had stabilized since birth; he has medical needs, but no longer requires continuous skilled nursing care.

The clinical rationale section of eQ's evaluation explains the denial decision:

The patient is an 8 year old with [REDACTED]. The petitioner has developmental delay and behavior issues. The patient is on an age-appropriate diet. The patient is on one scheduled medication. The patient is receiving behavior therapy as an outpatient. The clinical information provided does not support the medical necessity of the

requested services. The patient does not appear to have any skilled needs while attending PPEC. The request is denied.

12. Dr. Rakesh Mittal, physician reviewer with eQ, appeared as a respondent witness during the hearing. Dr. Mittal opined that the petitioner's care needs do not require the services of skilled nursing staff because he does not require mechanical devices (G-tube for feedings, ventilator, or IV for medications) to maintain life, nor does he have a history of frequent seizure activity. Dr. Mittal opined that it is not medically necessary for the petitioner to continue to receive PPEC services.

13. The petitioner's mother argued that he requires PPEC services. The petitioner was "small" when he was born. He could not eat by mouth and was fed by G-tube for some time (he is now on a regular diet and fed by mouth). The petitioner continues to lag behind his peers in development, both physical and cognitive. The petitioner functions on the level of an average two year old. He is a fall risk and has no awareness of danger. He also has behavior issues; he does not like wearing his safety helmet and will take it off and throw it.

14. The petitioner's mother also noted that he had one seizure, the first in his life, a short time ago and she is closely monitoring him on the advice of his physician. There had been no additional seizure activity as of the date of the hearing.

15. In rebuttal, Dr. Mittal opined that a single seizure does not warrant continuous skilled nursing care. Monitoring is the appropriate course of action and can be done by any responsible adult. eQ stands by its decision that it is no longer medically necessary for the petitioner to receive PPEC services.

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 respondent.

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 and therapeutic 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, through its agent eQ, denied the petitioner’s request for ongoing PPEC services. The respondent determined that the services were no longer

medically necessary because the petitioner does not require continuous skilled nursing care.

29. The petitioner argued that he is developmentally delayed and requires specialized care.

30. The petitioner's medical condition was not stable at birth; he was born prematurely, extremely low birth weight and required G-tube feeding. Skilled nursing care was required at that time. The evidence proves that the petitioner's medical condition has improved significantly over time. He is on a regular diet and fed by mouth. Except for a single, isolated incident, the petitioner does not suffer from seizures. He is developmentally delay and requires assistance, supervision, and monitoring to ensure his health and safety. However, the petitioner does not require G-tube feedings; he is not ventilator dependent; he does not require a medical apparatus to maintain life.

31. 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

FINAL ORDER (Cont.)

16F-04449

PAGE - 10

32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 25 day of October, 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

Oct 31, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04450
16F-07300

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 29, 2016, at 8:30 a.m. All parties appeared telephonically for different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Debbie Ellis, economic self-sufficiency supervisor.

STATEMENT OF ISSUE

At issue is whether the petitioner received the correct Temporary Cash Assistance (TCA) benefits between April 2016 and August 2016 as a result of adding a newborn to her case. Also at issue is whether the newborn is eligible for Medicaid benefits effective April 2016 to cover an unpaid medical bill. The petitioner is asserting

the affirmative and bears the burden of proof by a preponderance of the evidence in both cases.

PRELIMINARY STATEMENT

The appeal was reopened from closed as withdrawn at the petitioner's request and was continued on behalf of the respondent.

At the hearing, the petitioner presented eight (8) exhibits, which were accepted and entered into evidence as Petitioner's Exhibits 1 through 8. The respondent's exhibits were marked as Respondent's Exhibits 1 & 2. The record was left open through October 7, 2016 for the respondent to provide additional evidence. An extension of time was requested by the respondent and was granted. The information was received and marked as Respondent's Exhibits 3 through 7. The record was closed on October 11, 2016.

FINDINGS OF FACT

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

1. Prior to the action under appeal, the petitioner has been receiving \$298 in Cash Assistance for her niece under the Relative Caregiver Program (RCG). Her last month of eligibility was August 2016.
2. On April 22, 2016, the petitioner submitted an electronic application requesting additional benefits for her household. The application listed the petitioner, her 17 year-old niece (T H) and the niece's newborn (DOB [REDACTED]) as household members.
3. In May 2016, the petitioner submitted proof of immunization and application for a Social Security number for the newborn to the Department. The case was processed

and approved. On May 21, 2016, the respondent sent a Notice of Case Action (NOCA) to the petitioner informing her that she was approved.

4. On May 25, 2016, the respondent sent a NOCA to the petitioner informing her that her TCA benefits would stop as of June 30, 2016 due to a household member's failure to cooperate with child support enforcement.

5. On June 6, 2016, the respondent sent a NOCA to the petitioner informing her that she was approved \$298 in TCA benefits for T H. On July 28, 2016, the respondent sent a NOCA to the petitioner informing her that this benefit would stop as of August 31, 2016 due to a member receiving the same assistance from another program.

6. On September 12, 2016, the respondent sent a NOCA to the petitioner informing her that TCA benefits would stop as of September 30, 2016 due to a member's failure to cooperate with child support enforcement.

7. The newborn has a \$179 outstanding medical bill for laboratory services provided in April 2016. The bill was later adjusted to \$161. On June 8, 2016, a statement was sent to TH requesting payment. The respondent provided the petitioner with a Temporary Emergency Medicaid Identification Card effective May 1 through May 31, 2016 with the newborn's Medicaid identification number as proof of eligibility, See Petitioner's Exhibits 1 through 8.

8. TCA benefits begin from the date of disposition or 30 days after the date of application, whichever is sooner. The case was approved on May 20, 2016. The petitioner received \$35 for May 2016, \$158 for June 2016 (for two), \$69 for July 2016, \$95 for August 2016 and \$241 effective September 2016, See Respondent's Exhibit 7. The respondent explained the variations on a child support sanction. She explained

that the teen mother was incorrectly included in the TCA benefits for June due to a processing error. No child support enforcement agency was present as a witness. The respondent explained that the newborn was eligible for Medicaid and that the outstanding bill should be paid. On October 11, 2016, the respondent sent verification to the undersigned confirming newborn's Medicaid eligibility effective April 2016, See Respondent's Exhibits 3 through 6.

9. The petitioner did not dispute the facts presented by the respondent. She explained that she is not challenging the loss of the RCG benefits effective September 1, 2016 for TH turning 18. She is seeking additional TCA benefits from April 2016 through August 2016 for adding the newborn. Additionally, she is seeking to have the newborn's outstanding medical bills paid. During the hearing, the petitioner mentioned that she has paid some unspecified medical expenses out of pocket for TH and her newborn, but did not provide any verification to the respondent for consideration. The respondent explained that the medical bill not being paid could only be a provider issue, as the newborn was determined eligible from month of birth. She advised the petitioner to contact the Agency for Health Care Administration (AHCA) regarding any issues with medical expenses.

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 issue regarding newborn's Medicaid eligibility for April 2016 will be addressed first.

12. The petitioner is requesting Medicaid eligibility for the newborn to cover an unpaid medical bill for April 2016. The finding shows that the newborn has Medicaid benefits effective the month of his birth (April 2016). The undersigned finds the respondent has already remedied the Medicaid issue, if there was one and cannot find a more favorable relief to the petitioner. The respondent is encouraged to provide a Temporary Medicaid Identification Card covering April 1 through April 30, 2016 to the petitioner to be submitted to the medical provider. While the respondent is responsible for eligibility issues, AHCA is responsible for services/billings issues.

13. The petitioner has failed to meet her burden. The petitioner is encouraged to contact the newborn's Medicaid provider or the state Medicaid Options for information on how to resolve this issue. The petitioner may request a hearing through AHCA if a favorable outcome is not found.

Additional TCA benefits from April 2016 through August 2016 will now be addressed.

14. Petitioner is requesting additional TCA benefits from April 2016 through August 2016 for adding a newborn to her case. The findings show she received \$35 for May 2016, \$158 for June 2016, \$69 for July 2016 and \$95 for August 2016. The respondent explained the variations in benefits on the processor's confusion between RCG and TCA eligibility, in addition to a child support sanction.

15. Section 414.095, Florida Statutes., Determining eligibility for temporary cash assistance, states:

(4) CARETAKER RELATIVES.—A family that contains a caretaker relative of a minor child has the option to include or exclude the caretaker relative in determining eligibility... The level of temporary cash assistance for the minor child shall be based on the shelter obligation paid to the caretaker relative.

(8) APPLICATIONS.—The date of application is the date the department or authorized entity receives a signed and dated request to participate in the temporary cash assistance program...

(a) The beginning date of eligibility for temporary cash assistance is the date on which the application is approved or 30 days after the date of application, whichever is earlier.

(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
1	\$95	\$153	\$180

16. According to the above authority, the date of eligibility is the date the application was approved or 30 days after the date of application, whichever is sooner. The petitioner's date of application was April 22, 2016, and the approval date was May 20,

2016. Therefore, according to the above authority, the petitioner's TCA benefits were approved timely.

17. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at passage 0620.0400, addresses application time standards (TCA) and states, "Process applications as soon as possible after the assistance group (AG) completes all eligibility requirements. If the household completes all requirements and provides all information, process the application by the 30th day after the application date." The Department processed the petitioner's application by the 28th day after the application date.

18. The Policy Manual at passage 2620.0308 notes that Appendix A-6 contains a chart to assist in proration. Pertaining to the petitioner's TCA application, approval on May 20, 2016, corresponds to a proration factor of 0.37.

19. The Policy Manual passage 2620.0307 Prorating Methods (TCA) states:

If the date of eligibility is after the first day of the month and benefits are authorized, the first month's benefit must be prorated. The following procedures are to be used to determine the prorated benefit amount:

Step 1 - Compute the deficit (Payment Standard minus total net available income) for the month of eligibility using usual budgeting procedures.

Step 2 - Select from the first column of the Prorating Chart, shown in passage 2620.0308, the day of the month corresponding to the date of eligibility (if the date of eligibility is on the thirty-first, use day 30).

Step 3 - Select from the prorating factor column (second column) the figure which corresponds to the day of the month.

Step 4 - Multiply the deficit (before rounding) for the month of eligibility by the prorating factor (the product equals the prorated amount).

Step 5 - If the prorated amount results in dollars and cents, this amount must be rounded down to the next whole dollar amount.

Step 6 - If the prorated benefit amount is less than \$10, the benefit must be issued for the first month.

20. The petitioner received TCA benefits for her niece through August 2016. The maximum relative caretaker TCA benefits for additional member (the newborn) is \$95.

No benefit is allowed for April as the case was timely approved on May 20, 2016.

Petitioner received \$35 for May 2016, or 37% of \$95. The undersigned concludes that amount is correct.

21. The petitioner received \$158 for June 2016, \$69 for July 2016 and \$95 for August 2016. The respondent explained the variation in payments on an alleged child support enforcement sanction. However, petitioner did not miss any TCA payments between May 2016 and August 2016. In addition, the child support enforcement agency was not present as a witness.

22. Based on the above-cited regulations and evidence presented, the undersigned concluded that the petitioner is entitled to receive an additional \$26 for July 2016 (\$95 – \$69). The petitioner has partly met her burden that she is eligible for additional TCA benefits for that month only.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the following decisions are made:

1. The Medicaid appeal is denied as Medicaid eligibility for newborn is effective April 2016.
2. The TCA appeal is partly granted as the July 2016 Temporary Cash Assistance benefits amount was incorrect. Petitioner is due an additional \$26 for July 2016, and partly denied, as no additional Temporary Cash Assistance benefits were found for any other months between April 2016 and August 2016. The benefits are to be made available within 10 days from the date of this order.

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 31 day of October, 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 [REDACTED]

Office of Economic Self Sufficiency

Sep 08, 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-04481

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Citrus
UNIT: 88007

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:45 a.m. on August 12, 2016.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Sylma Dekony, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate the petitioner's Medicare Savings Plan, Qualifying Individual 1 (QI1) is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated March 3, 2016, the respondent (or the Department) notified the petitioner she was ineligible for QI1. Petitioner timely requested a hearing to challenge the QI1 ineligibility.

Petitioner did not submit exhibits. The respondent submitted six exhibits. The Hearing Officer entered the exhibits as Respondent Exhibits "1" and "3" through "7"; skipping number "2". The record remained open through end of business day on August 12, 2016, for the respondent to submit another exhibit. The exhibit was received timely and entered as Respondent Exhibit "8". The record was closed on August 12, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received QI1 benefits.
2. On February 22, 2016, the petitioner submitted an Interim Contact Letter, also referred to as an application. The Interim Contact Letter lists income from Social Security for the petitioner and her husband. QI1 benefits for the petitioner is the only issue.
3. The Department verified that the petitioner receives \$873 and her husband receives \$1003 Social Security Disability Income (SSDI).
4. The Department's QI1 calculation determination is as follows:

\$ 873	petitioner's SSDI
<u>+\$1,003</u>	<u>petitioner's husband's SSDI</u>
\$1,876	total household income
<u>-\$ 20</u>	<u>unearned income disregard</u>
\$1,856	total countable income

5. The income limit for the petitioner to be eligible for QI1 is \$1,803. Petitioner's \$1,856 household income exceeds \$1,803.
6. On March 3, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying she was ineligible for QI1 benefits effective February 2016.
7. Respondent's representative said that the petitioner received QI1 benefits through March 2016 not February 2016, as indicated on the NOCA. The record was held open for the respondent's representative to submit verification that the petitioner received QI1 benefits through March 2016.
8. After the hearing, the respondent's representative submitted evidence that the petitioner received QI1 coverage through March 2016.
9. Petitioner was upset because she was not notified, that the Social Security Administration was going to deduct her Medicare premium from her Social Security check.
10. Respondent's representative explained that the Social Security Administration is responsible for notifying her about the Medicare premium.

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. The Department has three types of Medicare Savings Plan; 1) Qualified Medicare Beneficiary (QMB), 2) Special Low-Income Medicare Beneficiary (SLMB) and 3) QI1.

14. 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.)...

15. 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...

16. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9 (April 2016), identifies the couple's MSP Program income standards at: \$1,335 for QMB, \$1,602 for SLMB and \$1,803 for QI1.

17. Federal regulations at 20 C.F.R. § 416.1121 define different types of unearned income as follows:

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits...

18. In accordance with the above authority, the Department included the petitioner's \$873 SSDI and her husband's \$1,003 SSDI, to arrive at \$1,876 combined income.

19. 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". Respondent deducted \$20 from the petitioner and her husband's \$1,876 combined income, to arrive at \$1,856 countable income.

20. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. The undersigned agrees with the respondent's action to terminate the petitioner's QI1 benefits, due to exceeding the income limit.

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 08 day of September, 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

Sep 08, 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-04539

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 03DDD

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 8, 2016 at 10:13 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

At issue is the Department's action on June 8, 2016 to deny the petitioner's application for SSI-Related Medicaid due to not meeting the disability requirement.

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

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on August 4, 2016 at 10:00 a.m. but was rescheduled to August 8, 2016 at 10:00 a.m. due to a conflict in the hearing officer's schedule.

Appearing as a witness for the petitioner was Juanita Jones, mother to the petitioner.

The respondent submitted evidence that was entered as the Respondent's Exhibits 1 through 2. The petitioner did not submit any evidence.

The record was closed on August 8, 2016 at the conclusion of the hearing.

FINDINGS OF FACT

1. On June 3, 2016, the petitioner (age 21) completed an application for SSI-Related Medicaid as a disabled adult. The petitioner will reach the age of 22 in November 2016. The petitioner lives with her grandmother and does not have any children. There was no evidence presented to show that the petitioner is pregnant.

2. On June 8, 2016, the Department mailed a Notice of Case Action to inform petitioner that her application for SSI-Related Medicaid was denied due to not meeting the disability requirement. She previously applied for and was denied disability benefits by the Social Security Administration (SSA).

3. The Department's records show that the petitioner's case was forwarded to the Division of Disability Determination (DDD) on March 30, 2016. On May 27, 2016, the DDD determined that the petitioner was not disabled. The basis code for the denial

was “N32”, which the Department defined as “Non-pay-Capacity for substantial gainful activity-other work, no visual impairment.”

4. The petitioner’s grandmother contends that the petitioner was receiving Supplemental Security Income (SSI) until 2013. The petitioner’s grandmother recalls that the petitioner began receiving Medicaid through the Children’s Medical Services (CMS) from 2014 through January 2016. The petitioner’s grandmother recalls that the petitioner applied for SSI in March 2016 and was denied on June 8, 2016. She did not file an appeal.

5. The petitioner and the petitioner’s grandmother do not agree with the Department’s denial as she suffers from [REDACTED]. The petitioner’s grandmother argues that the petitioner is [REDACTED] and cannot afford the medication needed to treat the [REDACTED]. The petitioner’s grandmother contends that the petitioner was twice confined under the Baker Act. The petitioner argues that she needs the medication to help her to stay focused and to complete tasks. The petitioner explained that she needs counseling and medical attention.

5. The petitioner was born with a [REDACTED], which was surgically corrected. However, the petitioner suffers from [REDACTED] as a result of the condition with her [REDACTED]. The petitioner lists her other medical conditions as asthma and [REDACTED]. The petitioner’s grandmother affirms that the SSA reviewed all of the petitioner’s medical conditions and that all of her medical records from birth to present have been forwarded to the SSA.

6. The Respondent's Exhibit 2, page 14, includes the Case Analysis (Form SSA-416) which lists all of the medical conditions that were reviewed during the disability determination and states, "...She is alleging [REDACTED] [REDACTED] ...The clmt's condition is not severe enough to keep her from working. The clmt is denied. N32 Voc. Rule 202.20."

7. The Department explained that it adopts the SSA disability 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 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

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

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

11. The findings show petitioner is 21 years old. In this case, before Medicaid eligibility can be determined, petitioner must meet the federal definition of disabled.

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

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.

(b) *Effect of SSA determinations.*

(1)...

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

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

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

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

(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 authorities explain that a disability application must be sent to the Division of Disability Determination to be reviewed for applicants who are under the age of 65, who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs. However, if SSA has denied disability within the past year, or if the denial is under appeal, the SSA decision is to be adopted. If the individual applies for Medicaid within one year of an SSA denial and provides evidence of a new disabling condition that was not considered by SSA, the Department must make an independent disability decision. The findings show that the petitioner has no new disabling conditions not considered by the SSA.

14. The findings show that the petitioner has reported her disabling conditions of to the SSA. The petitioner argues that she needs Medicaid in order to be treated for her medical conditions. Her concern and situation is recognized, however, the Department is required to follow the rules and regulations set forth by the governing authorities. The undersigned concludes that the petitioner did not meet her burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to adopt the SSA denial from June 2016 (within 12 months of the Medicaid application with the Department) which resulted in the Medicaid denial.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 08 day of September, 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

FILED

Sep 08, 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]
[REDACTED]

APPEAL NO. 16F-04549

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 12, 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 wisdom teeth extractions 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 Jackeline Salcedo, Complaint and Grievance Specialist, from DentaQuest, which is the petitioner's dental services review organization. Also present as witnesses for the respondent were Lisa Williams, Quality Operations Nurse, and Carlene Brock, Quality Operations Nurse, from Amerigroup, 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, Authorization Request, Authorization Determination, Denial Notice, and Dental Services Criteria.

FINDINGS OF FACT

1. The petitioner is a fourteen (14) 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 June 13, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Amerigroup to perform extractions of four wisdom teeth (Teeth 1, 16, 17, and 32). Amerigroup denied this request on June 13, 2016 based on medical necessity considerations.
3. The denial notice also stated the following regarding the reason for the denial:

Your dentist has asked to remove your tooth. To approve this service the root of your tooth must also be completely formed. Our dentist looked at the x-ray and information from your dentist. It does not appear that this tooth needs to be removed because the root of your tooth is not completely formed. This service is not medically necessary. We have told your dentist this also. Please talk to your dentist about other treatment choices.

4. The petitioner's mother testified her daughter needs the extractions because she is in extreme pain and has difficulty eating.

5. The respondent's expert witness, Dr. Mantega, stated that the denial of the wisdom teeth extractions was appropriate because there was no sign of infection or aberrant positioning. He also stated the wisdom teeth did not display any root formation.

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"), effective November 2011.

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. Section 120.80.

8. This is a final order pursuant to Fla. Stat. Section 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. 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. 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 Amerigroup denied the wisdom teeth extractions due to medical necessity considerations.

14. The petitioner's mother believes the extractions should be approved because her daughter is in pain and has difficulty eating.

15. The respondent's witness stated the denial of the extractions was appropriate since the teeth did not show any root formation and there were no signs of infection or aberrant positioning.

16. After considering the evidence presented and relevant authorities set forth above, the undersigned concludes the petitioner has not demonstrated that the denial of the request for the extractions was incorrect. The petitioner has not established that the request for this service is medically necessary as defined by Fla. Admin. Code R. 59G-1.010(166). Although the petitioner's dentist requested the extractions, this does not establish it is medically necessary. The respondent's witness testimony supports the denial of the requested service.

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 08 day of September, 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

FILED

Sep 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-04587

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 09DDD

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:48 p.m. on July 22, 2016.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Susan Marin, ACCESS
Operations Management Consultant I

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated May 27, 2016, the respondent (or the Department) notified the petitioner she was denied Medicaid. Petitioner timely requested a hearing to challenge the denial.

Petitioner was not present at the hearing. Lauren Coe, Department of Health Division of Disability Determination (DDD), Program Operations Administrator, appeared as a witness for the respondent.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record was closed on July 22, 2016.

FINDINGS OF FACT

1. On March 7, 2016, a Food Assistance and SSI-Related Medicaid web application was submitted on behalf of the petitioner (age 55 at time of application). Medicaid is the only issue.
2. For petitioner to be eligible for SSI-Related Medicaid, she 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.
3. Petitioner applied for disability through the SSA on December 10, 1979. The SSA denied petitioner disability on January 11, 1980.
4. Petitioner's father said they called the SSA in May 2016 regarding another disability application for the petitioner and are scheduled to meet with the SSA on August 16, 2016.

5. On April 6, 2016, the Department forwarded the petitioner's disability documents to DDD for review.

6. Petitioner's medical records reviewed by DDD's were from 2014 through 2016.

Respondent's witness said the petitioner's medical records only addressed her physical disabilities, which indicate petitioner has [REDACTED] DDD did not consider these impairments severe.

7. Petitioner's father stated that petitioner's disabilities are mental not physical. He said that the petitioner has had a learning disability all of her life, which has resulted in her having emotional and social problems.

8. DDD referred the petitioner to Hope Counseling Centers for a mental evaluation, which was completed on May 6, 2016. The summary section of the psychological evaluation states:

[Petitioner] is a single, Caucasian female, 55 years of age, who does not appear to meet criteria for mental health diagnosis at this time. It is possible that she does have some form of learning disability. Her earlier job history in association with Vocational Rehabilitation and Exceptional Student Education indicates a need for either a review of records or psychological testing. The overall presentation appeared valid and consistent with the reported conditions. Current prognosis for [petitioner] is guarded. In regards to financial management, [petitioner] is recommended to manage benefits and financial decisions.

9. Petitioner's father disagrees with the psychological evaluation, stating that a 20 minute discussion is not sufficient to make a decision on psychological testing.

10. DDD's psychiatric review of the petitioner states:

There is no evidence of psychopathology in either the ongoing treatment records or comprehensive mental status examination at a recent consultative exam. Functional report at mental exam is fully consistent with the finding of no mental illness.

11. DDD utilizes a Federal Regulation five-step sequential evaluation process in determining disability. DDD terminates the sequential evaluation when a determination of disabled or not disabled at a step; and will not continue to the next step. The following are petitioner's results (in bold) of DDD's sequential evaluation:

Step 1: Determines if the claimant is presently engaging in substantial gainful employment. **No**

Step 2: Determines severity of claimant's impairment(s). **NO**

12. Petitioner met step one because she has not been employed in over 15 years.

13. Petitioner's physical and mental impairments were not considered severe in step 2; therefore, the five-step sequential evaluation was terminated.

14. DDD's Case Analysis of the petitioner states:

Data, 55 year old female with allegation of minimal brain dysfunction. Findings of MER from Southeastern Integrated Medical PI and CE vendor Hope Counseling Centers.

ADLs: Spoke with clmt, she has not made SGA in 15 years. Clmt lives with her parents. Clmt is able to cook things in the microwave and her parents take care of the other chores in the house. During the day she will watch T.V., play music, and write stories. Clmt said that her disorder has been there since she was born. She did take ESE classes in school. She does have some memory problems, she has to be told several times to do something. She is able to take care of her personal hygiene. Spoke with clmt again to clarify what she meant by minimal brain dysfunction. Clmt said it was something she was born with, a brain defect back in 1960. There is no recent testing. Clmt does not see anyone for it, nor does she take medication for it. Clmt seemed hesitant when asked the questions there was a little bit of slowness to it, but she had no difficulty answering the questions.

Summary/Decision: 55 year old female with [REDACTED], which clmt was given medication to keep it under control. Clmt was sent for a CE to assess her mental disability in which he gave no diagnosis. There is no evidence of psychopathology in either the ongoing treatment records or mental status exam. Therefore, clmt impairment is not severe.

15. On May 27, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying the March 7, 2016 Medicaid application was denied; due to not meeting the disability requirement.

16. Respondent's representative explained that the denial reason on the NOCA should also have been for failure to provide verification of application for Social Security benefits.

17. Petitioner's father stated that the petitioner was born with mental problems. He submitted an evaluation completed on petitioner, dated April 9, 1968, to support his statement. And alleges that DDD did not review the 1968 evaluation in their analysis.

18. Respondent's witness said that petitioner's 1968 medical record was too old to consider in making a disability determination.

19. Petitioner's father alleges that DDD did not a complete a full analysis of petitioner's mental problems in accordance with 42 CFR 435.541, subparts (e) and (f).

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.** (emphasis added) 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.)

23. In accordance with the above authority, DDD utilized a five step sequential evaluation process in determining petitioner’s disability. DDD considered both physical and mental disabilities.

24. Petitioner met the first step because she is not presently employed.

25. The evidence submitted establishes that petitioner’s May 6, 2016, psychological evaluation concluded she does not meet the criteria for a mental health diagnoses.

26. DDD determined that “there is no evidence of psychopathology in either the ongoing treatment records or comprehensive mental status examination at recent consultative exam”.

27. Respondent’s witness testified that review of petitioner’s 2014 through 2016 medical records indicate petitioner has [REDACTED]. DDD did not consider these physical impairments severe.

28. Petitioner did not meet the second step of the five step sequential evaluation. And in accordance with the above authority (#22), DDD did not continue with the remaining steps.

29. Petitioner’s father agreed that petitioner’s physical disabilities are not severe.

30. Petitioner’s father argued that a 20 minute discussion with the Psychologist is not sufficient to make a decision on psychological testing. And argued that DDD did not complete full analysis of petitioner’s mental problems in accordance with 42 CFR 435.541, subparts (e) and (f).

31. 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.

(2) Composition. The review team must be composed of a medical or psychological consultant and another individual who is qualified to interpret and evaluate medical reports and other evidence relating to the

individual's physical or mental impairments and, as necessary, to determine the capacities of the individual to perform substantial gainful activity, as specified in 20 CFR part 416, subpart J.

(3) Periodic reexaminations. The review team must determine whether and when reexaminations will be necessary for periodic redeterminations of eligibility as required under §435.916 of this part, using the principles set forth in 20 CFR 416.989 and 416.990. If a State uses the same definition of disability as SSA, as provided for under §435.540, and a beneficiary is Medicaid eligible because he or she receives SSI, this paragraph (f)(3) does not apply. The reexamination will be conducted by SSA.

32. The evidence submitted establishes that DDD complied with subpart (e) Medical and nonmedical evidence, of the above Federal Regulation. DDD obtained and reviewed the petitioner's physical medical records between 2014 and 2016. The petitioner did not have recent mental medical records; therefore, DDD referred the petitioner for a mental evaluation, which resulted in a May 6, 2016, petitioner psychological evaluation. DDD also completed a nonmedical evaluation with the petitioner.

33. The evidence submitted establishes that DDD also complied with subpart (f) Disability review teams, of the above Federal Regulation. DDD's review team included the Medical Examiner and the Psychological Consultant (Ph.D.). DDD's team reviewed the petitioner's 2014 through 2016 physical medical records and the May 6, 2016, psychological evaluation.

34. The petitioner has an August 16, 2016, appointment with the SSA to apply for disability, which is in accordance with the Fla. Admin. Code R. 65A-1.702 (5) Requirement to File for Other Benefits.

35. In careful review of the cited authorities, testimonies and evidence, the undersigned concludes that the petitioner did not meet its burden of proof. The undersigned concludes the respondent's action to deny the petitioner Medicaid Disability is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 14 day of September, 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

Sep 08, 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-04608

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 Wakulla
UNIT: 88313

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 26, 2016 at 10:36 a.m. Eastern.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Pat Hernandez, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of May 25, 2016 denying his application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was scheduled for August 16, 2016. The petitioner requested a rescheduling of the hearing as he had not received the Department's evidence. The request to continue was granted. The hearing was rescheduled for August 26, 2016.

The Department submitted evidence prior to the hearing. It was entered during the hearing as Respondent's Exhibit 1.

The record closed at the end of the hearing on August 26, 2016.

FINDINGS OF FACT

1. The petitioner filed an application for Family-Related Medicaid on May 2, 2016. The petitioner's household consists only of himself, age 60.
2. The petitioner reported he retired from employment with [REDACTED] in April 2016 due to disability. He receives \$825.50 in state retirement benefits each month.
3. The petitioner filed an application with Social Security for disability on February 11, 2016.
4. Social Security mailed the petitioner a notice denying his application for disability on May 23, 2016.
5. The Department reported the application was forwarded to the Division of Disability Determinations (DDD) on May 10, 2016.
6. DDD responded to the Department on May 25 with a denial with reason code N31: "Non-pay – Capacity for substantial gainful activity – customary past work, no visual impairment".

7. The Department issued a Notice of Case Action on May 25, 2016 denying the petitioner's application for Adult-Related Medicaid due to not meeting the disability requirement.

8. The petitioner stated his primary health diagnosis is a [REDACTED] for which he must take 10 medications. His other medical diagnosis as: [REDACTED] [REDACTED]. The petitioner reported he has 21 medications for his various conditions. The onset of each of these conditions was prior to his application for Social Security. The petitioner expressed his concern that when his medications run out, he will die.

9. The petitioner states he was advised by Department personnel to apply for disability prior to his retirement.

10. The petitioner believes that his doctor's statement of his disability should satisfy the requirement for the Department.

11. The petitioner lost his health insurance when he retired, as he could not afford to keep it. He has no other means of obtaining his medication.

12. The petitioner has appealed his Social Security denial with the help of an attorney.

13. The petitioner does not report any new or worsened conditions since his application for Social Security.

14. The petitioner states he has exhausted all avenues of obtaining assistance with his medications.

15. The Department stated when Social Security issues a denial of disability, the Department must adopt that decision.

CONCLUSIONS OF LAW

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

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

18. 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.

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

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.

20. 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).

21. 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.

22. 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.

...

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

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

...

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

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

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, **and**—

(A) Has applied to SSA for reconsideration or reopening of its disability decision **and** SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

(emphasis added)

23. The undersigned explored potential eligibility for Medicaid for the petitioner under the SSI-Related (Adult) Medicaid program. The petitioner is 60 years old with no minor children in the home. As he is under age 65, a disability determination is required for eligibility determination in the SSI-Related Medicaid program.

24. The findings show the petitioner applied for disability with the Social Security on February 11, 2016. The findings show the petitioner applied for Medicaid with the Department on May 2, 2016. The findings also show SSA determined the petitioner was not disabled on May 23, 2016 and that decision has been appealed.

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. The undersigned concludes the Department correctly adopted the SSA decision on May 25, 2016.

25. Based on the evidence and testimony presented, the above-cited rules and regulations, the undersigned concludes the Department's action to deny Medicaid under the SSI-Related (Adult) Medicaid program is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)

16F-04608

PAGE - 8

DONE and ORDERED this 08 day of September, 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

FILED

Sep 15, 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-04635

PETITIONER,

Vs.

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

AND

SUNSHINE HEALTH

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 19, 2016 at 3:19 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Kizzy Allyn, Paralegal with Sunshine Health

STATEMENT OF ISSUE

At issue is onset date of the petitioner's enrollment in the Participant Directed Option (PDO) program.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (AHCA or Agency or respondent) administers the Florida Medicaid Program. The respondent contracts with healthcare maintenance organizations (HMOs) to provide medical services to its program participants. Sunshine Health (Sunshine) is the contracted HMO in the instant case.

By notice dated May 31, 2016, Sunshine informed the petitioner that she had been enrolled the PDO program: start date May 29, 2016, end date May 27, 2017. The notice informed the petitioner that she was approved to receive 20 hours homemaker services weekly and 10 hours of personal care services weekly.

On June 16, 2016, the petitioner requested a hearing to challenge the enrollment onset date. The petitioner seeks retroactive enrollment effective January 1, 2016.

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

Present as witnesses for the respondent from Sunshine: Dr. John Carter, Long Term Care medical director; Mike Thomas, supervisor of PDO program; Tammi Swan, director of Long Term Care program; and Mario McDonough, appeals coordinator. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite 1.

The record was held open until close of business on August 25, 2016 for the submission of additional evidence. Evidence was timely received from the respondent and admitted into the record as Respondent's Composite Exhibit 2.

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 31) is a Florida Medicaid recipient. The petitioner suffered a stroke in August 2015 which left her physically and cognitively impaired. The petitioner requires supervision, monitoring and some physical assistance with all the activities of daily living. She requires total assistance with homemaking, transportation, and money management. The petitioner lives in the family home with her husband and their mutual child.

2. The petitioner is enrolled with Sunshine HMO's Long Term Care Program (LTCP). LTCP provides home health services to individuals with complex medical conditions who would otherwise require nursing home placement. The petitioner's enrollment with LTCP began on January 1, 2016.

3. The petitioner also participates in the Medicaid's PDO program. PDO allows program participants to have more control over the provision and delivery of their services by choosing their own care providers. Participants may use community/outside care providers or have family members provide the services. The petitioner chose her husband to be her care provider for both homemaker and personal care services; he is paid \$10.70 hourly.

4. The petitioner's PDO enrollment began (with her husband as her PDO DSW/caregiver began effective May 29, 2016. The petitioner requested retroactive

PDO enrollment to coincide with her LTCP enrollment date of January 1, 2016.

Sunshine denied the petitioner's request verbally, but did not issue a written notice.

5. Sunshine argued that Medicaid rules require all participants and PDO DSWs/care providers undergo a program referral, an interview and a background screening prior program enrollment. The program does not include a provision for retroactive enrollment.

6. Sunshine asserted that the petitioner's PDO enrollment date did not correspond with her LTCP enrollment date of January 1, 2016 because the case manager was unable to reach the petitioner to complete the required interview and PDO referral process. Shortly after the January 2016 enrollment, a Sunshine case manager attempted to reach the petitioner by telephone to conduct a new member enrollment interview, but did not have a current contact number for the petitioner. The case manager visited the petitioner's home on or about January 5, 2016. No one was home and the case manager left a card in door, but did not receive a call back from the petitioner. The case manager sent the petitioner a "no contact" letter in January 2016, but did not receive a reply.

7. In March 2016, a third party service provider filed a payment claim for the petitioner which contained a current telephone number for her. It was via this claim, that Sunshine obtained a contact method for the petitioner. In early April 2016, a new Sunshine case manager made collateral contact with the petitioner at the telephone number obtained via the third party claim and completed the new member enrollment interview. During the interview, the petitioner requested to participate in the PDO

program with her husband as the DSW/caregiver. The case manager completed a PDO intake request forms and background screening referral.

8. Sunshine contracts with a vendor, Consumer Direct, to complete DSW/caregiver background screening. The background screening process generally takes four to six weeks to complete. The husband's background screening referral was initiated in April 2016 and completed on May 31, 2016, clearing him to serve as her DSW/caregiver. Because Sunshine's pay week begins on Sunday, the petitioner's PDO enrollment date was back dated to Sunday, May 29, 2016.

9. Sunshine argued that it enrolled the petitioner in the PDO program as early as Medicaid rule allows, there has been no adverse action in this case and the appeal should be dismissed. The petitioner argued that Sunshine's verbal refusal of retroactive PDO enrollment is an adverse action and the appeal should not be dismissed. The undersigned withheld ruling on the motion until issuance of the Final Order. The undersigned finds that Sunshine's verbal denial of the petitioner's request for retroactive enrollment in the PDO program is a denial of a request for additional medical assistance and constitutes an appealable adverse action. The respondent's dismissal motion is denied.

10. The petitioner's husband asserted that he called the Sunshine case manager (Kelly Minor) the same day she left her business card in his door, on or about January 5, 2016, but was not able to reach her. A new case manager did not contact him until April 2016. The husband argued that Sunshine is responsible for the delay in initiating his PDO background screening referral. He argued that the referral process

should have been initiated by Sunshine in January 2016. He argued that the petitioner's PDO enrollment and his eligibility for payment as her DSW/caregiver should correspond with her LTCP enrollment, January 1, 2016.

11. The petitioner's husband asserted that he contacted AHCA (the agency that administers the Medicaid program) after Sunshine's verbally denied his request for retroactive enrollment in the PDO program and was told by an AHCA employee (he could not recall the individual's name, title or contact number) that he and the petitioner were eligible for retroactive PDO enrollment and payment because he has been acting as her caregiver since her stroke in August 2015.

12. The record was held open for Sunshine to provide legal authorities and/or policy citations regarding 1) onset date of PDO program enrollment and DSW/caregiver start date and 2) issuance of notices in response to enrollees request for service modifications.

13. While the record was open, Sunshine provided a PDO Direct Services Worker Data Form signed by the petitioner's husband on May 3, 2016. The form reads "I understand that employment remains conditional until the results of the criminal background check have been received and approved...."

14. While the record was open, Sunshine also provided a copy of AHCA's PDO manual. The cover letter which accompanied the PDO manual reads, "the PDO manual is attached for reference of the process in order to establish both a participant and a direct service worker as eligible for the PDO program (pages 28, 29, 31 highlighted sections)." Page 31 of the PDO manual addresses background screening and reads, "It

is required that background screening be completed on all direct service workers and all representatives....The Managed Care Plan must receive the results of the background screening and make a determination of clearance, adhering to all requirements in Chapters 435 and 408.809 F.S.”

15. Sunshine’s post hearing filing of evidence did not include the requested policy citations or legal authorities which set forth notice requirements when an enrollee requests a modification of program services.

16. Sunshine’s post hearing filing included an assertion that the sole issue under appeal is payment of the petitioner’s husband for DSW/caregiver services rendered January 1, 2016 – May 28, 2016. Sunshine argued that provider reimbursement is not within the jurisdiction of the Office of Appeal Hearings and the appeal should be dismissed as non-jurisdictional. The undersigned concurs that provider reimbursement is not under the jurisdictional authority of the Office of Appeal Hearings; however, as previously noted, the denial of the petitioner’s request for retroactive enrollment in the PDO program is an appealable adverse action. The respondent’s dismissal motion is denied.

CONCLUSIONS OF LAW

17. 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.

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

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

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

21. 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 Diction

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

23. The respondent verbally denied the petitioner’s request for retroactive enrollment in the PDO program, but did not issue a written notice.

24. Federal Regulations at 42 C.F.R. §438.404, Timely and adequate notice of adverse action states in part:

a) *Notice.* The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10.

(b) *Content of notice.* The notice must explain the following:

(1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make.

2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

(3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at §438.402(b) and the right to request a State fair hearing consistent with §438.402(c).

(4) The procedures for exercising the rights specified in this paragraph (b).

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

(c) *Timing of notice.* The MCO, PIHP, or PAHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1).

(4) If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).

25. Denial of the petitioner's request for retroactive enrollment in the PDO program is an adverse benefit determination. The legal authority cited above states that AHCA and its contracted HMOs are required to issue a written notice which explained the reasons for its actions. The notice is also required to include appeal rights. The respondent's actions in this matter failed to comply with federal regulations. However, the undersigned concludes that the petitioner's due process rights were not ultimately violated because she received a fair hearing in this matter. A fair hearing is the only remedy available to a recipient who wishes to address an adverse agency action.

26. Sunshine enrolled the petitioner in the PDO program effective May 29, 2016. Sunshine argued earlier enrollment is not possible because Medicaid rules require the proposed DSW/caregiver undergo background screening prior to enrollment. The husband's background screening was concluded on May 31, 2016. The petitioner's PDO enrollment date was backdated to May 29, 2016 to correspond with the start of the PDO work week.

27. The petitioner seeks retroactive enrollment in the PDO program back to January 1, 2016, to correspond with the onset date of her LTCP enrollment. The petitioner argued that Sunshine delayed in contacting her, January 2016 – April 2016, to initiate the PDO referral and background screening process.

28. Sunshine acknowledged a delay in processing the petitioner's PDO referral, but states that the delay was caused by the fact that there was no current telephone

number for petitioner, no answer when a home visit was made and no response to contact later; all the contact attempts took place early January 2016. Sunshine discovered a viable contact number for the petitioner in March 2016, via a claim filed by a third party vendor, and immediately contacted the petitioner.

29. Sections 435.03 and 435.04, Florida Statutes, address employee background screenings and state that all employees required by law to be screened pursuant to those sections must undergo security background investigations as a condition of employment. Employment cannot began prior to receipt of the background screening results.

30. AHCA's PDO manual is the agency's formal interpretation of its rules. The manual addresses PDO enrollment and background screening on page 31: "It is required that background screening be completed on all direct service workers and all representatives....The Managed Care Plan must receive the results of the background screening and make a determination of clearance, adhering to all requirements in Chapters 435 and 408.809 F.S."

31. The respondent's PDO manual states that proposed DSWs/caregivers are required to pass a background screening prior to a participant's enrollment in the PDO program.

32. The evidence proves that the background screening for the petitioner's prosed DSW/caregiver (her husband) was completed on May 31, 2016 and she was enrolled in the PDO program on or about that date in accordance with the rules and regulations which govern program participation.

33. The petitioner argued that her enrollment was delayed because Sunshine did not timely contact her to complete the PDO referral. Sunshine argued that it tried to reach the petitioner by phone, by home visit and by mail, but was not able to make contact with her until April 2016 to initiate the PDO enrollment process. The undersigned concludes that evidence does not prove that Sunshine caused a delay in the initiation of her PDO enrollment process.

34. The undersigned carefully reviewed the controlling legal authorities, but found no exception which would allow for a participant to be enrolled in the PDO program prior to completion of the DSW/caregiver background screening. The undersigned concludes that the petitioner failed to prove by a preponderance of the evidence that she is eligible for retroactive enrollment in the PDO program.

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 15 day of September, 2016,

in Tallahassee, Florida.



Leslie Green
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]
AHCA, Medicaid Fair Hearings Unit
Sunshine Health

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

FILED

Sep 15, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-04643

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on August 1, 2016 at 8:32 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Linda Latson,
Registered Nurse Specialist,
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 the Petitioner's request for a partial upper denture (procedure code D5213). Because the issue under appeal involves a request for service, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Diana Anda, Grievance and Appeals Manager, and Dr. Francisco Hernandez, Medical Director, appeared as Respondent's witnesses from Petitioner's managed care plan Better Health. Dr. Daniel Dorrego, Dental Consultant, and Jackelyn Salcedo, Complaints and Grievance Specialist, appeared as Respondent's witnesses from DentaQuest.

In April 2016, Petitioner submitted a request for a partial upper denture, procedure code D5213, and a partial lower denture, procedure code D5214. DentaQuest approved the partial lower denture and denied the partial upper denture. Petitioner is appealing the denial of his request for a partial upper denture.

Respondent submitted a 24-page document, which was entered into evidence and marked Respondent Exhibit 1.

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 52 year-old Medicaid recipient enrolled with Better Health, a Florida Medical 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. The Petitioner's dentist requested prior authorization for dental procedures D5213, maxillary partial denture – cast metal framework with resin denture bases (partial upper denture). The request was received by DentaQuest on April 18, 2016.

4. DentaQuest made its determination on April 20, 2016. DentaQuest denied the request for a partial upper denture. Notice was sent to the provider providing the denial reason: Masticatory function does not appear to be severely impaired.

5. Respondent provided in its exhibit a Dental Consultant Review Form completed by DentaQuest's consultant on June 8, 2016. The review was performed as a result of Petitioner's appeal. The review upholds the denial of Petitioner's request for a partial upper denture and states in relevant part:

Adequate masticatory function is satisfied by occlusion of at least 8 posterior teeth, NATURAL or PROSTHETIC, as specified in the Office Reference Manual and the plan requirements. The teeth in occlusion for this case are maxillary natural teeth 4, 5, 12 and 13 with mandibular natural teeth 21, 28, 29 and additional mandibular partial teeth, indicating a functional occlusion of 8 posterior points of contact.

6. Petitioner explained he currently chews using his front teeth and is concerned he will lose these if he does not receive a partial upper denture. A letter sent by the Petitioner to DentaQuest was read into the record at Petitioner's request because he felt it better explained his concerns. It states in relevant part:

I am requesting your approval on the upper partials. I cannot chew with the lower ones alone. I am in tremendous pain using just my own front teeth. Hard to cut any food infant style in order to eat solids. I am in fear of losing my front teeth if I have to use them as molars.

7. Petitioner has not received his lower partial denture as of the date of the hearing.

8. DentaQuest's dental consultant explained that Petitioner has teeth 4, 5, 12 and 13 in his upper mouth. With his lower partial denture and his remaining natural lower teeth, Petitioner will have 8 points of contact for chewing. The dental consultant explained that Medicaid's Dental Handbook requires less than 8 points of contact in order for partial dentures to be medically necessary.

CONCLUSIONS OF LAW

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

10. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 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. 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.

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

14. 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.

15. 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.

16. The Florida Medicaid Dental Services Coverage and Limitations Handbook- November 2011 (Handbook)¹, which is incorporated by reference into Chapter 59G-4, Fla. Admin. Code, sets standards for dental services. Page 2-3 "Covered Adult Services (Ages 21 and Over) indicates:

The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.

Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to

¹ The Florida Medicaid Dental Services Coverage Policy Handbook-May 2016 took effect on May 3, 2016 via Rule 59G-4.060. Like the prior handbook, Prosthodontic Services (dentures) remain a covered service for Medicaid recipients. Page 5 of the May 2016 handbook also states Medicaid will not pay for partial dentures where there is 8 or more posterior teeth in occlusion.

make a diagnosis, extraction, and incision and drainage of abscess.

17. On page 2-33 of the Handbook, it lists exclusions for Medicaid coverage which includes: Partial dentures where there are at least eight posterior teeth in occlusion.

18. Petitioner states he is experiencing tremendous pain in using his front teeth to chew his food. He expressed fear of losing his front teeth if he continues to use them as molars.

19. Respondent explained that with the lower partial denture and four upper posterior teeth, Petitioner has 8 points of contact for chewing. Medicaid does not cover partial dentures unless there are less than 8 points of contact (occlusion).

20. Petitioner has failed to meet his burden of proof. The Respondent makes it clear that a partial upper denture is not medically necessary because Petitioner has 8 points of contact once he receives his lower partial denture. Petitioner should work with his dentist in assessing his dental needs after he receives his lower partial denture.

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-04643

PAGE - 7

DONE and ORDERED this 15 day of September, 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

FILED

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

Oct 11, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04677

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 18, 2016, at 9:50 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED].

For the Respondent: Sue-Jay Collins, operations & management consultant.

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 June 20, 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 \$2,057.

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The respondent submitted five exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 5.

The record was left open through August 25, 2016 for the respondent to submit additional information and through September 19, 2016 for the petitioner to submit evidence for consideration. The respondent's information was timely received and marked as Respondent's Exhibits 6 through 11. The petitioner's information was received and marked as Petitioner's Exhibits 1 through 4. The record was closed on September 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, petitioner has been applying for disability for her daughter and 2001 and 2011. Each time, she was found not disabled. The most recent denial was nine (9) months ago.

2. Disability Determination Explanation, See Petitioner's Exhibit 4, indicates an initial claim was filed on September 10, 2014 due to the following conditions: [REDACTED]

[REDACTED]

[REDACTED] (11/3/2014 & 11/18/2014); [REDACTED]s

(2/17/2015 and 3/3/2015); [REDACTED] (11/7/2014); [REDACTED]
[REDACTED] (11/7/2014) and [REDACTED]
(9/19/2014 & 2/12/2015) were considered as part of the disability process.

3. On March 12, 2015, the disability claim was denied (N32): “We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information and work experience in determining how your condition affects your ability to work.” On June 2, 2015 the petitioner requested a hearing by an Administrative Law Judge (ALJ), See Petitioner’s Exhibit 3. The petitioner has retained an attorney to help with the SSA appeal process.

4. On May 18, 2016, the petitioner submitted an application requesting Family-Related Medicaid benefits for her 19 year-old daughter only ([REDACTED]). On that application, the petitioner did not include herself. She reported that her daughter was disabled, with the following medical conditions: [REDACTED]

5. On May 23, 2016, the respondent sent a pending notice requesting income information from the petitioner. The verification was received and the case was processed and approved.

6. On June 6, 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 \$2,057 share of cost.

7. On June 20, 2016, the petitioner requested a hearing challenging the respondent’s action. The petitioner was seeking full Medicaid for her daughter only. She is not applying for herself. She is challenging her daughter’s enrollment in the Medically Needy Program.

8. Petitioner is gainfully employed and is responsible for health insurance premiums on herself. She is a tax filer and her daughter is her tax dependent. She provided the respondent with her paystubs. Initially, the respondent only used paycheck dated 5/27/16 (\$1,222.26) to determine eligibility for Medicaid for the daughter. Petitioner's biweekly income was converted to a monthly amount by 2 to equal \$2,444.52. 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. Initially, to determine the estimated SOC for the daughter, the respondent determined the household's MAGI to be \$2,431.06. 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 \$2,057. The insurance premiums were not included in the budget.

9. Respondent's representative explained that the 19-year old was no longer eligible for full Medicaid due excess income. In addition, she explained that she was not eligible for the 1931 Medicaid due to her age. The respondent explained that the daughter's disability conditions were considered, but no action was warranted as she was denied disability by the Social Security Administration and has a pending appeal before an ALJ.

10. 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 was recently diagnosed with [REDACTED] a condition not previously known by SSA

and that her [REDACTED] has worsened, See Petitioner's Exhibits 1 & 2. The respondent explained that any new conditions must be reported to SSA as part of the appeal. The respondent further explained that SSA decision is binding and must be accepted by the Department as final.

11. After a case review, the respondent used paychecks dated 5/13/16 (\$1,208.72) and 5/27/16 (\$1,222.26) to determine eligibility for Medicaid for the daughter.

Petitioner's biweekly income was converted to a monthly amount by adding two paystubs to equal \$2,431.06 as MAGI. 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 \$2,044. It was further reduced by \$253.86 total recurring medical insurance premiums, resulting in the final SOC being \$1,790.

12. On August 25, 2016, the undersigned received verification that the daughter's SOC has been lowered effective June 2016, See Respondent's Exhibits 10 & 11.

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.

The SSI-Related Medicaid issue will now be addressed.

15. The Code of Federal Regulations at 42 C.F.R. § 435.540 sets forth the definition of disability and states:

(a) *Definition.* The agency must use the same definition of disability as used under SSI, except that—

(1) In determining the eligibility of individuals whose Medicaid eligibility is protected under §§435.130 through 435.134, the agency must use the definition of disability that was used under the Medicaid plan in December 1973; and

(2) The agency may use a more restrictive definition to determine eligibility under §435.121, if the definition is no more restrictive than that used under the Medicaid plan on January 1, 1972.

16. In this instant case, SSA has determined that the child was not disabled. The respondent adopted the same decision.

17. Federal Regulations at 42 C.F.R. § 435.541 “Determination of Disability,” states:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of

ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section. (c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash recipient and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

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

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

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

18. The Code of Federal Regulations at 42 C.F.R. §416.920(g) addresses Evaluation of disability of adults and states:

(g) Your impairment(s) must prevent you from making an adjustment to any other work. (1) If we find that you cannot do your past relevant work because you have a severe impairment(s) (or you do not have any past relevant work), we will consider the same residual functional capacity assessment we made under paragraph (e) of this section, together with your vocational factors (your age, education, and work experience) to determine if you can make an adjustment to other work. (See §416.960(c).) If you can make an adjustment to other work, we will find you not disabled. If you cannot, we will find you disabled.

19. In this instant case, SSA has determined that the daughter's medical conditions were not severe enough to prevent her from engaging in work activities.

20. The Department's Policy Manual, CFOP 165-22 (The Policy Manual) at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP)" states:

...If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

21. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

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

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

6. When the individual files an application within 12 months after the last unfavorable disability determination by SSA, and the individual alleges no new disabling condition or claims a deterioration of an existing condition previously considered by SSA. Refer the individual to SSA for disability reconsideration or appeal. Only request a disability decision from DDD if:
 - a. SSA refuses (or has already refused) to reconsider the unfavorable disability decision, or
 - b. the applicant no longer meets SSI non-disability criteria such as income or assets.

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

22. Petitioner testified that the most recent denial was nine (9) months ago.

According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA.

Additionally, a worsening and deteriorating of conditions is directed to the SSA. In this instant case, SSA has determined that the daughter was not disabled based of the information it received.

23. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the respondent's action not to initiate a disability review on the petitioner's daughter under the SSI-Related Medicaid coverage group is correct. Medicaid eligibility for the daughter was explored under the Family-Related coverage group

The Family-Related Medicaid/Medically Needy issue will now be addressed.

24. 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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".

34. 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.

35. 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.

36. In accordance with the above controlling authorities, the respondent determined the petitioner's SFU as a household of one based on her tax filing status.

37. 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.

38. Originally, the daughter's SOC was estimated to be \$2,057, after further review, it was reduced to \$1,790. The hearing officer reviewed the respondent's most recent 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.

39. 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 actions are upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 11 day of October, 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

Sep 12, 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-04721

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 15, 2016 at 3:00 p.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 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 Maureen McNamara, Grievance and Appeals Manager, and Summer Brooks, Contract Manager, from Coventry Healthcare, which is the petitioner's managed health care plan. Also present as a witness for the respondent was Maryanne Acevedo, Grievance and Appeals Manager, from MCNA Dental, which reviews dental claims on behalf of Coventry Healthcare.

Respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Notice of Action, and x-rays.

FINDINGS OF FACT

1. The petitioner is a sixty-two (62) 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 Coventry Healthcare. Coventry utilizes MCNA Dental for review of requests for dental services.
2. On or about June 6, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from MCNA and/or Coventry Healthcare to perform various dental procedures, including tooth extractions, dentures, and medication related to those procedures. On or about June 7, 2016, Coventry approved the requests for tooth extractions and dentures, but denied the request for medication. The reason for the denial of the medication was that it was a non-covered service or benefit.

3. The petitioner stated she needs to have her gums opened to remove bones and roots of her teeth and the medication is needed to prevent infection. She stated this medication would be injected into her gums.

4. Ms. Acevedo from MCNA stated that the medication is not a covered service under Coventry Healthcare'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 and Limitations Handbook ("Dental Handbook"), effective November 2011.

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. Section 120.80.

7. This is a final order pursuant to Fla. Stat. § 120.569 and Section 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. The Medicaid Handbook and the Dental Handbook 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 medication was not denied due to any medical necessity considerations, but because that service is a non-covered service or benefit according to the Coventry dental plan provisions.

13. The Florida Medicaid Program provides limited dental services for adults. The Dental Handbook describes the covered services for adults as follows:

The adult dental program provides for the reimbursement of full and removable partial dentures. Extractions and other surgical procedures essential to the preparation of the mouth for dentures are reimbursable if

the patient is to receive dentures. Procedures relating to dentures such as repairs, relines and adjustments are reimbursable.

Medicaid will reimburse for medically-necessary emergency dental procedures to alleviate pain and or infection for eligible adult Medicaid recipients 21 years of age or older. Emergency dental care shall be limited to emergency problem-focused evaluations, necessary radiographs to make a diagnosis, extraction, and incision and drainage of abscess.

14. Managed care plans, such as Coventry Healthcare, may provide more generous benefits but cannot be more restrictive than the Medicaid guidelines contained in the Dental Handbook.

15. After considering the evidence and testimony presented, the undersigned concludes that the petitioner has not demonstrated that the requested service (medication) should have been approved by Coventry Healthcare. The medication is a non-covered service for adults under the Medicaid guidelines referenced above and under the Coventry Healthcare dental plan provisions. Therefore, the hearing officer cannot make a determination that this service must be covered by the petitioner's plan.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with

FINAL ORDER (Cont.)

16F-04721

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

DONE and ORDERED this 12 day of September, 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

Oct 06, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04756

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on August 23, 2016, at 12:50 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]
[REDACTED]

For the Respondent:

Stephanie Lang, R.N.
Registered Nurse Specialist/Fair Hearing Liaison
Agency for Health Care Administration

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the Agency for Health Care Administration incorrectly denied his request for an increase in his Personal Care Assistant ("PCA") services to 24 hours per day, seven days per week.

PRELIMINARY STATEMENT

The petitioner's father may sometimes hereinafter be referred to as the petitioner's "representative." The following individuals appeared as witnesses on behalf of the petitioner: [REDACTED], the petitioner's mother; and [REDACTED], the petitioner's Waiver Support Coordinator.

Elynn Theophilopoulos, J.D., M.D., Physician Reviewer and Medical Director for eQHealth Solutions, appeared as a witness on behalf of the Agency for Health Care Administration ("AHCA" or "Agency").

The respondent introduced Exhibits "1" through "4", inclusive, at the hearing, all of which were accepted into evidence and marked accordingly.

At the respondent's request, the hearing officer took administrative notice of Section 409.905, Florida Statutes; Rule 59G-1.001, Fla. Admin. Code; Rule 59G-1.010, Fla. Admin. Code; Rule 59G-4.130, Fla. Admin. Code; and the Florida Medicaid Home Health Services Coverage and Limitations Handbook.

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 20-year-old male.
2. The petitioner was eligible to receive Medicaid benefits through Medicaid State Plan at all times relevant to this proceeding.
3. The Medicaid State Plan is administered by the Agency for Health Care Administration.

4. The petitioner participates in the CDC+ Program within the Medicaid State Plan.

5. The CDC+ Program allows for the financial compensation of a parent for providing servicing to their child.

6. One of the petitioner's Personal Care Assistants is his mother.

7. The petitioner was approved to receive Personal Care Assistant services in the amount of eight hours per day, seven days per week, in the prior certification period. The prior certification period began on October 1, 2015 and ended on March 31, 2016.

8. On or about March 29, 2016, the petitioner's home health agency submitted a prior authorization request to eQHealth Solutions for Personal Care Assistant services to be approved for 24 hours per day, seven days per week, for the certification period April 1, 2016 through September 30, 2016.

9. eQHealth Solutions is the Quality Improvement Organization contracted by the Agency for Health Care Administration to review requests by Medicaid recipients for services available under the Home Health Services Program.

10. The Home Health Services Program includes various types of assistance including home health visits (which may be completed by either a nurse or home health aide), private duty nursing services, personal care services for children, therapy services, medical supplies, and durable medical equipment.

11. eQHealth Solutions is charged with the responsibility of determining if a requested service is medically necessary under the terms of the Medicaid Program.

12. A request for Personal Care Services is submitted directly to eQHealth Solutions by a petitioner's home health agency. Once eQHealth Solutions receives the

information, it completes a prior authorization review – it reviews the written request to determine if the number of hours requested are medically necessary.

13. The petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on April 6, 2016. The Physician Reviewer approved Personal Care Assistant services eight hours per day, seven days per week, and denied all of the remaining hours.

The Physician Reviewer supplied the following rationale for the decision:

[REDACTED]

The clinical information provided does not support the medical necessity of the additional services. There have been no significant changes in the patient's clinical condition. The additional hours appear to be for supervision which is not a covered service. The additional hours are not medically necessary.

14. A reconsideration review was not requested or conducted in this matter.

15. The petitioner is diagnosed with the following: [REDACTED]

[REDACTED]

16. The petitioner is ambulatory.

17. The petitioner is incontinent of both bowel and bladder.

18. The petitioner does not have a G-tube or a tracheostomy.

19. The petitioner requires assistance with meal preparation and eating. It is difficult to get the petitioner to eat. Although not diagnosed with such, the petitioner exhibits characteristics consistent with having an eating disorder.

20. The petitioner requires assistance with all activities of daily living (“ADLs”). Activities of daily living include eating (oral feedings and fluid intake), bathing, dressing, toileting, transferring, and maintaining continence.

21. The petitioner also requires assistance with all instrumental activities of daily living (“IADLs”). Instrumental activities of daily living include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone to take care of essential tasks, medication management, and money management.

22. The petitioner has significant behavioral problems, including aggression, elopement, rectal digging, fecal smearing, and a skin picking disorder.

23. The petitioner requires constant monitoring and supervision as a result of his behavioral problems. Monitoring and supervision are essential to maintaining his health and safety.

24. The petitioner resides in his own home which is close to that of his family. The petitioner’s parents are his stated caregivers.

25. The petitioner’s father testified the family was advised by an unspecified individual to move the petitioner into his own residence in order to maximize his receipt of benefits.

26. The petitioner does not attend school or an adult day program.

27. The petitioner’s father works full-time out of the home.

28. Although the petitioner’s mother has many responsibilities associated with caring for the petitioner, she does not work outside of the home.

29. The petitioner has a 17-year-old brother.

30. No evidence was presented to support a finding that the petitioner's brother has special needs.

31. The petitioner's parents do not have any documented physical limitations which affect their ability to care for the petitioner.

32. The petitioner's mother is one of his personal care assistants. She is compensated for a portion of her services through the Consumer Directed Care Plus ("CDC+") Program.

33. The petitioner is enrolled in the Florida Medicaid Developmental Disabilities Individual Budgeting Home and Community-Based Services ("HCBS") Waiver.

34. The Florida HCBS Waiver is administered by the Agency for Persons with Disabilities ("APD").

35. The petitioner is approved to receive two hours per week of behavior therapy and five hours per day of behavior assistant services through the HCBS Waiver.

36. The petitioner does not receive any additional Personal Care Assistant services through the HCBS Waiver. His sole receipt of Personal Care Assistant services is through the Agency for Health Care Administration.

37. The documentation submitted to eQHealth Solutions along with the request for Personal Care Assistant services includes a Physician Visit Documentation Form which indicates the petitioner was seen by a physician within the requisite amount of time before the request.

38. The petitioner's Personal Care Services Plan of Care lists the services to be performed by a Personal Care Assistant as follows: bathing and grooming; toileting and elimination; oral hygiene; oral feedings and fluid intake; and assistance with dressing.

39. The Plan of Care lists the petitioner's functional limitations as follows: bowel/bladder incontinence; speech difficulty; and behavioral difficulties including aggression and risk of elopement.

40. The petitioner has a valid prescription of Personal Care Assistant services.

41. Personal Care Assistant services may be approved by the Agency for Health Care Administration for the purpose of assisting a patient with activities of daily living, if a parent or caregiver is not available to provide the service.

42. Personal Care Assistant services may not be approved by the Agency for Health Care Administration for the purposes of providing monitoring and supervision.

43. The petitioner's father spends the overnight hours with the petitioner to ensure his health and safety. The petitioner's family also pays privately for some of the care provided to the petitioner.

44. The Physician Reviewer appearing as a witness for the respondent stated that the eight hours per day, seven days per week, of Personal Care Assistant services presently approved for the petitioner are sufficient to assist him with his activities of daily living and that any additional hours requested are for monitoring and supervision which are outside the scope of the home health services program.

CONCLUSIONS OF LAW

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

46. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.

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

48. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof with regard to the requested increase in the petitioner's services from eight hours per day, seven days per week, to 24 hours per day, seven days per week, is on the petitioner.

49. 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.).

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

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

....

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.

....

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing

services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, 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 ...

51. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in 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.

52. 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.

53. 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).

54. 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.

55. 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.

56. 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.

57. The Florida Medicaid Home Health Services Coverage and Limitations Handbook October 2014 (“Handbook”) is promulgated into rule by Fla. Admin. Code R. 59G-4.130(2).

58. The Handbook describes the Home Health Services Program, which consists of various services including: Registered Nurse services; Licensed Practical Nurse services; and Personal Care Services. All services provided under this Program, including Personal Care Assistant services, must be determined to be medically necessary in order to be approved under Florida Medicaid.

59. For Personal Care Assistant services to be approved, the services must not only be medically necessary but must also meet any further requirements set forth in the Handbook.

60. Page 1-2 of the Handbook states “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 recipients to accomplish tasks that they would normally be able to do for themselves if they did not have a medical condition or disability.”

61. Page 1-2 of the Medicaid Handbook provides a list of personal care (ADL) services. These services 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).

62. Personal Care Services are confined by the limitations specified in the Handbook. An individual's service needs relating to behavioral or supervisory issues do not supersede Handbook provisions.

63. The hearing officer acknowledges the petitioner requires monitoring and supervision due to his behavioral problems. However, monitoring and supervision may be provided by any responsible adult, a medically trained professional is not necessary.

64. The Handbook, on Page 1-3, 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."

65. The Handbook, on Pages 2-12 and 2-13, lists babysitting, day care or after school care, as examples of services that are not reimbursable under the Medicaid home health services program.

66. Eating, bathing, dressing, oral care, skin care, incontinent care, and assistance with toileting may be summarized as activities of daily living. These services may be approved and provided by a Home Health Aide if it is determined they are

medically necessary and a primary caregiver is unavailable to provide the care. (See Fla. Admin. Code R. 59G1.010 (111), *Definition of "Home Health Aide (HHA)"*).

67. Appendix L of the Handbook discusses "Medicaid Review Criteria for Personal Care Services" and sets forth each of the allowable personal care tasks and general time allowance for each task. The sum of time for all of the individual tasks performed by the petitioner's Personal Care Assistant is equal to or less than the eight hours per day approved by the Agency.

68. The definition of medical necessity set forth in Fla. Admin. Code R. 59G-1.010 (166)(a) explains goods or services furnished or ordered must:

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

This information is echoed on Page 2-2 of the Handbook.

69. The Handbook, on Page 2-25, discusses the requirement of parental responsibility. It explains:

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.

70. The above paragraphs highlight that the Home Health Services Program is a supplemental program. It is designed to supplement the care provided by the parents or caregivers and is not intended to assume the care of the patient under any circumstances. Parents and caregivers must participate in providing care to the fullest extent possible. However, since the petitioner in the present case participates in the CDC+ Program which provides for financial compensation to a parent for services they would otherwise be legally obligated to provide, the respondent may approve Personal Care Assistant services for the petitioner during the times his parents are at home.

71. In the present case, the eight hours per day, seven days per week, of Personal Care Assistant services approved by the respondent are sufficient to assist the petitioner with his activities of daily living. The hearing officer recognizes the petitioner requires monitoring and supervision due to his behavioral problems. However, page 2-2 of the Handbook indicates “[h]ome health services are not considered emergency services.” Monitoring and supervision are outside the scope of the Home Health Services program and services may not be properly approved for these functions.

72. Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the petitioner has not met his burden of proof that the Agency incorrectly denied his request for additional Personal Care Assistant services.

73. In rendering this decision, the undersigned hearing officer considered all of the testimony and documentary evidence submitted at the hearing and reviewed all conditions of “medical necessity” and Personal Care Assistant duties set forth in the Florida Administrative Code and the rules governing the Florida Medicaid program.

74. The hearing officer hereby affirms the decision of the Agency for Health Care Administration to approve Personal Care Assistant services eight hours per day, seven days per week.

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 06 day of October, 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
AHCA, Medicaid Fair Hearings Unit

FILED

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

Sep 21, 2016
Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

PETITIONER,

Vs.

APPEAL NO. 16F-04833
16F-04834

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88000

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on July 26, 2016 at 1:00 p.m.

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: Sylma Dekony, ACCESS Economic Self-Sufficiency
Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to approve him for Medicare Savings Plan (MSP) benefits, under the Special Low-Income Medicare Beneficiary (SLMB) benefits. Petitioner is seeking approval under the Qualified Medicare Beneficiaries (QMB) benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

The petitioner is also appealing the respondent's action to enroll him in the Medically Needy (MN) Program with a share of cost (SOC). The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By notice dated July 8, 2016, the respondent notified the petitioner that his SLMB benefits were reviewed and he remained eligible for the SLMB coverage. Petitioner timely requested an appeal.

At the outset of the hearing, the petitioner explained he did not have an issue regarding the MN Program. Therefore, appeal 16F-04833 is dismissed as invalid.

Petitioner did not submit any exhibits. Respondent submitted five exhibits, entered into evidence as Respondent's Exhibits "1" through "5". The record was held open until close of business on August 4, 2016 for submission of additional evidence from the respondent. Additional evidence was received from the respondent on July 29, 2016, which was entered into evidence as Respondent's Exhibit "6". The record closed on August 4, 2016.

FINDINGS OF FACT

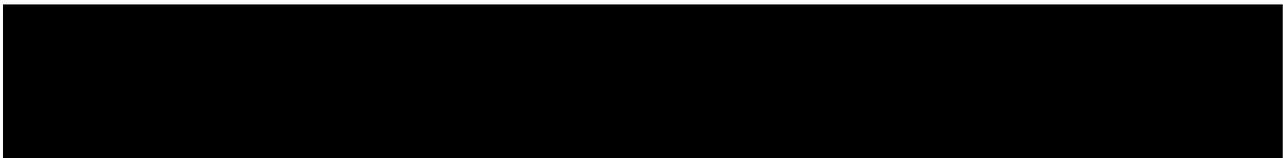
1. Prior to the action under appeal, the petitioner was receiving SLMB benefits from August 2015 through July 2016. On June 15, 2016, the petitioner submitted an application to recertify for MSP benefits. Petitioner reported his sources of income were Social Security Disability Income (SSDI) and his pension with Disney.
2. An applicant may be eligible to receive Medicare cost savings benefits for payment of the Medicare Part B premium through the Medicaid Program under one of three

categories: QMB, SLMB, or Qualifying Individual 1 (QI1) benefits, if all criteria are met.

To be eligible, the applicant must be enrolled in Medicare Part A, meet all technical criteria, and have income within established income limits.

3. The respondent reviewed the application for the recertification month of August 2016. The respondent verified the petitioner's SSDI through the State of Florida on-line query. The on-line query showed the petitioner's SSDI amount was \$958.00 per month. Petitioner submitted to the Department a pension letter from Disney. The letter indicated his monthly pension is \$100.38 per month. The respondent combined the petitioner's SSDI and pension to determine his total monthly income, which totaled \$1,058.38.

4. The respondent used the petitioner's \$1,058.38 total monthly income and calculated the MSP budget as follows:



TOTAL UNEARNED INCOME:	1058.38	COUNTABLE EARNED INCOME:	.00
PARENT'S DEEMED INCOME: +	.00	COUNTABLE UNEARNED INCOME: +	1038.38
MISC. INCOME DISREGARDS: -	.00	MEDICALLY NEEDY DISREGARD: -	.00
UNEARNED INCOME DISREGARD: -	20.00	TOTAL COUNTABLE INCOME: =	1038.38
COUNTABLE UNEARNED INCOME: =	1038.38		
		INCOME STANDARD:	1188.00
SELF-EMP. ADJ. GROSS EARN.:	.00		
ADDITIONAL EARNED INCOME: +	.00		
MISC. INCOME DISREGARDS: -	.00	TOTAL COUNTABLE INCOME:	.00
REM. UNEARNED INC. DISREGARD: -	.00	MNIL: -	.00
EARNED INCOME DISREGARD: -	.00	SHARE OF COST: =	.00
1/2 REMAINING DISREGARD: -	.00		
BLIND WORK EXPENSES: -	.00	MED. INSURANCE PREMIUM: -	.00
COUNTABLE EARNED INCOME: =	.00	RECURRING MED. EXPENSES: -	.00
		REMAINING SOC: =	.00

5. The respondent calculated the petitioner's countable income as \$1,038.38, after a \$20.00 unearned income disregard was subtracted from \$1,058.38. The petitioner's countable income of \$1,038.38 exceeded the income limit of \$990.00 for the petitioner to be eligible for QMB benefits. His income was compared to the next MSP category which was SLMB. The SLMB income limit for an individual is \$1,188. Based on the petitioner's countable income, the respondent determined he qualified for SLMB benefits.

6. Petitioner does not agree to the SLMB benefits. He is requesting to go back to the QMB benefits he had before. Additionally, he explained the QMB benefits pay for his co-pays to the doctors.

7. Respondent explained the petitioner's QMB benefits ended on July 2015 and he was approved for SLMB benefits beginning August 2015 through current.

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. Section 409.904, Florida Statutes, Optional payments for eligible persons, addresses who qualifies for this Program and states in part:

The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible

persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

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

11. The above authority sets forth that the SSI-Related Medicaid Program provides medical assistance to those who are aged or disabled according to the Social Security Act. Petitioner met the disability criteria; the next step is to determine income eligibility.

12. Fla. Admin. Code R. 65A-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...

13. Fla. Admin. Code R 65A-1.713 further addresses the “SSI-Related Medicaid Income Eligibility Criteria” and explains:

(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.

14. Federal regulations at 42 C.F.R. § 435.631, General requirements for determining income eligibility in States using more restrictive requirements for Medicaid than SSI, states in part:

(a) Income eligibility methods. In determining income eligibility of aged, blind, and disabled individuals in a State using more restrictive eligibility requirements than SSI, the agency must use the methods for treating income elected under §§ 435.121 and 435.230, under § 435.601. The methods used must be comparable for all individuals within each category of individuals under § 435.121 and each category of individuals within each optional categorically needy group included under § 435.230 and for each category of individuals under the medically needy option described under § 435.800.

15. The above authorities explain that an individual must have income that is within the income limits established by federal and state laws as well as the Medicaid State plan.

The MSP under Medicaid are QMB, SLMB and Q11.

16. The Department's Program Policy Manual at Appendix A-9 (July 2016), identifies the following MSP income limits for an individual:

QMB	\$ 990
SLMB	\$1,188
Q11	\$1,337

17. 20 C.F.R. § 416.1124(c) (12) establishes a \$20 disregard for "the first \$20 of any unearned income in a month" and income can be reduced by that amount. Respondent deducted \$20 from the petitioner's \$1, 058.38 total monthly income. Petitioner's

countable income (\$1,038.38) was compared to the MSP income limits. Petitioner's countable income exceeded the QMB benefits income limit of \$990.00; however, it was below the SLMB benefits income limit of \$1,188.00. Therefore, the respondent determined the petitioner was eligible for SLMB benefits.

18. In careful review of the cited authorities and evidence, the undersigned concludes the respondent's action to approve the petitioner for SLMB benefits, instead of QMB benefits, was correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, appeal 16F-04834 regarding the MSP, SLMB benefits, is denied and the Department's action is affirmed.

Appeal 16F-04833 regarding the MN Program is dismissed as invalid.

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 September , 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

Sep 16, 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-04854

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 St. Lucie
UNIT: 88500

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 29, 2016 at 3:06 p.m.

APPEARANCES

For the Petitioner: 

For the Respondent: Nardalisa Figueroa, senior caseworker

STATEMENT OF ISSUE

Petitioner is appealing the Department's action denying her application to participate in the Medicaid Home and Community Based Services Waiver. The petitioner also seeks reimbursement for out of pocket medical expenses. The petitioner holds the burden of proof in both matters by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (Department or DCF or respondent) determines eligibility for participation in the Florida Medicaid Home and Community Based Services (HCBS) Waiver.

By notice dated May 24, 2016, the Department informed the petitioner that her application to participate in the Medicaid HCBS Waiver was denied. The notice reads in pertinent part: "We did not receive all information needed to determine eligibility."

The petitioner timely requested a hearing to challenge the denial decision on June 23, 2016.

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

There were no additional witnesses for the Department. The Department 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 September 2, 2016 for the submission of additional evidence. Evidence was received from the Department and admitted into the record was Respondent's Composite Exhibit 2.

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 (age 90) was enrolled in Medicaid HCBS Waiver for individuals age 65 and older. The HCBS Waiver provides

home health and support services to medically complex individuals who would otherwise require nursing home placement.

2. The petitioner began participating in the HCBS Waiver in 2014. Her income exceeded waiver program limits. She was required to establish a Qualified Income Trust (QIT) bank account and fund the QIT monthly with the amount of income which exceeded the waiver limit in order to be eligible for program participation. (The petitioner's total gross monthly income is approximately \$2770. The waiver income limit for an individual is \$2,199. The petitioner would need to fund the QIT monthly in the amount of approximately \$571 in order to be eligible for waiver participation.) The petitioner properly funded the QIT from 2014 – mid/late 2015.

3. Waiver enrollees must apply for continued program participation annually. The petitioner filed a waiver recertification application in January 2016. The Department pended the petitioner for verification that she was properly funding the QIT. The bank statements provided by the petitioner showed that the QIT had not been funded for several months. The Department terminated the petitioner's waiver coverage effective February 29, 2016 because her income exceeded the program limit.

4. The petitioner reapplied for waiver participation on April 21, 2016. The Department pended the petitioner for verification that she was properly funding the QIT. The bank statements provided by the petitioner showed that the QIT had not been funded for several months. The Department denied the petitioner's waiver application on May 24, 2016 because her income exceeded the program limit.

5. The petitioner reapplied for waiver participation in August 2016. She provided documentation that the QIT was properly funded for August 2016. The Department approved waiver services effective August 2016 and ongoing.

6. The petitioner is incapacitated. Her daughter, [REDACTED], is her authorized representative and handles all of her business affairs, including her Medicaid HCBS Waiver applications. The daughter contacted an attorney in 2014 to establish the QIT necessary for the petitioner to be eligible for waiver participation. The attorney told the daughter how much to deposit into the QIT monthly. The daughter properly funded the QIT 2014 – mid/late 2015.

7. The petitioner's daughter admitted that she stopped funding the QIT sometime in 2015; she claimed mitigating circumstances. The daughter and her husband were living with the petitioner in her home. They helped care for the petitioner and the combined incomes of all three household members was used to pay household expenses. The daughter's husband passed away in 2015. She explained that the loss of her husband's income cause the household great financial hardship. In addition, the daughter was diagnosed with [REDACTED] and underwent [REDACTED]. She and the petitioner had to sell their home and buy a smaller home. The daughter asserted that she had to use the petitioner's full income, her full income, and charges to credit cards in order to pay their monthly expenses.

8. The petitioner's daughter admitted that she did not consult with counsel before she stopped funding the QIT. In addition, she admitted that did not inform the Department that the household was experiencing financial hardship or that she had stopped funding the QIT.

9. After the denial of the petitioner's January 2016 recertification application and April 2016 re-application, the daughter learned, during a collateral contact with a Department caseworker, that waiver rules allow withdrawal from the QIT under certain circumstances. The daughter argued that if the Department had told her this earlier, she would have continued to fund the QIT and gone through the proper channels to make withdrawals.

10. The waiver paid for the petitioner's adult day care services (\$650 monthly approximately), home health aide services (\$791 monthly approximately) and consumable medical supplies/adult diapers and wipes (monthly expense unknown). The daughter paid out-of-pocket for some of these services May 2016 – July 2016 because the petitioner's waiver coverage was terminated. The daughter does not exactly how much she paid out-of-pocket for the petitioner's care, but argued that the Department should reimburse her.

11. In rebuttal, the Department explained that it is prohibited from giving families legal advice in regards to establishing, funding, and managing QITs. Program policies are readily available online and applicants may retain the services of legal professionals, as the petitioner's daughter did in this case.

12. The Department noted that the petitioner's daughter was instructed by her attorney to fund the QIT monthly and the amount to deposit each month. The Department further noted that the petitioner's daughter stated that she stopped funding the QIT without advice of counsel or contacting the Department regarding the change in her household's finances. The Department asserted that all of its actions were in keeping with policy and procedure.

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 the same Florida Statutes.

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

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

16. Fla. Admin. Code § 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:

...

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C...

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

- (a) In-kind support and maintenance is not considered in determining income eligibility.
- (b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.
- (c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.
- (d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.
- (e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional programs ...
- (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.

17. Fla. Admin. Code § 65A-1.713 SSI-Related Medicaid Income Eligibility

Criteria in relevant part states:

(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.

(a) For MEDS-AD Demonstration Waiver, Protected Medicaid, Medically Needy, Qualified Working Disabled Individual, QMB, SLMB, QI1, and to compute the community spouse income allocation for spouses of ICP individuals, the following less restrictive methodology for determining gross monthly income is followed:

1. When income is received monthly or more often than once per month the monthly income from that source shall be computed by first determining the weekly income amount and then multiplying that amount by 4. A five-week month shall not be treated any differently than a four-week month.

2. When unearned income is received less often than monthly the total amount will be prorated over the period it is intended to cover. If prorating income adversely affects the client it will be counted in the month received and not prorated.

3. When earned income is received less often than monthly, the department counts the total amount in the month received and does not prorate.

(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.

18. The Department's ACCESS Florida manual, Appendix A-9, sets forth the HCBS Waiver income limit for an individual at \$2,199.

19. The cited authorities explain that in order for the petitioner to be eligible for the HCBS Waiver, her gross income cannot exceed 300% of the federal benefit rate. However, if the petitioner's income exceeds the limit, she is able to establish and fund a QIT with the excess income to qualify for HCBS Waiver participation.

20. The petitioner's income (approximately \$2,770 gross monthly) exceeded HCBS Waiver program limit (\$2,199 for an individual). In order to be eligible for participation in the HCBS waiver, the petitioner needed to establish and monthly fund a QIT with the income in excess of the waiver limit. The petitioner hired an attorney to set up the QIT and was told by the attorney how much to deposit into the QIT monthly. The

petitioner properly funded the QIT from the onset of her enrollment in the HCBS Waiver in 2014 to sometime mid/late 2015. The petitioner she stopped funding the waiver without advice of counsel and without notifying the Department.

21. The undersigned carefully reviewed the controlling legal authorities, but found no exception to the QIT funding requirement for the reasons asserted by the petitioner (change in household finances caused by the death of her son-in-law and her daughter's health issues). The Department's denial of the petitioner's January 2016 and April 2016 HCBS waiver applications was correct. The petitioner's income exceeded the program limit.

22. The petitioner seeks reimbursement for unspecified out-of-pocket medical expenses incurred May 2016 – July 2016 while her waiver benefits were terminated. The petitioner asserted that she should be reimbursed for out-of-pocket expenses because she believes the Department should have informed her of allowable QIT withdrawals. The petitioner argued that she would have not stopped funding the QIT if she was aware that specified withdrawals were allowed.

23. Department policy transmittal I-13-07-0009, Unlicensed Practice of Law, dated July 2013, reads in pertinent part:

This memorandum is to remind and caution staff about unlicensed practice of law. In interactions and communications with customers, staff must refrain from engaging in any communication with customers that may be considered the practice of law.

Unlicensed practice of law may be defined as giving legal advice or counsel to the customer wherein the rights and property of the person receiving the advice might be affected. It could also be advising the customer how to create or change a document in a way that needs a lawyer's opinion about the effect of lawfulness of the change of the effect or lawfulness of the document after the change has been made.

Two examples that may be considered the unlicensed practice of law are:

- Telling a customer a specific amount of money to be deposited into a qualified trust account or other trust or financial account, or
- Telling a customer how to spend down accumulated assets to qualify for Medicaid.

Staff must not advise customers or their representatives, either verbally or in writing, about actions to take in utilizing their resources and income. Staff may provide information on Medicaid eligibility policies and may refer customers to the Department's website for additional resources, such as eligibility fact sheets.

24. The Department's policy transmittals are formal interpretations of its rules and regulations. The cited transmittal prohibits Department staff from advising applicants on how to utilize their income. The petitioner retained the services of an attorney to establish and fund the QIT. The petitioner stopped funding the QIT without seeking advice of counsel or notifying the Department. The undersigned concludes that the Department's actions were in keeping with its rules.

25. The petitioner incurred unspecified out-of-pocket medical expenses while her HCBS Waiver benefits were terminated. She argued that the Department should reimburse her for those expenses.

26. Fla. Admin Code R 59G-5110, "Claim Payments" provides information regarding the conditions under which direct payments can be made:

(1)(a) The agency provides eligible individuals with access to Medicaid services and goods by direct payment to the Medicaid provider upon submission of a payable claim to the fiscal agent contractor. Except as provided for by law or federal regulation, payments for services rendered or goods supplied shall be made by direct payment to the provider except that payments may be made in the name of the provider to the provider's billing agent if designated in writing by the provider. **Direct payment may be made to a recipient who paid for medically necessary, Medicaid-**

covered services received from the beginning date of eligibility (including the three-month retroactive period) and paid for during the period of time between an erroneous denial or termination of Medicaid eligibility and a successful appeal or an agency determination in the recipient's favor [Emphasis Added]. The services must have been covered by Medicaid at the time they were provided. Medicaid will send payment directly to the recipient upon submission of valid receipts to the Agency for Health Care Administration. All payments shall be made at the Medicaid established payment rate in effect at the time the services were rendered. Any services or goods the recipient paid before receiving an erroneous determination or services for which reimbursement from a third party is available are not eligible for reimbursement to the recipient.

27. The cited rule explains that direct payment can be made to a Medicaid recipient who paid for medically necessary and covered services during a period of erroneous denial of Medicaid eligibility coupled with a successful appeal or agency determination in the recipient's favor.

28. The evidence in this case proves the petitioner's Medicaid waiver applications were not erroneously denied. The petitioner was ineligible for program participation because her income exceeded the program limit. The petitioner does not meet criteria for reimbursement of medical expenses.

29. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the Department's actions in this matter were correct.

DECISION

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

FINAL ORDER (Cont.)

16F-04854

PAGE - 12

the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The 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 September, 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]
Office of Economic Self Sufficiency

Oct 25, 2016

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGSOffice of Appeal Hearings
Dept. of Children and Families[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-04860

PETITIONER,

Vs.

CASE NO. 1323131523

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88374RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter September 14, 2016, at 9:39 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Mary Triplett, supervisor

STATEMENT OF ISSUE

At issue is the denial of Emergency Medicaid for Aliens (EMA) for dates of service of January 27, 2016 through January 31, 2016. The petitioner carries the burden of proof by a preponderance of evidence in this appeal.

PRELIMINARY STATEMENT

At the hearing 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. The record was held open until September 23, 2016, for the petitioner to provide proof that her children were residing with her from January 27, 2016 through January 31, 2016. The petitioner provided school records which was accepted into evidence and marked as Petitioner's Exhibit 2. The record was closed on September 23, 2016.

FINDINGS OF FACT

1. On December 16, 2015, the petitioner submitted an application requesting EMA. The petitioner's request for EMA was approved as her children were already in the case, although she did not list them on her application.
2. The petitioner's children were removed from her case and added to their grandmother's case, where they received Food Assistance and Medicaid benefits.
3. On June 9, 2016, the petitioner submitted an application for disability Medicaid. Her children were not listed on that application. The petitioner was approved for disability Medicaid with DDD. The respondent sent a request to the DDD via a 2931 form for retro disability Medicaid for January 2016. The DDD replied that retro Medicaid was not possible unless there was an earlier application. There was not. The petitioner was approved for retro Medicaid back to a March 2016, based on her June 2016 application.
4. On June 27, 2016, the petitioner's representative requested a hearing to challenge the respondent's action to deny EMA.
5. The respondent did not provide the petitioner a denial Notice of Case Action advising her of the status of the requested EMA.

6. On July 1, 2016, the petitioner's representative submitted an application for EMA on behalf of the petitioner. The petitioner's two children were listed on this application. The medical emergency date requested was June 13, 2016. She was 32 years old at the time. Medicaid was approved for EMA for June 13, 2016. The DDD did not approve disability back to January 2016, as the earliest disability application was June 9, 2016.

7. On September 14, 2016, the respondent denied the EMA for January 2016 because the petitioner did not meet the technical criteria and had no application on file that would provide retro Medicaid eligibility for the time period she was seeking. She was not aged, pregnant, disabled and did not have children age 18 and under living with her at the time.

8. The petitioner's representative argued that the children lived with the petitioner but lived with their grandmother periodically when the petitioner was ill or in the hospital.

9. The respondent agreed to determine eligibility if her representative provided proof that the children were living with the petitioner at the time of the emergency. The record was held open for her to provide the evidence.

10. The petitioner's representative provided school records stating the children are currently residing at their mother's address. No proof was provided that the children were residing at the petitioner at the time the medical emergency occurred. The undersigned finds that the children were not living at the petitioner for the dates of service requested.

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.

Jurisdiction will be addressed first

13. Before addressing the merits, it is necessary to establish that a timely hearing request was filed. Fla Admin. Code R. 65-2.046, sets forth the regulatory requirements as follows:

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

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

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

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

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

14. According to the above authority the 90 day time limit does not apply when the Department fails to send a notice. The Department did not send a Notice of Case Action to the petitioner's representative regarding the EMA Medicaid. The undersigned

retains jurisdiction and will rule on the denial of EMA Medicaid since no Notice of Case Action was issued to the petitioner regarding EMA.

EMA Medicaid will now be addressed.

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.

16. The cited rule explains that when the Department determines verification is necessary to determine an applicant's eligibility, it is the applicant's (or designated representative's) responsibility to provide the verification. The Department is to provide as much assistance as possible, but the ultimate responsibility for providing the verification rests with the applicant (or designated representative).

17. The Fla. Admin. Code R. 65A-1.715, Emergency Medical Services for Aliens, sets forth:

(1) Aliens who would be eligible for Medicaid but for their immigration status are eligible only for emergency medical services. Section 409.901(10), F.S., defines emergency medical conditions.

(2) The Utilization Review Committee (URC) or medical provider will determine if the medical condition warrants emergency medical services and, if so, the projected duration of the emergency medical condition. The projected duration of the emergency medical condition will be the eligibility period **provided that all other criteria are continuously satisfied.**

(3) Emergency services are limited to 30 consecutive days without prior approval. For continued coverage beginning with the 31st day prior authorization must be obtained from the Agency for Health Care Administration (Medicaid Program Office).

18. The Department's Program Policy Manual (Policy Manual) CFOP 165-22 at section 0230.0105 addresses Emergency Medical Assistance for Noncitizens (MFAM) and states:

This program provides emergency Medicaid coverage for noncitizens who would otherwise be eligible for Medicaid except for their noncitizen status. They must meet all technical requirements except for citizenship, child support enforcement cooperation, and welfare enumeration.

To be eligible for emergency Medicaid benefits, the noncitizen must meet the income requirements for whichever Medicaid coverage group the noncitizen is determined to be eligible.

Medicaid coverage is for the duration of the emergency medical situation only, as certified by a health professional. This includes emergency labor and delivery.

19. The above authority states that for Emergency Medicaid for Noncitizens all technical factors must be met except citizenship.

20. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for Family-Related Medicaid Program benefits a dependent child must be living in the home. The petitioner's representative provided

school records stating the children are currently residing with the petitioner. No proof were provided that the children were living with the petitioner during the period of the medical emergency. The respondent requires this proof as there is a discrepancy since the children were receiving Food Assistance and Medicaid in their grandmother's case.

21. Fla. Admin. Code, Section 65A-1.710, sets forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level.

For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. Social Security found the petitioner ineligible for disability Medicaid for January 2016

22. The undersigned reviewed Medicaid rules and regulations, and found that the petitioner had to be disabled, aged, have children under 18 years of age living with her or be pregnant in order to receive Medicaid. She did not meet the technical factors for the month of January 2016 in order to receive EMA benefits.

23. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner's designated representative did not meet her burden of proof in this matter. The Department's action to deny EMA for January 27, 2016 through January 31, 2016 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.

DONE and ORDERED this 25 day of October, 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]
Office of Economic Self Sufficiency

FILED

Sep 09, 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-04884

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 CHARLOTTE
UNIT: 88287

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter August 15th, 2016, at 10:37 a.m.

APPEARANCES

For the Petitioner: [REDACTED].

For the Respondent: Mary Lou Dahmer, Senior Worker for the Economic Self-Sufficiency Program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll her in the Medically Needy (MN) program, as opposed to approving full Medicaid. The petitioner is also requesting multiple medical bills from 2013 be paid through her Supplemental Security Income (SSI) Medicaid. On the record, the hearing officer assigned the burden of proof to the petitioner. After further review, the hearing officer determined that the respondent has the burden of proof.

PRELIMINARY STATEMENT

A hearing was scheduled for August 16th, 2016, at 8:30 a.m. but was rescheduled at the petitioner's request.

The record was held open until the close of business August 22nd, 2016, to allow the petitioner time to provide additional information. The petitioner provided the requested information timely and the record was closed.

On August 23rd, 2016, additional documents were received from the respondent. However, as the record was not held open for any additional information from the respondent, the documents will not be considered.

Petitioner's exhibit 1 was admitted into evidence.

Respondent's exhibits 1 through 8 were admitted into evidence.

By way of Notice of Case Action dated May 26th, 2016, the respondent informed the petitioner that her application for MN dated April 29th, 2016 was approved. On June 27th, 2016, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner applied to recertify her SSI-Related Medicaid on April 29th, 2016. As part of the application process, the respondent is required to explore and verify all factors of eligibility, which include but are not limited to all sources of income and allowable expenses.

2. The petitioner is a single-person household, aged 26.

3. The petitioner is disabled and receives Social Security Disability (SSD) of \$843 per month.

4. The petitioner has been covered by Medicare part A and B since September 2015.

5. The petitioner was receiving Supplemental Security Income (SSI) Medicaid from May 1st, 2015, through May 31st, 2016, before being placed on SSD according to the respondent's evidence packet (see Resp. Ex. 5 p. 26).

6. The respondent calculated the petitioner's countable income for the MN program as follows:

\$843.00 Total unearned income	
<u>- \$ 20.00 Unearned income disregard</u>	
\$823.00 Countable unearned income	
Total countable income:	\$823.00
<u>-Medically Needy Income Limit (MNIL)</u>	<u>\$180.00</u>
Remaining Share of Cost (SOC)	\$643.00

7. The petitioner lost full Medicaid coverage when she gained SSD eligibility. Now she is required to pay \$40-160 per month in co-payments and \$600 per month (\$20 per day) to visit a pain management clinic. The petitioner also pays housing expenses. The petitioner would like all expenses considered in an effort to reduce her income and increase her chances of being eligible for Medicaid.

8. The petitioner provided to the respondent multiple bills from various years and months for bill tracking. Some of the bills are from the year 2013, during which time the petitioner asserts she was receiving SSI. The petitioner did not provide evidence to verify monthly SSI eligibility or the dates of the unpaid bills in question.

9. The respondent's position is since the majority of the 2013 bills are in collections, they are unable to be tracked. The respondent did not cite a specific policy explaining why bills in collections could not be tracked.

10. The respondent has no record of the petitioner receiving SSI in the year 2013. Therefore, there is no Medicaid coverage open during time period.

11. The respondent is willing to review Medicaid eligibility for 2013 if the petitioner provides proof that she was receiving SSI during the time she incurred her alleged medical expenses.

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

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

14. Fla. Admin Code 65-2.060, Evidence states:

(1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

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

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and **are not receiving Medicare** [*emphasis added*] 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-1.713 defines the income limits for SSI - Related

Medicaid programs:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

...

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

17. The ACCESS Florida Program Manual at 2640.0500, Share of Cost (MSSI)

sets forth:

The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's assets and/or income exceeds the appropriate categorical asset/income limits. The eligibility specialist determines whether the assistance group's assets are within the Medically Needy asset limits and whether the assistance group members meet the technical factors. If the Medically Needy asset limit is met and the assistance group meets all technical factors, the eligibility specialist determines the amount of countable income and computes a budget using the MNIL which is the same for both family and SSI-Related Medicaid coverage groups (refer to Appendix A-7).

If income is equal to or less than the MNIL, there is no share of cost and the individual is eligible. Medicaid is authorized for individuals who are eligible without a share of cost.

If income is greater than the MNIL, share of cost is determined for appropriate members. Appropriate members are enrolled but cannot be eligible until the share of cost is met.

18. The Code of Federal Regulations 20 C.F.R. Section 416.1124 defines

unearned income that is not counted in SSI – Related Medicaid programs:

(C)(12) The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see Section 416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility.

19. Fla. Admin. Code R. 65A-1.713 sets forth the Income Budgeting

Methodologies for the Medically Needy Program:

(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.

The hearing officer will first address the issue of the termination of full Medicaid.

20. The above-cited authorities set forth income limits for full Medicaid, as well as, the rules for enrollment and budgeting for the MN program. As noted in the Findings of Fact, the petitioner has had Medicare parts A and B since September 2015. The petitioner is not covered by institutional care services, hospice services or home and community based services. Therefore, she is not eligible for full Medicaid and Medicare concurrently. In conclusion, the respondent was correct to terminate Medicaid coverage and enroll the petitioner in MN.

21. The hearing officer recognizes the petitioner's claim that she has housing expenses and those should be used to reduce her income in determining eligibility for Medicaid. In careful review of the authorities, the hearing officer finds nothing to support the inclusion of these expenses to reduce her SOC. Furthermore, including the expenses to make her eligible for Medicaid is a moot point since she is ineligible as cited above. The hearing officer also recognizes that the petitioner has multiple outstanding medical expenses. The respondent was correct to exclude the expenses from the MN budget since the petitioner has submitted or is planning to submit the expenses for bill tracking to meet her SOC.

The hearing officer will now address the issue of bill tracking for bills incurred in 2013.

22. The above-cited authority states that the party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer. In regards to SSI coverage in 2013, the petitioner failed to meet her burden of proof. The Social Security award letter provided by the petitioner is inconclusive. The award letter shows a lump sum amount of \$4,350 beginning January 2010 through December 2015 but doesn't provide a monthly breakdown. In addition, it shows a disability begin date of March 16, 2013 which contradicts the lump sum start month (January 2010). Therefore, the hearing officer concludes that the petitioner's SSI Medicaid coverage cannot be determined by this document.

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 09 day of September, 2016,
in Tallahassee, Florida.

FINAL ORDER (Cont.)

16F-04884

PAGE-8



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

Sep 15, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04905

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 18, 2016 at 1:30 p.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 action to partially deny Physical Therapy (PT) service hours that were requested for the petitioner for the certification period April 4 through September 30, 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 Dr. Darlene Calhoun, Physician-Consultant with eQHealth Solutions, Inc. The respondent's composite Exhibit 1 was entered into evidence, consisting of documents such as a statement of matters, outpatient review history, denial notices, and therapy evaluation/plan of care.

FINDINGS OF FACT

1. The petitioner's PT service provider, Kids Quality Therapy (hereafter referred to as "the provider"), requested the following PT service hours for the certification period at issue: 4 units (1 hour), three times per week, or a total of 3 hours weekly.
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; 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. All pertinent information was submitted by the provider directly to eQ Health.
4. The medical information submitted by the provider contained, in part, the following information in regard to the petitioner:

- 17 years old
- Diagnosis includes [REDACTED]

5. The petitioner was approved for 1 hour weekly (2 units, 2 times per week) of physical therapy services in the prior certification period. She also currently receives occupational therapy and speech therapy services through the Medicaid program.

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 PT provider.

The duties include, in part:

- Balance training activities
- Functional mobility training
- Gait training
- Therapeutic exercises
- Muscle re-education
- Home program
- Range-of-motion, strengthening, endurance training, postural training

7. A physician at eQHealth Solutions, who is board-certified in pediatrics, reviewed the submitted information and denied the partially denied the requested PT services, approving 1 hour weekly rather than 3 hours weekly. This physician-reviewer wrote, in part: "Recipient is a 17 year old female with [REDACTED] receiving physical therapy to improve strength, ROM, transitioning movements, gait. Request based on the patient's deficits and needs is partially approved." A notice of this determination was sent to all parties on April 7, 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 by the Petitioner's provider.

9. A second physician at eQ Health Solutions reviewed the submitted information and upheld the initial decision to approve 1 hour of physical therapy weekly. A notice of this reconsideration decision was sent to all parties on April 7, 2016.

10. The petitioner thereafter requested a fair hearing and this proceeding followed.

11. The petitioner's mother, who is also a pediatrician, stated her daughter has severe [REDACTED] and needs more therapy hours. She was with a different therapy provider previously for 3 years and her mother states she was not making any progress there. The petitioner's mother does not agree with the prior therapy reports which stated her daughter was making progress in therapy and meeting 70% of her goals. She also stated her daughter is not currently getting therapy because the current provider was giving 3 hours weekly of therapy, which used up all the approved hours for the current period since the approval was for 1 hour weekly.

12. The respondent's witness, Dr. Calhoun, stated the denial of the petitioner's request for additional therapy hours was appropriate due to the petitioner's age and the length of time she has had [REDACTED]. She also stated a home program should be utilized to supplement the therapy sessions and a maintenance program should be implemented.

13. PT 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 petitioner since the petitioner was previously approved for 1 hour weekly of physical therapy and is seeking an increase in these services for the current certification period. 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 PT 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 (PT 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 ...

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

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 PT services.

26. In the petitioner's case, the respondent determined that 1 hour weekly of physical therapy service is medically necessary, rather than the 3 hours weekly requested by the petitioner.

27. 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.

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. PT services are described on page 1-3 of the Therapy 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.

30. The Therapy Handbook on page 2-2 sets forth the requirements for PT 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 PT service frequency greater than that approved by eQHealth Solutions. Rule 59G-1.010(166) (c), however, specifically states a prescription does not automatically mean the requirements of medical necessity have been satisfied.

32. The respondent's witness stated that an increase in physical therapy was not warranted in the petitioner's case.

33. The petitioner's mother feels the services should be increased to 3 hours weekly since her daughter was not making any progress with her previous therapy provider and she needs more therapy.

34. After considering all the documentary evidence and witness testimony presented, the undersigned concludes the petitioner has not demonstrated the physical therapy services should be increased at this time. Although the petitioner's mother disagreed with the prior provider's therapy reports of progress, this is not a basis to increase services at the present time. The petitioner's progress, deficits, and needs should be properly documented by the current therapy provider, and the service needs should be re-evaluated at the appropriate time once it is determined whether her needs are being met at the level of 1 hour weekly. The therapy should not be provided for 3 hours weekly, since this results in an early exhaustion of approved hours which is what happened in the current period.

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-04905

PAGE - 11

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 September, 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

Sep 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-04912

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 29, 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 dental services (partial upper dentures) was correct. The petitioner has the burden of proving his case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a letter from his dentist as evidence for the hearing, which was marked as Petitioner Exhibit 1.

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 pursuant to its request to be added as a party.

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 sixty-one (61) 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 Humana, which utilizes DentaQuest for review and approval of dental services.
2. On or about April 11, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest for partial upper metal-based dentures. DentaQuest denied this request on April 12, 2016.

3. DentaQuest's denial notice to the petitioner advised him of the following reason for the denial of his request for the upper dentures:

Your teeth are not healthy enough for this service because they have large cavities and poor bone support. Please talk to your dentist about your choices to treat your teeth.

4. The petitioner stated the upper dentures should be approved because he was approved for lower dentures, and the condition of his teeth is poor.

5. The respondent's expert witness, Dr. Hudson, testified that the denial of the Petitioner's request for the upper partial dentures was appropriate because some healthy teeth are needed for that type of denture and the petitioner needs to have dental work done on 6 of his 9 teeth in his upper arch. Dr. Hudson also advised that a resin-based denture would be more appropriate since any missing teeth can be added to the denture.

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"), effective November 2011.

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. Partial dentures are covered services for adults under the Medicaid Program.

The Dental Handbook, on page 2-31, describes partial dentures as follows:

Partial dentures refer to the prosthetic appliance that replaces missing teeth and is on a framework that is removed by the patient. Prior authorization is required for reimbursement of removable partial dentures and must be submitted to the dental consultant for determination of medically necessity prior to the procedure being performed.

Removable partial dentures are reimbursable for all eligible Medicaid recipients regardless of age.

15. The petitioner believes the upper dentures should be approved since he was approved for lower dentures.

16. The respondent's witness testified resin-based dentures are more appropriate for the petitioner than metal dentures due to the condition of his existing teeth in his upper arch.

17. After considering the evidence and testimony presented, the undersigned concludes the respondent correctly denied Petitioner's request for the upper partial metal dentures. The evidence demonstrates that resin-based dentures are a more appropriate alternative, and the petitioner should explore this option with his provider.

Although the petitioner's treating dentist has requested the partial metal dentures, this does not in itself establish that this service is medically necessary according to the rule provisions outlined above. In addition, the fact the petitioner was approved for lower dentures does not require automatic approval of the upper dentures since this service depends on the condition of the teeth in the upper arch, not the lower arch.

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 September, 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

FINAL ORDER (Cont.)

16F-04912

PAGE - 7

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

FILED

Sep 29, 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]
[REDACTED]

APPEAL NO. 16F-04922

PETITIONER,

Vs.

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

And

AMERIGROUP,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 9, 2016 at 3:00 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

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 custom shoe inserts 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 Carlene Brock, Quality Operations Nurse, and Dr. Lynn Berger, Medical Director, from Amerigroup, which is the petitioner's managed health care plan. Amerigroup was included as an additional respondent in this proceeding pursuant to its request to be added as a party.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Hearing Summary, Authorization Request, Denial Notice, Medical Records, and Medical Criteria.

Also present for the hearing was a Spanish language interpreter, [REDACTED], Interpreter Number 705, from Propio Language Services.

FINDINGS OF FACT

1. The petitioner is a five (5) 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.
2. On or about May 3, 2016, the petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Amerigroup for approval of custom shoe inserts. On May 11, 2016, Amerigroup denied the request based on medical necessity considerations and Medicaid guidelines.
3. The denial notice contained the following reason for the denial:

We cannot approve your child's foot inserts. We know your child has bunions. These supports can only be approved when the child is less than 18 months old. These can be approved if an older child cannot walk. We are not told if these supports are being used in a special leg brace. There are other items his doctor can ask for (non-custom arch supports).

4. The petitioner's mother stated her daughter's doctor prescribed the special inserts because her daughter's feet are crooked and she sometimes falls when she's walking. She wants the problem corrected before her daughter's condition worsens or reaches a point where it requires surgery.

5. The respondent's witness, Dr. Berger, stated there was no indication from the petitioner's podiatrist describing why a non-custom shoe insert would be inadequate in this case. She stated the petitioner was not born with any abnormality or deformity of the feet and the diagnosis was bunions, although an x-ray does show a dislocation of the second toe. She also stated the petitioner would probably grow out of any walking problem.

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. Durable medical equipment, including orthopedic footwear devices, is also addressed in the Florida Durable Medical Equipment and Medical Supply Services Handbook ("DME Handbook"), effective July, 2010.

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. Section 120.80.

8. This is a final order pursuant to Fla. Stat. Sections 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. 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. Orthopedic footwear for children is a covered service under the Florida Medicaid Program. This service is addressed in the DME Handbook, which states as follows on page 2-56:

Orthopedic footwear includes orthopedic shoes, shoe modifications, wedges, heels, and miscellaneous shoe additions.

Foot orthotics are for congenital forefoot deformities in children who are under 18 months of age, unless determined medically necessary for an older child who is not yet walking.

15. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not established by a preponderance of the evidence that the requested custom shoe inserts should have been approved by Amerigroup. The medical records submitted do not indicate why the petitioner cannot utilize a non-custom insert. Therefore, the medical necessity requirement that there is "no equally effective and more conservative or less costly treatment available" has not been met in this case.

DECISION

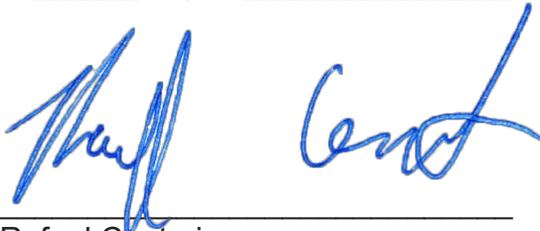
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 September, 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

FILED

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

Sep 26, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-04948

PETITIONER,

vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 01 Escambia
UNIT: AHCA

RESPONDENT.

FINAL ORDER

Pursuant to notice and agreement, Hearing Officer Patricia C. Antonucci convened hearing in the above-captioned matter on August 4, 2016 at approximately 12:24 pm., Central Standard Time (CST). All parties and witnesses appeared via teleconference.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Dianne Soderlind, Registered Nurse Specialist,
Agency for Health Care Administration

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

At hearing, the minor Petitioner was not present, but was represented by his mother, who also presented a witness from Petitioner's PPEC facility: Patti Moore, RN, Administrator/Director of Nursing. Respondent was represented by Dianne Soderlind, RN, on behalf of AHCA. Respondent presented one additional witnesses: Darlene Calhoun, M.D., Physician Reviewer with eQHealth Solutions (eQHealth).

Respondent's Exhibits 1 through 14, inclusive, and Petitioner's Exhibits 1 through 4, inclusive, were admitted into evidence. Administrative Notice was taken of Fla. Stat. § 409.905, Fla. Admin. Code R. 59G-1.001, Fla. Admin. Code R. 59G-1.010, Fla. Admin. Code R. 59G-4.260, and pertinent pages of the September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook).

FINDINGS OF FACT

1. The Petitioner is a 4-year-old male, born in 2012. He is diagnosed with a reduction [REDACTED]
[REDACTED] He suffers one to two seizures per month, but is not currently taking seizure medication due to side effects from same.
2. The Petitioner requires assistance with all activities of daily living (ADLs), is unable to walk independently, uses leg braces (AFOs), and has an unsteady gait. He has low muscle tone and frequently falls, both while attempting to ambulate and during seizure activity. He cannot stand, and uses a walker and/or wheelchair to mobilize over long distances. Petitioner is unable to verbalize his needs and is incontinent.

3. The Petitioner resides at home with his single, working mother, who adopted both the Petitioner and his twin brother (who also has special needs). He receives Occupational, Physical, and Speech Therapies. Petitioner attends school during the day, but seeks PPEC services for school breaks and holidays. His mother has contacted various day care centers in the community, but has been unable to locate one equipped to provide care to or willing to enroll the two boys. The mother notes that she is concerned about the possibility of Petitioner having a seizure or falling while in the care of someone who does not know how to respond.

4. Petitioner is and has been eligible to receive Medicaid services at all times relevant to these proceedings.

5. On or about June 21, 2016, Petitioner's PPEC provider submitted a request on behalf of the Petitioner, to continue his previously authorized PPEC services of 180 full days and 180 partial days into the new certification period, spanning June 25, 2016 through December 21, 2016.

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

7. On June 24, 2016, the PRO reviewed Petitioner's request for services and all supporting documentation. By letter dated June 27, 2016, the PRO notified Petitioner's provider of its decision to terminate PPEC, stating, in pertinent part:

Clinical Rationale for Decision: The patient is a 4 year old with [REDACTED] [REDACTED] The patient has had two reported seizures but [the seizures] have not required any skilled interventions such as Disastat [*sic*].

The patient has an as needed nebulizer treatment order but has not required any recent treatments. The patient is on an age-appropriate diet. The patient uses a walker and receives OT and PT as an outpatient. The patient attends school and uses PPEC after school and on non-school holidays. The clinical information provided does not support the continued PPEC services. There no longer appears to be any skilled needs. The request is denied.

8. The June 27, 2016 letter, which eQHealth sent to Petitioner, notes only:

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

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

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

9. In response to this notice, on or about June 28, 2016, Petitioner's requested a hearing to challenge termination of PPEC. As this was a timely request, Petitioner's services have continued, pending outcome of his appeal.

10. At some point during the pendency of the appeal process, eQHealth conducted a reconsideration review of Petitioner's request. The resultant Notice references dates that do not line up with the progression of Petitioner's case, and the copy of the Notice mailed to Petitioner provides little new information. However, the Notice of Reconsideration Determination issued to Petitioner's providers on or about July 14, 2016 states, in pertinent part:

PR Recon Determination: 4 yo with a history of [REDACTED] and absence seizures. However, the patient is on PO/PRN meds and currently has no skilled needs.

Uphold previous denial. All submitted documentation was reviewed. The patient lacks sufficient medical needs to warrant PPEC care.

11. At hearing, Dr. Calhoun testified based upon her review of Petitioner's request for services, in conjunction with his Plan of Care, assessments, care coordination and progress notes, and testimony from Petitioner's caregivers. Dr. Calhoun noted that while the Petitioner clearly requires precautions/monitoring, the only interventions indicated on the Plan are the administration of as-needed medications/nebulizer and ADL care.

12. Per Dr. Calhoun, Petitioner's assessments and notes reflect that Petitioner is not dependent upon mechanical devices, and does not have multiple seizures per day. While Dr. Calhoun agrees that Petitioner requires adjustments to his seizure medication, continued therapeutic services, and assistance with ambulation and ADL development, she does not feel these needs indicate a medical necessity for continuation of PPEC.

13. Petitioner's PPEC provider noted that eQHealth's reviews as to who qualifies for PPEC services are becoming increasingly stringent. In her experience, PPEC used to be authorized for any child who had a seizure disorder and was taking seizure medication. At some point, the criteria became whether the child had a seizure within the year; then whether he/she had a seizure within the certification period; then whether the seizures required Diastat; then whether more than one of the seizures required Diastat. She does not feel that this is fair to Petitioner, and doesn't think his seizure disorder, or his overall medical status can be properly monitored in a regular day care setting.

14. The provider expressed concerned that Petitioner's overall condition was not considered, as in addition to seizures, he is a fall risk, cannot stand on his own, is

incontinent, cannot express himself verbally, and is developmentally delayed. He has [REDACTED] which results in an unsteady, “scissor” gait. He also suffers from a swallowing disorder, which requires Botox injections and close monitoring/assistance with eating, to prevent aspiration.

15. The provider emphasized that the nursing staff at PPEC assess Petitioner twice per day and closely monitor him. They are trained to notice subtle differences in his appearance and behavior, which may signify a change in his neurological status. If the Petitioner does have a seizure, staff respond to keep him stabilized, keep his airway open, and prevent him from falling/injuring himself, all while preparing to administer Diastat, if needed. The provider questioned why PPEC is frequently authorized for services such as g-tube and tracheostomy care, which are both tasks that can be taught to any responsible adult, but denied when the nursing service provided via PPEC is assessment and monitoring – tasks that are much more difficult to designate to a lay/non-nurse caregiver.

16. Petitioner’s mother testified that although eQHealth noted otherwise, Petitioner *does*, in fact, have an on-duty nurse (two nurses, who rotate schedules) at his school. She stated that she specifically sought a school setting where a nurse would be on staff, such that Petitioner would have immediate care in the event of an emergency, and be able to receive routine medication during the school day. She also testified that Petitioner is further delayed/requires more assistance than does his twin brother.

17. On or about June 27, 2016, Petitioner was hospitalized for lower extremity weakness after beginning Keppra therapy (for seizures). Keppra was started following a 1-2 minute seizure in May of 2016, but Petitioner sustained weakness and inability to

ambulate, along with possible muscle pain, after Keppra administration. As such, this medication was subsequently discontinued.

18. During his stay at the hospital, Petitioner underwent an EEG, MRI, and lab work; however, as of the date of hearing, Petitioner's mother was still awaiting the results of these tests. The Petitioner is currently taking [REDACTED] to assist in regaining muscle control, and his doctors are awaiting further progress in that regard before reinstating a seizure medicine.

19. It is Dr. Calhoun's opinion that at this time, Petitioner does not require skilled nursing interventions on a regular basis. Even though he is currently undergoing medication changes, and even though his seizures may have increased since stopping Keppra, said seizures still do not require regular intervention. The PPEC facility monitors Petitioner for seizures, and provides ADL care; however, Dr. Calhoun opined that this type of care and supervision can be provided by any trained adult and/or via nurse visits, as opposed to full or partial day services. Per Dr. Calhoun, if Petitioner were to experience a seizure while at a regular day care facility, the staff would call 9-1-1 and either be instructed as to administration of [REDACTED], or advised as to how to manage Petitioner until paramedics arrived.

20. Dr. Calhoun did testify that Petitioner might qualify for home health services/personal care, to assist in meeting his ADL needs. She agreed that, unfortunately, there is no day care alternative program/service for children who require some care, but do not qualify for PPEC services; however, she opined that Petitioner's ambulation issues should continue to be addressed through PT, and his communication

issues should be addressed through ST, both of which, along with OT, Petitioner can request as distinct services, outside of the PPEC setting.

21. AHCA agreed to assist Petitioner's mother in seeking additional and/or alternate supports within her community, and also suggested that she contact the Department of Children and Families (DCF) to explore their child care resources.

CONCLUSIONS OF LAW

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

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

24. The September 2013 Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook (PPEC Handbook) has been promulgated into rule by Fla. Admin. Code R. 59G-4.260.

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

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

27. The burden of proof in the instant case is assigned to Respondent, who seeks to terminate Petitioner's PPEC services. The standard of proof in an administrative hearing is preponderance of the evidence. (See Fla. Admin. Code R. 65-2.060(1).)

28. Section 409.905, Florida Statutes,

'= addresses mandatory Medicaid services under the State Medicaid Plan:

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

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

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

30. On page 2-1 – 2-2, the PPEC Handbook lists the requirements for PPEC services.

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

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

(emphasis added)

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

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

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

(emphasis added)

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

33. Fla. Admin. Code Rule 59G-1.010(166) defines medical necessity, as follows:

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

(a) Meet the following conditions:

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

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

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

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

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

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

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

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

(4) The treating physician assumes “the primary responsibility of determining what treatment should be made available to his patients.”

Both the treating physician and the state have roles to play, however, and “[a] private physician’s word on medical necessity is not dispositive.”

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

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

37. In the instant case, PPEC is requested to treat and ameliorate the supervisory, monitoring, and continuous therapy needs which Petitioner’s health conditions require.

As such, in a general sense, PPEC is in keeping with Fla. Admin. Code R. 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, per Fla. Admin. Code R. 59G-1.010(166)(3).

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

39. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life-sustaining medical intervention or equipment. While he is currently undergoing medication changes that may result in increased/breakthrough seizures, these seizures do not consistently

require “short, long-term, or intermittent *continuous* therapeutic interventions or skilled nursing care.” They require monitoring and may result in administration of Diastat.

However, Dr. Calhoun testified that any adult caregiver can be taught to look for seizure activity and to respond, as necessary, when seizures occur.

40. Similarly, although Petitioner clearly requires continued therapy services and ADL care, particularly with regard to eating and monitoring at meal times, these services can be provided outside of the PPEC setting. Therapy can be offered on an out-patient basis, and Petitioner may request personal care assistance and/or nursing visits (for assessments) on days when he is unable to attend school. As such, the provision of PPEC is currently in excess of Petitioner’s medical needs.

41. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that Respondent has met its burden of proof to terminate PPEC.

42. Again, Petitioner’s mother is to be commended for her dedication to her adopted sons, and her concern for their welfare is duly noted. Should Petitioner’s health decline, such that he regularly requires medical or nursing interventions, and/or should his MRI, EEG, or blood work results indicate a need for increased care, his mother is encouraged to reapply for PPEC services. Additionally, she is encouraged to coordinate with AHCA and to contact the Department of Children and Families to seek assistance with locating an appropriate day care facility, and obtaining any other services which may be appropriate to meet Petitioner’s needs. If any subsequent requests for services are denied, she will retain the right to appeal that/those, specific denial(s).

DECISION

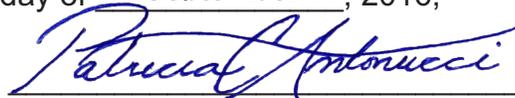
Based upon the foregoing, Petitioner's appeal is hereby DENIED.

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 26 day of September, 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
AHCA, Medicaid Fair Hearings Unit
Patti Moore

FILED

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

Sep 16, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-04989

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 2, 2016 at 11:30 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 a nursing facility/rehabilitation center stay was correct. The petitioner bears 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 Diana Anda, Grievance and Appeals Manager, and Dr. Vincent Pantone, Medical Director, from Simply Healthcare, which is the petitioner's managed health care plan.

The respondent submitted the following documents as evidence for the hearing, which were marked as follows: Exhibit 1 – Pre-Admission Screening; Exhibit 2 – Medical Records; Exhibit 3 – Additional Medical Records; Exhibit 4 – Denial Notice; and Exhibit 5 – Updated Medical Records.

FINDINGS OF FACT

1. The petitioner is a sixty (60) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan from Simply Healthcare.
2. The petitioner suffered a broken leg in January, 2016 which required surgery. He was hospitalized from approximately January through April, 2016. He was thereafter transferred to a nursing facility/rehabilitation center.
3. On or about June 14, 2016, the nursing facility (hereafter referred to as “the provider” or “the facility”), requested prior authorization from Simply Healthcare for the petitioner's stay in the facility. On June 29, 2016, Simply partially denied the request – approving the stay in the facility only until June 29, 2016. The reason for the denial was because the services could be provided at a lower level of care.

4. The petitioner thereafter requested a fair hearing and this proceeding followed.

The petitioner was still residing in the nursing facility at the time of the hearing.

5. The petitioner stated he needs to see a trauma specialist before the facility can determine an appropriate discharge date. He also stated he needs physical therapy and he is currently homeless, so he would have nowhere to stay if he is discharged from the facility.

6. The respondent's witness, Dr. Pantone, stated the decision to partially deny the stay in the nursing facility was made because the care could be provided at a lower level of care, such as an out-patient setting. He noted the petitioner could only walk 5 feet when he was first admitted to the nursing facility, but by June 28 he could walk 90 feet. He also stated the petitioner could use a walker or wheelchair to assist with ambulation. Home care can be provided as further assistance. Dr. Pantone stated homelessness was not a sufficient reason for the petitioner to remain in a skilled nursing facility. He also stated the petitioner may be eligible for Long-Term Care benefits.

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 Fla. Stat. Section 120.80.

9. This is a final order pursuant to Fla. Stat. Sections 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. The Medicaid Handbook referred to above is incorporated by reference in Fla. Admin. Code R. 59G-4.001.

13. Florida Statute § 409.912 requires that respondent “...purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

14. The Medicaid Handbook and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

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

(a) Meet the following conditions:

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

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

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

15. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not established by a preponderance of the evidence that Simply Healthcare should have approved the continued stay in the nursing facility. The testimony at the hearing establishes that the services can be provided at a lower level of care in an out-patient setting. Therefore, the medically necessity requirement that there be "no equally effective and more conservative or less costly treatment available" was not met in this case.

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-04989

PAGE - 6

DONE and ORDERED this 16 day of September, 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]
AHCA, Medicaid Fair Hearings Unit
Randy Colegrove – additional address

FILED

Sep 20, 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-05020

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 5, 2016 at 1:30 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

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 weight loss 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. Ian Nathanson, Medical Director, and 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 pursuant to its request to be added as a party.

The respondent submitted the following documents as evidence for the hearing, which were marked as respondent's composite Exhibit 1: Case Summary, Authorization Request with Medical Records, and Denial Notice.

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. She receives services under the plan from Humana.
2. On or about June 22, 2016, the petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Humana to perform weight loss surgery. Humana denied this request on or about June 28, 2016 based on medical necessity criteria. The denial notice stated the following:

Your request for surgery to lose weight is denied. Your medical record has been reviewed. You have high blood pressure and are also being treated for behavioral health issues. Your BMI is 46.7 (weight of 308 pounds and 5'8" tall). In order to be a candidate for this surgery, there needs to be blood work that shows that you do not have any illness that is causing you to gain weight and you need to have been on a physician supervised diet. While your record states that you have been on different

commercial diets, there is no record of a physician supervised diet. Please discuss this further with your physician and get the care you need.

3. The petitioner has been diagnosed with [REDACTED]. She is seeking the requested surgery as a means of achieving weight loss.

4. The respondent's witness, Dr. Nathanson, stated that the applicable medical necessity criteria for this type of surgery require there be documentation that the patient has tried and failed a medically supervised weight loss program. He stated the petitioner would meet criteria for the surgery based on her BMI, but there is no record of a supervised weight loss program.

5. The petitioner stated she believes the surgery should be approved because she is borderline diabetic and she cannot walk or stand for very long. She also has pain in her legs, back, and hips due to excess weight. She also stated she cannot wash herself properly and has difficulty getting out of a car. She stated she has been on an 1800-calorie-per-day diet with a dietitian since January, 2016.

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. 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 general references to various commercial diet plans, 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

FINAL ORDER (Cont.)

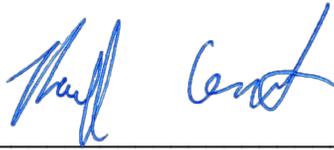
16F-05020

PAGE - 6

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 20 day of September, 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

Sep 29, 2016

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-05042

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 66292

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on August 15, 2016 at 1:00 p.m.

APPEARANCES

For the petitioner: 

For the respondent: Stan Jones, ACCESS Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the respondent's action to enroll the petitioner in the Medically Needy (MN) Program with a share of cost (SOC) of \$3,173.00 beginning January 2016.

Petitioner is seeking to lower his SOC. The petitioner carries the burden of proof by a preponderance of the evidence.

At issue is also the respondent's action to deny the petitioner's Medicaid benefits for June 2016 due to not meeting his SOC. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

On August 10, 2016, the petitioner forwarded an email to the Office of Appeal Hearings requesting to also appeal the respondent's action to deny him Medicaid benefits for June 2016.

Petitioner submitted one exhibit, entered into evidence as Petitioner's Exhibit "1". Respondent submitted five exhibits, entered into evidence as Respondent's Exhibits "1" through "5". The record was held open until close of business on August 23, 2016 for submission of additional evidence from the respondent. Additional evidence was received from the petitioner, which the undersigned accepted and entered into evidence as Petitioner's Exhibits "2" through "4". The undersigned received additional evidence from the respondent on August 23, 2016; however, it did not explain its position regarding the policy at issue.

On August 26, 2016, the undersigned issued an Order requiring the respondent to submit additional evidence necessary to make a decision; the respondent had ten days from the date of the Order to submit the requested information. On August 29, 2016, the undersigned received an email from the petitioner. The email indicated that the petitioner objected to the Order issued on August 26, 2016 as he did not agree with the respondent having more time to provide the additional information.

Fla. Admin. Code R. 65-2.057(12) states "the hearing officer shall request, receive and make part of the record information determined necessary to decide the issues being raised." The undersigned concludes the additional information requested from the respondent was necessary to make a decision on the issues raised on August

15, 2016. Therefore, pursuant to the above authority, the petitioner's objection is overruled.

On September 6, 2016, the additional evidence was received from the respondent, which was entered into evidence as Respondent's Exhibits "6" and "7". The record closed on September 6, 2016.

FINDINGS OF FACT

1. By notice dated June 14, 2016, the respondent notified the petitioner that he and his wife were enrolled in the MN Program with a \$3,173.00 SOC beginning January 2016.
2. On July 1, 2016, the petitioner went to a DCF storefront office to request the respondent review and reduce his and his wife's current SOC amount on the basis of the Achieving a Better Life Experience (ABLE) Act which was passed by Congress and took effect on July 1, 2016.
3. The ABLE Act allows individuals, who meet disability requirements, to place funds in a tax-free account to assist with qualified disability expenses.
4. The petitioner is not disputing the household income, which includes him and his wife. The petitioner is disputing the respondent's action to include all of their income when determining the SOC. The petitioner argued that the first \$14,000.00 of his and his wife's annual income (total \$28,000.00) should be excluded when determining their eligibility for the MN Program based on the ABLE Act. Additionally, the petitioner is requesting the Department consider the following expenses to meet the SOC: automobile insurance, purchases to rebuild his vehicle and mortgage payments as it relates to disability expenses.

5. The respondent sought policy clarification through the Department's virtual policy consultant. It was explained that the ABLE account will not be counted as an asset, however; the petitioner and his wife's income is counted.
6. The petitioner must meet his SOC on a monthly basis in order to be eligible for Medicaid benefits. The SOC is met when the total allowable medical expenses meet or exceed the SOC; Medicaid eligibility begins on the date the SOC is met until the end of the month.
7. The petitioner submitted unpaid medical bills on June 11, 2016 for bill tracking consideration. The respondent explained that the medical bills did not meet or exceed the SOC for the month of June 2016; therefore, the petitioner was not eligible for Medicaid benefits. On or about July 2016, the respondent notified the petitioner that the unpaid medical bills submitted for bill tracking were denied due to not meeting the SOC.
8. The petitioner submitted into evidence the following unpaid medical bills:

Providers Name	Dates of Service	Unpaid amount
[REDACTED]	12/4/14	\$107.56
[REDACTED]	6/6/16	\$35.66
[REDACTED]	6/12/16	\$35.66
[REDACTED]	6/14/16	\$405.79
[REDACTED]	6/5 - 6/7/16	\$124.43
[REDACTED]	6/7- 6/13/16	\$212.59
[REDACTED]	6/9/16	\$1,288.00
[REDACTED]	6/9/16	\$35.99
[REDACTED]	6/5/16	\$21.07
[REDACTED]	6/6/16	\$14.58
[REDACTED]	6/7/16	\$29.87
TOTAL		\$2,311.20

9. The petitioner is requesting his automobile insurance, automobile monthly payments and mortgage be considered allowable expenses in order to meet his SOC.

10. Respondent did not submit the Notice of Case Action mailed to the petitioner informing him he did not meet the SOC for June 2016.

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.

LOWER SOC AMOUNT ISSUE

13. Social Security Administration- Program Operations Manual System (POMS) SI 01130.740 Achieving a Better Life Experience (ABLE) Accounts, states in part:

A. What is an ABLE Account?

An Achieving a Better Life Experience (ABLE) account is a type of tax-advantaged account that an eligible individual can use to save funds for the disability-related expenses of the account's designated beneficiary, who must be blind or disabled by a condition that began before the individual's 26th birthday.

An ABLE program can be established and maintained by a State or a State agency directly or by contracting with a private company (an instrumentality of the State). An eligible individual can open an ABLE account through the ABLE program in any State.

An eligible individual can be the designated beneficiary of only one ABLE account, which must be administered by a qualified ABLE program. Upon the death of the designated beneficiary, funds remaining in the ABLE account, after payment of any outstanding, qualified disability expenses, reimburse the State(s) for certain Medical Assistance (Medicaid) benefits that the designated beneficiary received.

B. Definitions of terms...

2. Contributions

A contribution is the deposit of funds into an ABLE account. Any person can contribute to an ABLE account. ("Person," as defined by the Internal Revenue Code, includes an individual, trust, estate, partnership, association, company, or corporation.) However, the Internal Revenue Service (IRS) limits the total annual contributions that any ABLE account can receive from all sources to the amount of the per-donee gift-tax exclusion in effect for a given calendar year. For 2016, that limit is \$14,000...

8. Qualified disability expense (QDE) for housing

Housing expenses for purposes of an ABLE account are the same as they are for in-kind support and maintenance purposes, except for food. QDEs for housing are payments for:

- Mortgage (including property insurance required by the mortgage holder);
- Real property taxes; , •Rent; , •Heating fuel; , •Gas; , •Electricity;
- Water; , •Sewer; or , •Garbage removal.

C. When to exclude ABLE account contributions, balances, earnings, and distributions...

1. Exclude contributions

Exclude contributions to an ABLE account from the income of the designated beneficiary. Excluded contributions include rollovers from a family member's ABLE account to an SSI recipient's ABLE account.

NOTE: Do not deduct contributions from the countable income of the person who makes the contribution. **The fact that a person uses his or her income to contribute to an ABLE account does not mean that his or her income is not countable for SSI purposes.** (emphasis added)

For example, a recipient or deemor can have contributions automatically deducted from his or her paycheck and deposited into an ABLE account. In this case, include the income used to make the ABLE-account contribution in the recipient or deemor's gross wages.

14. Internal Revenue Code Title 26 U.S. Code § 529A - Qualified ABLE programs

states:

...

(b) Qualified ABLE program

For purposes of this section—

(1) In general

The term "qualified ABLE program" means a program established and maintained by a State, or agency or instrumentality thereof—

(A) under which a person may make contributions for a taxable year, for the benefit of an individual who is an eligible individual for such taxable year, to an ABLE account which is established for the purpose of meeting

the qualified disability expenses of the designated beneficiary of the account,

(B) which limits a designated beneficiary to 1 ABLE account for purposes of this section,

(C) which meets the other requirements of this section.

...

(c) Tax treatment

(1) Distributions

(A) In general

Any distribution under a qualified ABLE program shall be includible in the gross income of the distributee in the manner as provided under section 72 to the extent not excluded from gross income under any other provision of this chapter.

(2) Gift tax rules

For purposes of chapters 12 and 13—

(A) Contributions

Any contribution to a qualified ABLE program on behalf of any designated beneficiary—

(i) shall be treated as a completed gift to such designated beneficiary which is not a future interest in property,

...

(e) Other definitions and special rules

For purposes of this section—

...

(5) Qualified disability expenses

The term “qualified disability expenses” means any expenses related to the eligible individual’s blindness or disability which are made for the benefit of an eligible individual who is the designated beneficiary, including the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses, which are approved by the Secretary under regulations and consistent with the purposes of this section.

(6) ABLE account

The term “ABLE account” means an account established by an eligible individual, owned by such eligible individual, and maintained under a qualified ABLE program.

...

(g) Regulations

The Secretary shall prescribe such regulations or other guidance as the Secretary determines necessary or appropriate to carry out the purposes of this section, including regulations—

(1) to enforce the 1 ABLE account per eligible individual limit,...

(3) to generally define qualified disability expenses,

15. Section 1009.986, Florida Statutes, Florida ABLE program, states in part:

(1) LEGISLATIVE INTENT.—It is the intent of the Legislature to establish a qualified ABLE program in this state which will encourage and assist the saving of private funds in tax-exempt accounts in order to pay for the qualified disability expenses of eligible individuals with disabilities. The Legislature intends that the qualified ABLE program be implemented in a manner that is consistent with federal law authorizing the program and that maximizes program efficiency and effectiveness.

(2) DEFINITIONS.—As used in ss. 1009.987 and 1009.988 and this section, the term:

(a) “ABLE account” means an account established and maintained under the Florida ABLE program.

(b) “Contracting state” means a state that has entered into a contract with Florida ABLE, Inc., to provide residents of Florida or that state with access to a qualified ABLE program.

(c) “Designated beneficiary” means the eligible individual who established an ABLE account or the eligible individual to whom an ABLE account was transferred.

(d) “Eligible individual” has the same meaning as provided in s. 529A of the Internal Revenue Code.

(e) “Florida ABLE program” means the qualified ABLE program established and maintained under this section by Florida ABLE, Inc.

(f) “Internal Revenue Code” means the United States Internal Revenue Code of 1986, as defined in s. 220.03(1), and regulations adopted pursuant thereto.

(g) “Participation agreement” means the agreement between Florida ABLE, Inc., and a participant in the Florida ABLE program.

(h) “Qualified ABLE program” means the program authorized under s. 529A of the Internal Revenue Code which may be established by a state or agency, or instrumentality thereof, to allow a person to make contributions for a taxable year to an ABLE account established for the purpose of meeting the qualified disability expenses of the designated beneficiary of the ABLE account.

(i) “Qualified disability expense” has the same meaning as provided in s. 529A of the Internal Revenue Code.

...

(4) FLORIDA ABLE PROGRAM.—

1(a) On or before July 1, 2016, Florida ABLE, Inc., shall establish and administer the Florida ABLE program....

1(b) The participation agreement must include provisions specifying:

1. The participation agreement is only a debt or obligation of the Florida ABLE program and the Florida ABLE Program Trust Fund and, as

provided under paragraph (f), is not a debt or obligation of the Florida Prepaid College Board or the state.

2. Participation in the Florida ABLE program does not guarantee that sufficient funds will be available to cover all qualified disability expenses for any designated beneficiary and does not guarantee the receipt or continuation of any product or service for the designated beneficiary.

...

(f) A contract or participation agreement entered into by or an obligation of Florida ABLE, Inc., on behalf of and for the benefit of the Florida ABLE program does not constitute a debt or obligation of the Florida Prepaid College Board or the state, but is only a debt or obligation of the Florida ABLE program and the Florida ABLE Program Trust Fund. The state does not have an obligation to a designated beneficiary or any other person as a result of the Florida ABLE program. The obligation of the Florida ABLE program is limited solely to amounts in the Florida ABLE Program Trust Fund. All amounts obligated to be paid from the Florida ABLE Program Trust Fund are limited to the amounts available for such obligation. The amounts held in the Florida ABLE program may be disbursed only in accordance with this section.

...

(7) MEDICAID RECOVERY; PRIORITY OF DISTRIBUTIONS.—

(a) Upon the death of the designated beneficiary, the Agency for Health Care Administration and the Medicaid program for another state may file a claim with the Florida ABLE program for the total amount of medical assistance provided for the designated beneficiary under the Medicaid program, less any premiums paid by or on behalf of the designated beneficiary to a Medicaid buy-in program. Funds in the ABLE account of the deceased designated beneficiary must first be distributed for qualified disability expenses followed by distributions for the Medicaid claim authorized under this paragraph. Any remaining amount shall be distributed as provided in the participation agreement.

(b) Florida ABLE, Inc., shall assist and cooperate with the Agency for Health Care Administration and Medicaid programs in other states by providing the agency and programs with the information needed to accomplish the purpose and objective of this subsection.

16. The Department of Children and Families published Transmittal No. P-16-09-0006 on September 1, 2016 relating to “Achieving a Better Life Experience (ABLE) Accounts Exclusion,” it states in part:

What is an ABLE account?

An ABLE account is a tax sheltered account used for disability-related expenses of an individual entitled to Social Security benefits based on

blindness or disability, or a certification of disability signed by a physician prior to age 26. Each state's ABLE Program will determine if the individual meets the qualifying factors to establish an ABLE account. The Florida Prepaid College Board will complete this determination for accounts established in Florida.

Policy

ABLE accounts not exceeding \$100,000 are excluded as an asset for all programs. Amounts over \$100,000 are counted in the asset determination. The current total annual limit for donations to an ABLE account is \$14,000 for 2015. The amount will be adjusted annually for inflation.

ABLE Account Verification:

When an individual is not potentially over the asset limit based on the sum of all assets including the ABLE account, staff may accept client statement of the ABLE account and exclude it from the budget.

When an individual is potentially over the asset limit based on the sum of all assets including an ABLE account, staff must request verification to confirm the account can be excluded as an ABLE account....

The application must not be denied if verification of an ABLE Account is the only outstanding verification needed to process the case. If the individual requires assistance with obtaining verification of an ABLE account, regional staff may contact their Region's Program Office staff to contact the Florida Prepaid College Board to obtain verification.

Deposits (Contributions to an ABLE account are:

-Excluded as an asset

-Contributions by others to an ABLE account are excluded as income to the beneficiary of the account

-Income of the beneficiary is counted in the eligibility determination, even if subsequently deposited into an ABLE account (emphasis added)

-Any interest, dividend or other earnings increase to an ABLE account is excluded as income

...

ABLE Accounts Funds for SSI Recipients:

-Funds accrued in an ABLE account up to \$100,000 are excluded as an asset with no effect on the individual's eligibility for Supplemental Security Income (SSI) payment and Medicaid coverage.

-Funds accrued in an ABLE account in excess of \$100,000 continue to be excluded as an asset; however, the individual's SSI payment is suspended. They remain Medicaid eligible

17. Pursuant to the above authorities, the purpose of a qualified ABLE program is to encourage and assist the saving of private funds in tax-exempt accounts in order to pay for the qualified disability expenses of eligible individuals with disabilities. The bill aims

to ease financial strains faced by individuals with disabilities by making tax-free savings accounts available to cover qualified expenses such as education, housing and transportation while still keeping their eligibility for federal public benefits. The petitioner argued that the first \$14,000 of his and his wife's annual income (total \$28,000) should be excluded when determining the household SOC amount. The above authorities explain an individual may only have one ABLE account and the total annual contributions, by all participating individuals (including family and friends) is \$14,000.00. This amount will be adjusted annually for inflation. Under current tax law, \$14,000.00 is the maximum amount an individual can gift to someone else and not pay taxes (as long as the funds are used to pay for qualified disability expenses). In this case, the petitioner meets the disability criteria; therefore, his ABLE account will be excluded as an asset as long as it does not exceed \$100,000.

18. The undersigned did not find any law or authority that directs the Department to exclude these funds when it determines eligibility for the MN Program. Based on the above-cited authorities, the undersigned concludes the Department was correct not to exclude \$28,000 of the petitioner and his wife's annual income when it determined their eligibility for MN benefits.

JUNE 2016 MEDICAID DENIAL DUE TO NOT MEETING SOC ISSUE

19. Fla. Admin. Code R. 65A-1.702 addresses Medicaid coverage provisions, as follows:

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

an individual was eligible any time during the month, with the following exceptions...

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

20. Fla. Admin. Code R. 65A-1.713 sets forth when bills are deducted to meet the SOC as follows:

(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:

1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

21. The above authorities explain that individuals enrolled in the MN

Program become eligible for Medicaid on the date they incurred allowable medical

expenses (excluding payments by all third party sources) equal their SOC. The SOC

represents the amount of recognized medical expenses that a MN enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits.

22. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2640.0505, Date of Service (MSSI), and states in part that:

In order to determine the date of eligibility for the assistance group members with a share of cost, the eligibility specialist must be able to track the medical expenses that are incurred. To do so, the eligibility specialist must determine the date of service to be one of the following:

1. the date of service is the date a recognized medical service is actually rendered;
2. the date of service is the date a charge related to usage of a health insurance policy is actually incurred, such as a co-payment or deductible;

Note: Medicare deductible is incurred on the first day of admission for each benefit period.

...

Additionally, there are two types of allowable medical expenses:

1. recognized health insurance costs, and
2. recognized medical services.

Only allowable medical expenses can be used to meet Share of Cost (SOC).

23. The Policy Manual, passage 2640.0506.01, Allowable Medical Expenses (MSSI), continues and states:

Allowable medical expenses are medical expenses that are:

1. unpaid and still owed, or
2. paid during the current month,

...

2640.0506.04 Recognized Medical Services (MSSI)

Recognized medical services are:

1. cost of public transportation to obtain recognized medical services;

...

Examples of recognized services include:

1. ambulance, bus, or taxi (to receive medical services);
2. prosthetic devices, orthopedic shoes, wheelchairs, walkers, crutches,...

...

Examples of expenses or items which are not recognized include:

1. medicine chest supplies, such as
 - a. nonprescription cold remedies,
 - b. nonprescription ointments,

- c. thermometers,
- d. handrails,
- e. alcohol,
- f. cotton swabs;
- 2. heavy housekeeping;
- 3. household repairs; and
- 4. yard work

24. Pursuant to the above authorities, the petitioner's medical expenses can be utilized to meet his SOC amount for June 2016. Petitioner provided unpaid medical expenses with dates of service ranging from December 14, 2014 through June 14 2016. The petitioner's total unpaid medical expenses were \$2,311.20, which did not meet his \$3,173.00 SOC for June 2016. Petitioner argued his automobile and shelter expenses should be counted as medical expenses on the basis of the ABLE Act qualified disability expenses. The undersigned could find no law or regulation to support the petitioner's argument that automobile and shelter expenses should be considered "allowable" medical expense to meet the SOC.

25. The petitioner's unpaid medical expenses of \$2,311.20 are lower than the SOC amount for June 2016; therefore, the undersigned concludes that the Department was correct in its action to deny Medicaid benefits for the petitioner due to not meeting his SOC.

DECISION

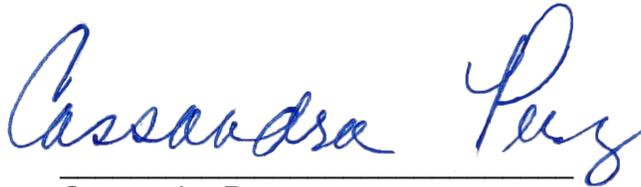
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's actions are affirmed.

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 29 day of September, 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

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

Sep 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NOs. 16F-05046
16F-06614

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 LEE
UNIT: 88287

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter August 4th, 2016, at 8:40 a.m. The hearing was scheduled to reconvene August 16th, 2016, at 10:30 a.m., but the petitioner did not phone in. The petitioner called the hearing officer within five business days and requested the hearing be rescheduled. The hearing was rescheduled a second time and convened September 6th, 2016, at 1:03 p.m.

APPEARANCES

On both dates:

For the Petitioner: [REDACTED].

For the Respondent: Nicole Nuriddin, Eligibility Services Specialist II, Hearings Unit, Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the WAGES (Work Activity) and Child Support Enforcement (CSE) sanctions placed on his Food Assistance (FA) case by the respondent (appeal number 16F-5046). At the end of the September 6th, 2016, hearing, the petitioner also chose to appeal the CSE sanction placed on his Medicaid benefits by the respondent (appeal number 16F-6614). In both appeals, the respondent carries the burden of proving its position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The petitioner did not submit any documents for the hearing officer's consideration.

Respondent's exhibit's 1 through 12 were admitted into evidence.

By way of a Notice of Case Action dated May 20th, 2016, the respondent informed the petitioner that his FA benefits would decrease from \$771 to \$649 effective June 1st, 2016 for failing to cooperate with CSE. On July 1st, 2016, the petitioner filed a timely request to challenge the respondent's action.

The same Notice of Case Action notified the petitioner that he was ineligible to receive Medicaid benefits for the same reason. On the record of September 6th, 2016, the petitioner requested to challenge the respondent's action on his Medicaid benefits.

FINDINGS OF FACT

1. The petitioner applied for FA, Temporary Cash Assistance (TCA), and Medicaid benefits on April 19th, 2016. As part of the application process, the respondent is required to explore and verify all factors of technical eligibility.

2. The petitioner's household includes himself, aged 40; and four children, ages 18, 14, 12, and 9.

3. No one in the household is disabled.

4. No one in the household is employed.

5. The respondent issued a Notice of Case Action on May 4th, 2016, informing the petitioner that his application for FA was approved in the amount of \$308 for April 2016 and in the amount of \$771 for May 2016 through September 2016. The notice also informed the petitioner that he was approved for Medicaid from April 2016 through ongoing. The respondent issued a second Notice of Case Action dated May 9th, 2016, informing the petitioner that TCA benefits were approved in the amount of \$210 for May 2016 and \$254 for June and ongoing.

6. On May 17th, 2016, the petitioner provided a Need for Care statement signed by a physician to the respondent showing that his mother required round-the-clock care.

7. On May 19th, 2016, the respondent placed a CSE sanction on the petitioner in the FA, TCA, and Medicaid categories beginning June 1st, 2016 (see Respondent's Exhibit 8 p. 90 and 93). The TCA benefits were closed the same day.

8. According to a May 27th, 2016 entry in the respondent's business notes (CLRC), the respondent removed the CSE sanction from the FA and Medicaid effective May 24th, 2016 (see Respondent's Exhibit 8 p. 94).

9. On May 28th, 2016, a TCA WAGES sanction was automatically imposed by the system. This sanction was also applied to the FA benefits, which is the matter under appeal. According to the respondent's evidence, the sanction was to take effect July 1st, 2016, but was changed to September 1st, 2016 (see Respondent's Exhibit 5 p. 76-77).

The respondent was unable to provide a reason as to why the dates of the sanction were changed.

10. The petitioner voluntarily closed his CSE case and provided two different CSE case closure dates. The petitioner only requested his CSE case be closed because he thought he was in cooperation and believed the WAGES sanction was the reason his TCA was terminated. In addition, the petitioner understood CSE cooperation to be a requirement for TCA only.

11. On July 22nd, 2016, the respondent received a non-cooperation alert from CSE and placed a second CSE sanction on the petitioner in the FA and Medicaid categories. Both benefits remained open, but only the petitioner's children were eligible.

12. Despite a CSE sanction being placed on the FA benefits, as of September 6, 2016, the respondent states the level one TCA WAGES sanction is in effect for the FA beginning September 1st, 2016. A CSE sanction remains in effect for Medicaid with a begin date of September 1st, 2016.

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

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

The hearing officer will first address the issue of the CSE sanction relating to the petitioner's Medicaid benefits.

15. Fla. Admin. Code Section 65-2.046 Time Limits in Which to Request a Hearing states:

(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. ... The time period begins with the date following:

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

16. The above authority explains that for all programs, an individual must file a request for an appeal within 90 calendar days of the date of the written notification of an action which aggrieves the petitioner. In this case, the petitioner did not request an appeal against the respondent's termination of his Medicaid benefits within the specified timeframe. The evidence shows that the petitioner was properly notified of this action by way of notice dated July 1st 2016. The notice also informed the petitioner of his right to appeal the action, but that the request must be made within 90 days from the date of the notice. The request date of September 6th, 2016 is beyond the 90-day time standard to request an appeal, and therefore not within the jurisdiction of the undersigned.

The hearing officer will now address the issue of the petitioner's FA reduction by the respondent.

17. Florida State Statute 445.024 Work requirements states in part:

(3) Exemption from Work Activity Requirements.—The following individuals are exempt from work activity requirements:

(d) An individual who is exempt from the time period pursuant to s. 414.105.

18. Florida State Statute 414.105 Time limitations of temporary cash assistance states in part:

(9) A person who is totally responsible for the personal care of a disabled family member is not subject to time limitations if the need for the care is verified and alternative care is not available for the family member. The department shall annually evaluate an individual's qualifications for this exemption.

19. The Department of Children and Families Policy Manual passage

1420.1906.05 states:

An individual is exempt from participation in work activities when the individual is required to be in the home to provide for the personal care of a family member with a disability. The individual is not subject to time limits during the allowed exemption period.

The care given may include such things as supervision, arranging services, transportation and such tasks that are typically completed during the family member's waking hours. **The caregiver's statement of their need to provide care in the home for the disabled individual is sufficient to establish the exemption. Verification of the family member's disability is required. Statement of Need for Care, CF-ES 2094, can be used to verify the disability and get the caregiver's statement. A verbal statement from the caregiver to the questions in Part A of this form may substitute for the caregiver completing this section [emphasis added].** A disabled family member is any person related by blood or marriage and who resides in the home with the caregiver. The individual in need of care need not be a member of the assistance group/standard filing unit (AG/SFU) and may be either an adult or child. The caregiver may self-declare to the lack of alternative care, including lack of alternative care from other family members, for the disabled individual.

A family member is considered disabled if receiving temporary or permanent disability benefits issued by a government or a private source, or if a statement from a physician or licensed certified psychologist indicates that the family member is disabled [emphasis added]. The age of the family member is not a factor in the need for care. The need for care of the disabled individual must be reviewed annually to evaluate whether or not the TCA recipient still qualifies for this exemption. When the family member requiring care is temporarily disabled, the disability verification is valid until the temporary disability is expected to end or one year, whichever is earlier. If the disability is total and permanent, there is no need to re-verify the family member's disability. In either case, the department must annually require a verbal or written statement explaining the caregiver provides personal care for the disabled individual in their home.

20. As established in the Findings of Fact, the petitioner provided to the respondent signed documents from his mother's physician on May 17th, 2016. The FA level one sanction was not imposed until eleven days later on May 28th, 2016. As stated in the above-cited authority, a statement from a physician showing the temporary or permanent care for a disabled family member is sufficient to exempt the petitioner from work registration requirements for TCA. The respondent failed to review this exemption both at the time of application for TCA and during the hearing review process which resulted in a WAGES sanction being imposed on the petitioner's FA benefits.

21. The Code of Federal Regulations appearing in 7 C.F.R. 273.11 Action on households with special circumstances states in part:

(1) *Option to disqualify custodial parent for failure to cooperate.* At the option of a State agency, subject to paragraphs (o)(2) and (o)(4) of this section, no natural or adoptive parent or, at State agency option, other individual (collectively referred to in this paragraph (o) as "the individual") who is living with and exercising parental control over a child under the age of 18 who has an absent parent shall be eligible to participate in SNAP unless the individual cooperates with the agency administering a State Child Support Enforcement Program established under Part D of Title IV of the Social Security Act (42 U.S.C. 651, *et seq.*), hereafter referred to as the State Child Support Agency.

(2) *Determining refusal to cooperate.* If the State Child Support Agency determines that the individual is not cooperating in good faith, then the State agency will determine whether the non-cooperation constitutes a refusal to cooperate. Refusal to cooperate is when an individual has demonstrated an unwillingness to cooperate as opposed to an inability to cooperate.

(3) *Individual disqualification.* If the State agency has elected to implement this provision and determines that the individual has not cooperated without good cause, then that individual shall be ineligible to participate in SNAP. The disqualification shall not apply to the entire household. The income and resources of the disqualified individual shall be handled in accordance with paragraph (c)(2) of this section.

22. As stated in the above-cited authority, the petitioner shall not be eligible for FA (Supplemental Nutritional Assistance Program or SNAP) unless he is cooperating with CSE. CSE determines whether or not cooperation has been made. As established in the Findings of Fact, the petitioner voluntarily closed his CSE case. On July 22nd, 2016, the respondent received a non-cooperation alert from CSE and placed the second of two sanctions on the petitioner's case. The petitioner is currently disqualified from participating in FA benefits.

23. The respondent erred when it did not accept the physician's statement as a valid reason to exempt the petitioner from work registration for TCA benefits. Not accepting the statement began a chain of events and unnecessary hardship on the petitioner. A work sanction was incorrectly imposed on the FA benefits. The petitioner believed he was cooperating with CSE and that the work sanction was the reason for the TCA closure only. Therefore, when the TCA closed, the petitioner voluntarily closed his CSE case. Voluntary closure of a CSE case means the custodial parent is no longer in cooperation and he or she is disqualified from receiving benefits. After closing his case, the petitioner became disqualified from FA benefits. In conclusion, the respondent was incorrect to request that the petitioner to register in the Work Activity program, but as stated in the above-cited authority, the petitioner must cooperate with CSE in order to be eligible for FA.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, appeal number 16F-05046 is granted in part because the respondent failed to review a good cause

exemption for work registration, and denied in part because the petitioner must establish cooperation with CSE in order to have the CSE sanction removed. Appeal number 16F-06614 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 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 27 day of September, 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

Sep 22, 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-05063

PETITIONER,

Vs.

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

And

UNITED HEALTHCARE

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 8, 2016 at 1:30 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 custom knee brace 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 Susan Frishman, Senior Compliance Analyst, and Dr. Ina Fishman, Medical Director, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional respondent in this proceeding pursuant to its request to be added as a party.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Statement of Matters, Authorization Request, Medical Records, and Denial Notice.

FINDINGS OF FACT

1. The petitioner is a sixty-three (63) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from United Healthcare.
2. On or about June 27, 2016, the petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from United Healthcare for approval of a custom knee brace. On July 2, 2016, United Healthcare denied the request based on medical necessity considerations.
3. The denial notice contained the following reason for the denial:

Your doctor has asked for a custom-made knee brace. We reviewed the notes. The records we reviewed do not support the need for a custom-

made knee brace. You have not had an injury or an operation. It is not medically necessary.

4. The petitioner stated the back of her knee is injured, although there is nothing wrong with the knee itself. She also stated she has fallen down twice because she cannot walk for long.

5. The respondent's witness, Dr. Fishman, testified that the custom knee brace was denied because the physician's notes did not describe any injury or instability of the knee. She also stated there was no indication why a custom brace was required or why a standard non-custom knee brace could not be used by the patient.

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.

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. Section 120.80.

8. This is a final order pursuant to Fla. Stat. Sections 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. 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. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not established by a preponderance of the evidence that the requested custom knee brace should have been approved by United Healthcare. The medical records submitted do not indicate why the petitioner cannot utilize a non-custom knee brace. Therefore, the medical necessity requirement that there is "no equally effective and more conservative or less costly treatment available" has not been met in this case.

DECISION

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

NOTICE OF RIGHT TO APPEAL

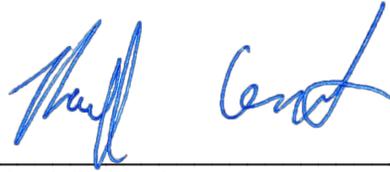
This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 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 22 day of September, 2016,
in Tallahassee, Florida.

FINAL ORDER (Cont.)

16F-05063

PAGE - 6



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

Sep 30, 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-05090
APPEAL NO. 16F-05697

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 66397

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened two administrative hearings by phone in the above-referenced matter on July 29, 2016 at 2:33 pm.; and on August 25, 2016 at 1:09 p.m. One continuance granted for the petitioner.

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Sylma Dekony, Economic Self Sufficiency Specialist II
Stan Jones, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue are whether the respondent's actions to approve the petitioner's Food Assistance benefits at \$16.00 per month effective July 2016 and ongoing; and to enroll the petitioner's husband in the Medically Needy (MN) program effective June 2016 and ongoing are correct. The petitioner carries the burden of proof by a preponderance of the evidence for both issues.

PRELIMINARY STATEMENT

At both hearings, Anne Smith (hereafter “petitioner”) was present, but did not testified. Petitioner was represented by her husband, Michael Smith, who testified. At the July 29, 2016 hearing, the petitioner submitted one exhibit, which was accepted into evidence and marked as Petitioner’s Exhibit “1”. At the July 29, 2016 hearing, the respondent was represented by Sylma Dekony with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). At the August 25, 2016 hearing, the respondent was represented by Stan Jones with DCF. At the August 25, 2016 hearing, the respondent submitted thirteen exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” through “13”.

Subsequent to the hearing, the undersigned discovered two exhibits marked as Respondent’s Exhibit “6”. The undersigned consolidated both exhibits into one Respondent’s Exhibit “6”. The undersigned also discovered two exhibits marked as Respondent’s Exhibit “8”. The undersigned remarked the second Respondent’s Exhibit “8” as Respondent’s Exhibit “9”; remarked Respondent’s Exhibit “9” to Respondent’s Exhibit “10”; remarked Respondent’s Exhibit “10” to Respondent’s Exhibit “11”; remarked Respondent’s Exhibit “11” to Respondent’s Exhibit “12”; and remarked Respondent’s Exhibit “12” to Respondent Exhibit’s “13”.

FINDINGS OF FACT

1. On June 29, 2016, the petitioner completed an application for Food Assistance (FA) and SSI-Related Medicaid benefits. The application listed the petitioner and her husband as the only household members; the petitioner’s Social Security Disability Insurance (SSDI) income as \$725 per month; her husband’s SSDI income as \$1,525

per month; their rental expense as \$285 per month; their electric expense as \$230 per month; and her husband's medical expenses as \$250 per month.

2. On July 7, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's FA benefits would remain the same.

3. On July 11, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's FA benefits would remain the same. The notice also indicated the petitioner's Medically Needy (MN) Medicaid application dated June 29, 2016 was approved and the petitioner and her husband's monthly share of cost (SOC) amount was \$2,100 effective June 2016 and ongoing.

4. Petitioner's SSDI amount is \$724.90 (gross) per month and she has Medicare Part A and B. She pays her monthly Medicare Part B premium of \$54.90. Petitioner's husband's SSDI amount is \$1,747.90 (gross) per month and he has Medicare Part A and B. He pays his monthly Medicare Part B premium of \$54.90.

5. Respondent determined the petitioner does not pay yearly property taxes as the Polk County Tax Collector's website (Respondent's exhibit 5) indicated the petitioner's yearly property tax and assessment as \$0.

6. Respondent initially calculated the petitioner's monthly medical expenses as \$359.80; however, prior to the hearing, the respondent recalculated the petitioner's monthly medical expenses as \$544.80.

7. Respondent initially calculated the petitioner's monthly FA benefits as \$16; however, the respondent did not submit into evidence the petitioner's initial FA budget.

8. Prior to the hearing, the respondent calculated the petitioner's FA budget for June 2016 and ongoing as follows:

Expenses/Income	Dollar Amount
Unearned Income	\$2318.00
Total household income	\$2318.00
<u>Standard deduction for a household of</u>	<u>-\$ 155.00</u>
<u>Excess Medical Expenses</u>	<u>\$ 509.80</u>
Adjusted income after deductions	\$1653.20
Total Medical Costs	\$ 544.80
<u>Medical Deduction</u>	<u>-\$ 35.00</u>
Excess Medical Expenses	\$ 509.80
Rent/shelter	\$ 285.00
<u>Standard utility allowance</u>	<u>+\$ 345.00</u>
Total rent/utility costs	\$ 630.00
<u>Shelter standard (50% adjusted income)</u>	<u>-\$ 826.60</u>
Excess shelter deduction	\$ 0.00
Adjusted income	\$1653.20
<u>Excess Shelter Deduction</u>	<u>-\$ 0.00</u>
Adjusted income after shelter deduction	\$1653.20

9. Respondent took 30% of \$1653.20 to calculate the benefit reduction of \$496, which exceeds \$357 or the maximum FA benefit amount for a household of two. Petitioner was eligible for the minimum monthly FA benefit amount of \$16 as she lived in a two-member household where both members were disabled.
10. Petitioner reported at the hearing she pays tangible taxes of \$500 to \$600 per year. She also reported she does not pay any property taxes.
11. Petitioner did not agree with the respondent's determination that her FA benefit amount should be \$16 per month because her husband requires a special diet that is more expensive than a regular diet.
12. Respondent calculated the petitioner and her husband's MN SOC amount as \$2,100 effective June 2016 and ongoing as follows:

\$2471.00	petitioner and her husband's SSDI income
<u>-\$ 20.00</u>	<u>unearned income disregard</u>
\$2451.00	total countable income
<u>-\$ 241.00</u>	<u>MNIL for a household of one</u>
<u>-\$ 109.80</u>	<u>Medical Insurance Expenses</u>
\$2100.00	share of cost

13. Petitioner did not agree with the respondent's determination that her husband was not eligible for full SSI-Related Medicaid benefits as he has medical conditions that require multiple medications, physician visits, specialist visits; and various tests. Petitioner explained they cannot afford to pay for all of his medical expenses and they require Medicaid to pay for them.

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 Florida Administrative Code R. 65-2.056.

As to the monthly FA benefit amount for June 2016 and ongoing

16. The Code of Federal Regulations 7 C.F.R. § 273.9 defines income and deductions and states, in part:

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; strike benefits; foster care payments for children or adults who are considered members of the household...

(d) Income deductions. Deductions shall be allowed only for the following household expenses...

(1) Standard deduction—(i) 48 States, District of Columbia, Alaska, Hawaii, and the Virgin Islands. Effective October 1, 2002, in the 48 States and the District of Columbia, Alaska, Hawaii, and the Virgin Islands, the standard deduction for household sizes one through six shall be equal to 8.31 percent of the monthly net income eligibility standard for each household size established under paragraph (a)(2) of this section rounded up to the nearest whole dollar...

(3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in § 271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction. Allowable medical costs are:

(i) Medical and dental care including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by State law or other qualified health professional. . .

(iii) Prescription drugs, when prescribed by a licensed practitioner authorized under State law, and other over-the-counter medication (including insulin), when approved by a licensed practitioner or other qualified health professional.

(A) Medical supplies and equipment. Costs of medical supplies, sick-room equipment (including rental) or other prescribed equipment are deductible;

(iv) Health and hospitalization insurance policy premiums. The costs of health and accident policies such as those payable in lump sum settlements for death or dismemberment or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled are not deductible;

(v) Medicare premiums related to coverage under Title XVIII of the Social Security Act...

(6) Shelter costs...

(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.

(A) Continuing charges for the shelter occupied by the household, including rent, mortgage, condo and association fees, or other continuing charges leading to the ownership of the shelter such as loan repayments for the purchase of a mobile home, including interest on such payments.

(B) Property taxes, State and local assessments, and insurance on the structure itself, but not separate costs for insuring furniture or personal belongings. . .

(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)...

17. Pursuant to the above authority, the petitioner and her husband's monthly SSDI income must be included in the determination of her household's monthly FA benefit amount. Furthermore, shelter costs, utilities, excess medical expenses, and a standard deduction must also be included in the determination of her household's monthly FA benefit amount.

18. Petitioner does not pay yearly property taxes; however, the petitioner pays yearly tangible taxes of \$500 to \$600. Although the petitioner reported she pays yearly tangible taxes, the undersigned cannot find any rule, law, or policy to include tangible taxes in her FA budget.

19. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-1 sets forth the following Eligibility Standards for Food Assistance benefits effective June 2016 through September 2016:

(1) \$357 maximum FA benefit for a household size of two; (2) \$345.00 standard utility allowance; (3) \$155.00 standard deduction for a household size of two; (4) uncapped shelter deduction for AGs with elderly or disabled members; and (5) \$16 per month for the minimum allotment for one or two member household.

20. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-1 sets forth the following Eligibility Standards for Food Assistance benefits effective October 2016:

(1) \$357 maximum FA benefit for a household size of two; (2) \$338.00 standard utility allowance; (3) \$157.00 standard deduction for a household size of two; (4) uncapped shelter deduction for AGs with elderly or disabled members and (5) \$16 as the minimum allotment for a one or two member household.

21. The Department's Policy transmittal numbered C-13-10-0007, Food Assistance Minimum Benefit dated October 11, 2013 shows in pertinent part that:

...all one and two member assistance groups (AGs) are eligible for the minimum monthly food assistance benefit allotment, which is 8% of the maximum allotment for a one person household....The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and....the AG has income less than or equal to the 200% gross income limit or the AG contains an elderly or disabled member and does not pass the 200% gross income test but does have income less than or equal to the 100% of the net income limit...

22. The Policy Manual, CFOP 165-22, passage 2610.0106.02, Minimum Benefits (FS) states in part, "Recurring months: Issue a minimum of eight percent of the maximum benefit for a one-person assistance group to one or two person assistance groups who meet the net income test or are categorically eligible".

23. Pursuant to the above transmittal and policy, a two-person household, which passes the gross income test or has an elderly or disabled member with income below the net income limit, is entitled to receive a minimum FA benefit amount that equals to

eight percent of the maximum amount for a one-person household. Petitioner's FA group is a two-person household with a disabled member that passes the net income test; therefore, the petitioner and her husband are eligible to receive the \$16 monthly minimum FA benefit amount.

24. Pursuant to the various aforementioned authorities, the respondent correctly calculated the petitioner's monthly FA benefit amount for June 2016 and ongoing by including all the required income, expenses, and deductions allowed in the determination of FA benefits.

25. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met her burden of proof in establishing the respondent incorrectly calculated her monthly Food Assistance benefits for June 2016 and ongoing.

As to the petitioner's husband's eligibility for full SSI-Related Medicaid benefits

26. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, defines the criteria to receive SSI-Related Medicaid benefits and states, in part:

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

(1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

27. Pursuant to the above authority, the petitioner's husband is eligible for the SSI-Related Medicaid programs as he is considered disabled.

28. Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, defines the types of included and excluded income and states, in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan...

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

(e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional programs...

29. Pursuant the above authority, the petitioner and her husband's SSDI income are considered included income in the determination of her husband's SSI-Related Medicaid Benefits.

30. Fla. Admin. Code R. 65A-1.701(20) states:

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.

31. Pursuant to the above authority, the petitioner's husband is not eligible for full SSI-Related Medicaid benefits as he receives Medicare Part A and B, but does not

receive at the same time, Institutional Care Services, hospice services, or home and community based services. Respondent correctly denied the petitioner's husband's full SSI-Related Medicaid benefits and instead enrolled him in the SSI-Related MN Medicaid with a monthly SOC.

32. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met her burden of proof in establishing the respondent incorrectly enrolled her husband in the SSI-Related Medically Needy Program with a monthly share of cost instead of approving him for full SSI-Related Medicaid benefits effective June 1, 2016 and ongoing.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's Food Assistance and SSI-Related Medicaid 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 30 day of September, 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@myffamilies.com

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

FILED

Sep 12, 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]
[REDACTED]

APPEAL NO. 16F-05091

PETITIONER,

Vs.

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

And

UNITED HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 8, 2016 at 1:30 p.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 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. Brittany Vo, Dental Consultant, and Susan Frishman, Senior Compliance Analyst, from United Healthcare, which is the petitioner's managed health care plan. United Healthcare was included as an additional respondent pursuant to its request to be added as a party.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent composite Exhibit 1: Statement of Matters, Denial Notices, and Grievance System Information.

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 United Healthcare.
2. On or about June 10, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from United to perform extractions of four wisdom teeth, along with bone adjustment (alveoplasty) and medication related to those extractions. United Healthcare partially denied this request on June 16, 2016 – approving the four extractions but denying the request for alveoplasty and medication.
3. The denial notice stated the alveoplasty and medication requests were denied as not being covered benefits under the health plan. However, the respondent's position at the hearing was that these services were not medically necessary.

4. The petitioner's mother stated her daughter needs the alveoplasty along with the extractions because of the position of the wisdom teeth. She also stated her daughter needs the medication to prevent infection because she suffers from an auto-immune disorder called [REDACTED]

5. The respondent's expert witness, Dr. Vo, stated that the alveoplasty and medication were denied because they were deemed to be not medically necessary based on the information submitted by the provider. She stated alveoplasty is usually needed for prosthetic devices (such as dentures), not for tooth extractions. She also stated the provider needs to submit more information concerning what medication will be utilized and why it is needed.

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"), effective November 2011.

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. Section 120.80.

8. This is a final order pursuant to Fla. Stat. Sections 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. 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. United Healthcare approved the request for tooth extractions, but initially denied the requests for alveoplasty and medication as not being covered services. However, the petitioner is under age 21, and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions of the Medicaid Program are applicable. Those provisions state that the Medicaid program must provide all medically necessary services to individuals under age 21 regardless of whether they are covered services or not. Therefore, the focus at the hearing was whether the denied services are medically necessary.

14. The petitioner's mother believes the alveoplasty should be approved because of the position of the wisdom teeth, and the medication should be approved to prevent infections.

15. The respondent's witness stated that the denial of the alveoplasty was appropriate since that procedure is usually needed for a prosthesis, not for tooth extractions. Regarding the medication, the respondent's position is that the provider must submit further information or explanation describing what medication is to be used and why it is necessary.

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 requests for the alveoplasty and medication 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 these services, this does not establish it is medically necessary. The respondent's witness testimony supports the denial of the requested services.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 12 day of September, 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]

AHCA, MEDICAID FAIR HEARINGS UNIT
UNITED HEALTH CARE HEARINGS UNIT

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

FILED

Oct 25, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05119

PETITIONER,

Vs.

CASE [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88701

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 20, 2016 at 3:29 p.m., in [REDACTED].

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Mary Triplett, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his May 25, 2016 application for disability-related Medicaid. The burden of proof is assigned to the petitioner. The standard of proof at a fair hearing is a preponderance of the evidence.

PRELIMINARY STATEMENT

The respondent submitted documents which were entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner provided a letter from his doctor which was entered into evidence and marked as Petitioner's Exhibit 1. The

record was held open until September 30, 2016, for the petitioner to provide the letter from the Social Security Administration (SSA) showing what medical conditions were reviewed. On September 23, 2016, the petitioner provided medical documents but did not provide the letter from SSA. The medical documents were entered into evidence and marked as Petitioner's Composite Exhibit 2. The record was closed on September 30, 2016.

FINDINGS OF FACT

1. The petitioner (age 54) applied for Medicaid on May 25, 2016.
2. 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 the above-mentioned application, the petitioner reported that he was disabled; therefore, a disability eligibility was initiated.
4. On June 16, 2016, the respondent forwarded the petitioner's disability package to the Division of Disability Determination (DDD) for review and eligibility determination.
5. On June 22, 2016, the DDD reported its decision to the respondent. The DDD responded, via a Disability Determination Transmittal. Written in the remarks section of the transmittal, "Hankerson, July 2015, same allegations, hearing pending." The denial code was N30 which signifies, "Non-pay-slight impairment-medical consideration alone, no visual impairment."
6. On June 23, 2016, the respondent denied the petitioner's application.
7. On June 24, 2016, the respondent issued a Notice of Case Action informing the petitioner that his Medicaid application dated May 25, 2016 was denied. The reason

cited for the denial was, "You or a member of your household do not meet the disability requirement. No household members are eligible for this program."

8. On July 1, 2016, the petitioner requested a hearing to challenge the respondent's decision.

9. The petitioner had applied for disability-related Medicaid through SSA. That application was denied in July 2015 and is currently under appeal.

10. The petitioner confirmed that he has no new medical conditions nor has his medical condition worsened or changed since the SSA denial. He still suffers from [REDACTED], [REDACTED] and [REDACTED]. Many days he cannot function or leave his house.

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

13. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations of disability states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.(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 Sec. 435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically

confers Medicaid eligibility, as provided for under Sec. 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....

14. According to the regulations above, the Department is bound by the SSA decision unless there is evidence of a new disabling condition not reviewed by SSA.

The petitioner stated that he has no new or disabling conditions.

15. The above authorities explain that if SSA has denied disability within the past year, or if the denial is under appeal, the SSA decision is to be adopted.

The findings show that on July 2015, SSA denied the petitioner's Medicaid application. The findings show that the petitioner filed an appeal to challenge SSA's action and that appeal is still pending.

16. 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.

DONE and ORDERED this 25 day of October, 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]
Office of Economic Self Sufficiency

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

FILED

Sep 29, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05179

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 23, 2016 at 11:30 a.m. in Doral, Florida.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Linda Latson, Registered Nurse Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny Prescribed Pediatric Extended Care (PPEC) service hours that were requested for the petitioner for the certification period July 8, 2016 through January 2, 2017, 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 witnesses for the petitioner were [REDACTED]

[REDACTED]s, which is the petitioner's PPEC facility.

Appearing telephonically as a witness for the respondent was Rakesh Mittal, M.D., Physician-Consultant with eQHealth Solutions, Inc. The respondent submitted the following documents into evidence, which were marked as Respondent composite Exhibit 1: Statement of Matters, Outpatient Review History, Denial Notices, and Supporting Documentation.

FINDINGS OF FACT

1. The petitioner's PPEC service provider, CSI Pediatric Services (hereafter referred to as "the provider"), requested the following PPEC service hours for the certification period at issue: full day and partial day services (up to twelve hours daily), Monday to Friday.
2. eQHealth Solutions, Inc. is the Quality Improvement Organization (QIO) contracted by the respondent to perform prior authorization reviews for PPEC services. The petitioner's provider submitted the service request through eQHealth's internet based system. The submission included, in part, information about the petitioner's medical conditions; her functional limitations; and other pertinent information related to the household.

3. eQHealth Solutions' personnel conducted face-to-face visits with the petitioner and also had telephone conversations with her caregivers. The provider also sent information directly to eQ Health.

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

- 3 years old
- Currently resides with foster parents
- Diagnosis includes [REDACTED]

5. The petitioner was previously in state custody and is now residing with foster parents. She was approved for PPEC services beginning in April, 2016 for approximately a three-month period to determine her need for medical foster care.

6. A Plan of Care was submitted by the provider. This document was signed by a physician and outlined the type of assistance to be provided by the PPEC facility. The duties include, in part:

- Daily head-to-toe assessment
- Maintain daily hygiene requirements
- Follow-up of developmental therapies
- Medication administration
- Monitor for respiratory distress and administer treatments
- Monitor caregiver compliance with child care needs
- Assess daily nutrition and hydration status
- Instruct family on signs/symptoms of diaper rash; also on fall prevention and caloric intake
- Coordinate physician visits

7. A physician at eQHealth Solutions, who is board certified in pediatrics, reviewed the submitted information and denied the request for PPEC services after the initial

approval period. A notice of this determination was sent to all parties on July 6, 2016.

The physician-reviewer wrote, in part:

[REDACTED]

8. The above notice stated should the parent, provider, or the petitioner's physician disagree with the decision, a reconsideration review could be requested. Additional information could be provided with the request. A reconsideration review was not requested in this case.

9. Although the initial approval of PPEC services was only for approximately a three month period (until July 7, 2016), the respondent has administratively approved the requested services pending the outcome of the hearing process. Therefore, the petitioner is still currently attending the PPEC facility.

10. The petitioner's foster mother stated the petitioner has improved while at the PPEC facility. She believes the petitioner will not receive the same quality of service at a regular daycare. The petitioner attends the PPEC from 6:00 a.m. to 4:30 p.m. and also receives speech, occupational, and physical therapy at the PPEC.

11. The PPEC witness, Ms. Montoto, stated the petitioner was referred to the PPEC by the Department of Children and Families due to her medical complexity. The petitioner has a history of extreme malnutrition and multiple healing fractures. She also

had seizures due to tonsillitis and she receives oxygen therapy at the PPEC. The PPEC needs to monitor her nutrition status and swallowing ability. Ms. Montoto stated the petitioner's condition has not changed since the initial approval of services.

12. The respondent's witness, Dr. Mittal, testified that the petitioner does not meet the requirements for PPEC services since she does not require skilled nursing interventions. She does not have a gastrostomy tube (G-tube) or a breathing tube. She is only given oxygen on an as-needed basis. He also stated febrile seizures are not considered a seizure disorder and they do not require any medication. He also noted the petitioner has gained 5 pounds since she started at the PPEC and she consumes a high calorie diet by mouth. He also noted she is not on a complex medication regimen, receiving 2 medications twice daily and Tylenol as needed. He also stated that the therapies (speech, occupational, physical) can be given at any location.

13. PPEC service for children is a covered service under the Medicaid State Plan in Florida. These services are provided in accordance with the respondent's Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook ("PPEC Handbook"), effective September, 2013.

CONCLUSIONS OF LAW

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 petitioner since this was an initial request for 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.).

18. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent. The PPEC Handbook described above is incorporated by reference in Fla. Admin. Code R. 59G-4.260.

19. The petitioner has requested PPEC services. As the petitioner is under twenty-one (21) years of age, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements apply to the evaluation of the petitioner’s eligibility for or amount of this service.

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 (PPEC services) is one of the services provided by the State to treat or ameliorate an individual's conditions under the State plan. Chapter 409.905, Florida Statutes, states, in part:

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

(4) (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services ... The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for any other family dependents.

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...

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

...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. 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 PPEC services.

26. In the petitioner's case, the respondent has determined that PPEC services are not medically necessary at this time.

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. The purpose of PPEC services is described on page 1-1 of the PPEC Handbook as follows:

The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) services is to enable recipients under the age of 21 years with medically-complex conditions to receive medical and therapeutic care at a non-residential pediatric center.

30. The PPEC Handbook on page 2-1 sets forth the requirements for PPEC services, as follows:

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

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

31. Rule 59G-1.010, F.A.C., defines the terms “medically complex” and “medically fragile” as follows:

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

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

32. 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.

33. The respondent’s witness stated that the petitioner did not meet the requirements for PPEC services since she did not required skilled nursing interventions.

34. The petitioner’s witnesses stated she should be approved for PPEC services due to her medical conditions, such as [REDACTED]

35. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not demonstrated that PPEC services should have been approved by the respondent. Although the petitioner suffers from various ailments, her medical condition does not meet the definition of “medically complex” or “medically fragile” as outlined above in the applicable regulations. She is not on a ventilator or dependent on any other medical apparatus and does not require 24-hour per day nursing or medical supervision/intervention. In addition, she has gained weight since being placed in foster care and she seems to be improving, Her various therapies can be administered at any location and she is not required to be in a PPEC facility to receive those therapies.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

FILED

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

Sep 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05197

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 9, 2016 at 10:00 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

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 July 1, 2016 through December 27, 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 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.

Also present for the hearing was a Spanish language interpreter, [REDACTED]

FINDINGS OF FACT

1. The petitioner's home health agency, Better Support and Service (hereafter referred to as "Provider"), requested the following PCS hours for the certification period at issue: 6 hours daily, Monday to Friday, and 8 hours daily on Saturday and Sunday.
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 mother on May 12, 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, grandmother, and 2 siblings
- Diagnosis includes [REDACTED]
- Legally blind and hearing-impaired
- Incontinent
- Non-verbal

5. The petitioner's mother is self-employed as a house cleaner and she works from 3:00 p.m. to 11:00 p.m. Monday to Friday, from 9:00 a.m. to 3:00 p.m. on Saturday, and from 8:00 a.m. to 12:00 p.m. on Sunday.

6. The petitioner attends school from 8:00 a.m. to 2:00 p.m., Monday to Friday.

7. The petitioner is currently approved for 4 hours of PCS daily from Monday to Friday and 2 hours daily on the weekends. Those hours are utilized for 2 hours in the morning and 2 hours in the afternoon on the weekdays, and from 10:30 a.m. to 12:30 p.m. on the weekends.

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. This physician-reviewer wrote, in part: *"The grandmother is home to provide supervision and*

assistance with care of the 2 siblings and the mother is available to provide ADL care in the evenings on the weekends. Would only approve HHA 4 hrs/d M-F and 2 hrs/d Sa/Su.” A notice of this determination was sent to all parties on June 25, 2016.

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 not requested in this case.

11. The petitioner’s mother stated her son needs the additional hours of service because he requires constant supervision due to behavioral problems. He has engaged in self-injurious behavior such as hitting himself.

12. The respondent’s witness, Dr. Mittal, stated that supervision is not a covered service. However, he also stated it would be appropriate to approve 2 additional hours of personal care services on Saturday and Sunday since the mother must also care for the two siblings.

13. 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

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

16. This is a final order pursuant to Fla. Stat. § 120.569 and § 120.57.
17. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
18. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner since the petitioner 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.).
19. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Medicaid Program is administered by the respondent.
20. 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.
21. The Centers for Medicare and Medicaid Services, State Medicaid Manual makes available to all State Medicaid agencies informational and procedural material needed by the States to administer the Medicaid program. It is the method by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.
22. The State Medicaid Manual in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services section states in part:

5010. Overview

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

5110. Basic Requirements

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

23. The service the petitioner has requested (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.

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

24. The issue to be decided is the medical necessity of the service or amount of service. The State Medicaid Manual provides for limitations on services as follows:

5110. Basic Requirements...

...Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

5122. EPSDT Service Requirements

F. Limitation of Services.--The services available in subsection E are not limited to those included in your State plan.

Under subsection E, the services must be "necessary . . . to correct or ameliorate defects and physical or mental illnesses or conditions . . ." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental.

5124. Diagnosis and Treatment

B. Treatment.--

1. General. - You must make available health care, treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services. Treatment services may be limited as described in §5122 F.

25. Once a service has been identified as requested under EPSDT, the Medicaid program determines the amount or necessity for that service based on the State of Florida's published definition of medical necessity. 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.

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

27. 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 6 hours daily, Monday to Friday, and 8 hours daily on the weekends as requested by the petitioner's provider.

28. 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.

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

30. The 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.

31. 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.

32. 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.

33. 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

34. 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.

35. The respondent's witness, Dr. Mittal, stated the additional requested hours appear to be for supervision, which is not a covered service. He also stated it would be

appropriate to approve 2 additional hours on the weekends since there are two other siblings in the household.

36. The petitioner's mother stated her son needs constant supervision due to his behavioral problems.

37. 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.

38. The undersigned concludes that the petitioner has not demonstrated that the respondent was incorrect in partially denying the requested personal care services. However, the testimony at the hearing establishes that it would be appropriate for the petitioner to receive 2 additional hours of service on Saturday and Sunday.

DECISION

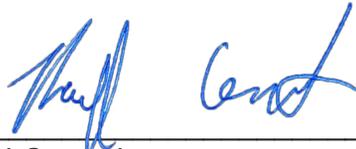
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED, in part, and the petitioner shall receive 4 hours daily of personal care services, 7 days per week.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 27 day of September, 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:

██
AHCA, MEDICAID FAIR HEARINGS UNIT
AHCA HEARINGS UNIT

FILED

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

Sep 27, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05201

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT:

RESPONDENT.
_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 9, 2016 at 1:12 p.m.

APPEARANCES

For the Petitioner: [REDACTED] r

For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to continue to receive Prescribed Pediatric Extended Care (PPEC) services through Medicaid. 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 perform prior services authorizations for certain Medicaid services, including PPEC services.

By notice dated July 6, 2016, eQ informed the petitioner that her request for continued PPEC services for the certification period July 16, 2016 – January 11, 2017 was denied. The notice reads in part: “the services are not medically necessary.”

The petitioner timely requested a hearing to challenge the denial decision on July 8, 2016. The petitioner’s PPEC services have been continued pending the outcome of the hearing.

Present as a witness for the petitioner: [REDACTED]

[REDACTED] The petitioner did not submit documentary evidence.

Present as a witness for the respondent from eQ: Dr. Darlene Calhoun, physician reviewer. The respondent submitted documentary evidence which was admitted into the record as Respondent’s Composite Exhibit 1. The record was closed on September 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 2) is a Florida Medicaid recipient.

2. The petitioner's diagnoses includes [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

3. In early 2014, the petitioner was approved for seven hours (9am to 4pm) of PPEC services (specialized medical daycare for children with complex medical needs) daily, Monday – Friday for six months, due to serious coexisting medical issues, including the fact that she wore a full body brace.

4. Continued eligibility for PPEC service must be reviewed every six months. The petitioner was recertified for PPEC services at each review over the last two years.

5. In June 2016, the petitioner's treating physician submitted a request for continued PPEC services to eQ (AHCA's contracted review agent) for another six month certification.

6. All Medicaid services must be medically necessary as determined through a prior service authorization process. eQ reviews the authorization request form and all supporting documentation during the review process. eQ has no direct contact with the child or child's family.

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

8. The Plan of Care describes the petitioner as a child with: numerous coexisting medical conditions; ambulatory, but fall risk; requires monitoring and supervision, multiple therapies, and administration of medication as needed.

9. The clinical notes from the petitioner's PPEC record monitoring of low calcium diet, monitoring for constipation, physical therapy, speech therapy, occupational therapy, and administration of medication as needed. The PPEC notes reflect that the petitioner is scheduled to start transitioning to elementary school on or about September 20, 2016.

10. The petitioner lives in the family home with her mother. The mother has no known medical issues. The mother is the only source of natural support. The mother is employed outside of the home and attends school.

11. eQ concluded that the petitioner's medical condition has stabilized since birth (she is no longer in a full body brace, she only wears ankle braces and ambulates independently now). She has medical needs, but no longer requires continuous skilled nursing care. The clinical rationale section of eQ's evaluation explains the denial decision:

[REDACTED]

12. Dr. Darlene Calhoun, physician reviewer with eQ, appeared as a respondent witness during the hearing. Dr. Calhoun opined that the petitioner's needs can be met

by a capable and responsible adult. Dr. Calhoun concluded that the petitioner's care needs do not require the services of skilled nurse staff because she does not suffer from seizures nor does she require mechanical devices (G-tube for feedings, ventilator, or IV for medications) to maintain life. Dr. Calhoun opined that it is not medically necessary that the petitioner continue to receive PPEC services.

13. The petitioner's mother and PPEC provider asserted that her needs cannot be met at a standard daycare center for the following reasons: she is on a special "no calcium, no dairy" diet; she requires close monitoring for chronic, severe constipation; she has therapy at the PPEC four times weekly; she has a history of kidney stones which must be closely monitored.

14. In rebuttal, Dr. Calhoun explained that a responsible adult can address the services needs described by the petitioner and her PPEC provider. Regarding the therapies the petitioner receives at PPEC, Dr. Calhoun explained that these services can be received on an outpatient basis.

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

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

19. 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.).

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

21. 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.

22. 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.

23. 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.

24. 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.”

25. 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.

26. 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.

27. The respondent, through its agent eQ, denied the petitioner’s request for ongoing PPEC services. The respondent determined that the services were not medically necessary because the petitioner did not meet the eligibility requirements.

28. The petitioner’s medical condition was not stable at birth. Skilled nursing care was required at that time. The evidence proves that the petitioner’s medical condition has improved significantly. She is no longer in a full body brace and no longer has serious ongoing issues with kidney stones. The petitioner has multiple coexisting conditions that require monitoring and supervision; however, the evidence does not prove that she requires continuous therapeutic interventions or skilled nursing care. The petitioner does not require G-tube feedings; she is not ventilator dependent nor does she require a medical apparatus to maintain life.

29. The petitioner's mother argued that her needs cannot be met at a standard daycare and the respondent did not make the argument that a standard daycare was appropriate for the petitioner. The respondent argued that her care needs can be met by a capable and responsible adult, i.e., an in-home caregiver/baby sitter. The undersigned concurs with the respondent's conclusion.

30. 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 27 day of September, 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]
AHCA, Medicaid Fair Hearings Unit

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

FILED

Oct 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05208

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88369

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on September 15, 2016 at 2:50 p.m.

APPEARANCES

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

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

ISSUE

Petitioner is appealing the Department's action of June 17, 2016 to deny her application for SSI-Related Medicaid on its contention that she did not complete the disability interview.

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

PRELIMINARY STATEMENT

The hearing originally convened on August 23, 2016 at 11:41 p.m. However, the hearing exceeded the allotted time and required rescheduling. The hearing was scheduled to reconvene on September 15, 2016 at 2:45 p.m.

The hearing convened as scheduled. Evidence was submitted and entered as the Petitioner's Exhibit 1 through 2 and the Respondent's Exhibits 1 through 3.

The record was held open until 5:00 p.m. on September 20, 2016 to allow the petitioner to submit additional evidence. Evidence was submitted on September 18, 2016, September 20, 2016, September 21, 2016, and September 23, 2016, and admitted as the Petitioner's Exhibits 3 through 6.

The record was closed at 5:00 p.m. on September 23, 2016.

FINDINGS OF FACT

1. On May 17, 2016, the petitioner (age 40), completed a web-based application for SSI-Related Medicaid for herself.

2. On May 20, 2016, the Department mailed to the petitioner the Notice of Case Action with the following: "You will receive a call at phone number on application for a Medicaid Disability interview scheduled for 6/2/16 between the hours of 8AM AND 11AM Have your medical information (Doctors/Hospital (names/address/phone number's) along with your current medical conditions available for the interview..."

3. On June 2, 2016, the DCF caseworker realized there was not a number listed on her application and was unable to complete the interview. On June 17, 2016, the

Department denied the petitioner's application as the disability interview was not completed.

4. The petitioner does not agree with the Department's denial and argues that she did not receive the Notice of Case Action to inform her of the request for a disability interview. The petitioner reports that she has had issues with her mailbox being broken into and has a letter from management that there were reports of mail theft. The petitioner contends that her landlord has given her a new lock and key for her mailbox. The petitioner reports that she has had her mail delivered to her neighbors by mistake. The petitioner contends that she brought this issue to the attention of her postmaster. The Petitioner's Exhibit 5 includes an email from the petitioner. The email is dated September 21, 2016 and includes an attached note from the alleged postmaster, GT, and states, "(YKR) told me months back that she went to the post office to let them know her mail was put in the wrong box. They said they would let her carrier know."

5. The petitioner has received her high school diploma. The petitioner is currently unemployed. The petitioner recalls that she began working as a bagger at the age of 16 at the commissary on a military base; she worked here for four years. The petitioner began working for [REDACTED] as a commissioned salesperson in 1994 and stayed with the company until approximately 1995. The petitioner worked for fast food restaurants, including [REDACTED], around 2002 through 2003. The petitioner believes she last worked part-time in 2014 for a sales company, which required her to sell merchandise inside of a local [REDACTED] store. The Department pointed out that its records show that an earning statement from [REDACTED]

dated January 10, 2016 was submitted by the petitioner in February 2016. The petitioner explained that she worked for [REDACTED], which had a booth set up inside of the Walmart store.

6. The petitioner contends that she began having medical issues when she was injured in 1996 while riding a bicycle; she was struck by a car. The petitioner contends that she was physically assaulted in 2002. The petitioner asserts that she was involved in a car accident after 2002 when she hurt her neck. The petitioner contends that she was injured further, after 2002 but before 2010, when a typewriter was thrown at her back. The petitioner recalls that she fell on a sidewalk in 2010 or 2011. The petitioner explained that her disability is not visible to the eye.

7. The petitioner lists her medical conditions as [REDACTED]. The petitioner believes her conditions are permanent. The petitioner has a metal brace in her shoulders. The petitioner explained that the brace has wires that have broken through the skin and have caused nerve damage. The Petitioner's Exhibit 1 includes x-rays taken on January 21, 2014 of the petitioner's shoulder that shows the injury to her shoulder. The petitioner's evidence does not include any documentation to show the duration of her medical conditions or if any subsequent surgeries or other procedures are scheduled to treat her conditions. The petitioner contends that she had a bone removed from her hip to repair her shoulder. The petitioner explained that the removal of the hipbone causes her to walk with a limp. The petitioner contends that the hipbone was subsequently removed from her shoulder, which caused a broken collar bone. The

petitioner argues that she wakes up in pain in the middle of the night due to the shoulder injury.

8. The petitioner also complains of dizziness upon standing up and that she tends to collapse. The petitioner complains of a stabbing pain that interferes with her concentration. The petitioner asserts that she used to have a service dog who became ill and died. The petitioner contends that she is depressed due to the death of her service dog and needs counseling. The petitioner argues that she lives alone and has no one to assist her. The petitioner contends that she has traveled to Georgia to receive the medical attention she needs but has not applied for Medicaid in Georgia. The petitioner explained that she does not intend to remain in Georgia because she does not have a place to stay and that the waiting list for housing is a few years' long.

9. The petitioner complains of not being able to bend to the left but can bend a little to the right. The petitioner asserts that she cannot sleep with her arms raised above her head. The petitioner asserts that she cannot sit for a long period of time. The petitioner contends that she cannot push items and cannot open a car door. The petitioner reports she wears glasses but has no other issues with her vision. The petitioner reports she has issues with her hearing.

10. The petitioner contends that she received disability payments from 2011 until 2014. The petitioner believes she received Medicaid until 2014. The petitioner believes she appealed the SSI denial on March 12, 2015. The petitioner contends that her appeal is currently pending. The petitioner contends that she had a hearing scheduled in 2014 or 2015 but collapsed on the bus on the way to the hearing and was unable to

make it on time. The petitioner believes she was denied disability, not because she is not disabled, but because she did not attend the hearing with SSA. The petitioner believes the Social Security Administration (SSA) reviewed her medical conditions of shoulder and nerve damages. The petitioner believes her medical conditions have worsened.

11. The Department's records do not show any returned mail that was sent to the petitioner.

12. The Department contends that it attempted to contact the petitioner on June 2, 2016 to conduct the disability interview when it realized the petitioner did not list a phone number on her application. On June 21, 2016, the Department was able to locate a telephone number from the financial disclosure dated May 31, 2016 (*Respondent's Exhibit 2, page 14*). The telephone number was located after the Department's denial dated June 17, 2016. The Department contends that an attempt to conduct the disability interview with the petitioner was made on June 21, 2016. The Department contends that the petitioner would not answer the questions in order to gather the information that was needed to submit her application to the Division for Disability Determination (DDD).

13. The Department's records show that the petitioner was called on June 21, 2016 to conduct the disability interview but was unable to make a determination because the petitioner did not answer the questions necessary to forward her application to the DDD.

14. The Department explained that its records show that the petitioner was receiving SSI until January 2014. The Department's records show that the denial code is listed as "T31", which was defined by the SSA online query system as "Terminated. System-generated termination. Payment previously made or refund on record." The Department's records show the petitioner's SSA appeal date was on June 3, 2014 and is currently in the appeals process.

15. The Department explained that a disability packet can be sent to DDD during the appeal process but it could not send the petitioner's disability packet to DDD because the interview was not completed.

16. The petitioner argues that she was ill on the day she was called for the disability interview. The petitioner argues that she did not know who called her to conduct the interview. The petitioner contends that the interviewer was angry and rude to her. The petitioner contends that the interviewer asked her if she spoke English. The petitioner argues that she was denied a translator when she requested for one. The petitioner contends that the interviewer told her "no" and hung up on her when she requested a hearing.

CONCLUSIONS OF LAW

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

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

R. 65-2.056.

19. 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 which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.)

20. Federal regulations at 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.

21. 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. The findings show that the petitioner's disability was terminated with a termination code of "T31". The findings also show that the petitioner filed an appeal on June 3, 2014 and is currently pending. The petitioner applied for SSI-Related Medicaid on May 17, 2016 and alleges her condition has deteriorated. Therefore, the undersigned concludes that the Department is to make an independent disability determination.

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

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

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

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

(4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your

residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:

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

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) of this section and § 416.960(b).)

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 416.960(c).)

18. The findings show that petitioner has medical conditions of shoulder damage that causes severe pain and nerve damage. The petitioner also complains of being depressed. The petitioner is currently unemployed. Step one of the disability evaluation is if the applicant is working, and it is substantial gainful activity, the applicant is not disabled. Substantial gainful activity (SGA) is defined in 20 C.F.R. § 416.974 and

the current dollar amount is defined in Social Security's 2016 Red Book A Summary Guide to Employment Supports for Persons with Disabilities Under the Social Security Disability Insurance and Supplemental Security Income Programs and states, "If your impairment is anything other than blindness, earnings averaging over \$1130 a month (for the year 2016) generally demonstrate SGA." The petitioner is not working at this time; therefore, she is not earning the threshold amount. The petitioner passes step one of the 5 steps to determine a disability.

19. Step two is whether or not an individual has a severe impairment. The regulation at 20 C.F.R. § 416.909, How long the impairment must last, states, "Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement." The findings show that petitioner has a severe impairment. However, the petitioner did not meet her burden to show that her impairment is permanent or expected to last for a period of 12 months. To meet step two of the disability determination, the individual's impairment must have lasted or be expected to last for a continuous period of at least 12 months. Therefore, the undersigned concludes petitioner does not meet the duration requirement at step two of the disability evaluation. Therefore, the undersigned concludes petitioner is not eligible for Medicaid as she is not determined to be disabled based on the facts of this record.

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 27 day of October, 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]
Office of Economic Self Sufficiency
Yazmin Rivera

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

FILED

Oct 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05212

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 66032

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 17, 2016 at 9:30 a.m.

APPEARANCES

For the petitioner [REDACTED]

For the respondent: Stan Jones, ACCESS Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action to deny his adult related Medicaid application. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner submitted one exhibit, entered as Petitioner's Exhibit "1". Respondent submitted four exhibits, entered as Respondent's Exhibits "1" through "4". The record remained open until close of business on August 23, 2016 for the parties to submit

additional evidence. On August 17, 2016, additional evidence was received from the petitioner and entered as Petitioner's Exhibit "2". The respondent was to submit the Notice of Case Action (NOCA) regarding the petitioner's May 9, 2016 application and the Department's running record comments (CLRC) regarding the application process for April 25, 2016 and May 9, 2016. The respondent did not submit the additional evidence. The record closed on August 23, 2016.

FINDINGS OF FACT

1. Petitioner (56) filed an application for disability Medicaid with the Department on the following dates: April 25, 2016, May 9, 2016 and June 3, 2016. Petitioner reported on each of his applications that he is disabled. Petitioner is not age 65 or older and does not have any minor children.
2. Petitioner's disabling conditions [REDACTED], and [REDACTED].
3. Petitioner applied for disability with the Social Security Administration (SSA) on February 3, 2016. Petitioner has reported all of his disabling conditions to SSA. Petitioner was denied disability benefits through SSA on May 3, 2016 with a denial code N-31. N-31 means Non-pay- Capacity for substantial gainful activity-customary past work, no visual impairment. Petitioner appealed the SSA denial decision on May 2016. The appeal remains pending.
4. On May 26, 2016, the respondent mailed a NOCA denying the petitioner's April 25, 2016 application due to not completing an interview necessary to determine eligibility.
5. Petitioner submitted additional applications on May 9, 2016 and June 3, 2016. It is unknown if a NOCA was issued to the petitioner regarding his May 9, 2016 application.

No NOCA was submitted to the undersigned regarding the petitioner's May 9, 2016 Medicaid application denial. On June 13, 2016, the respondent mailed a NOCA denying the petitioner's June 3, 2016 application due to not meeting the disability requirement.

6. 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 Department's running record comments (CLRC) from June 6, 2016 indicate that the petitioner's application was referred to DDD on May 13, 2016; and that DDD denied the petitioner's disability claim by adopting the SSA denial decision (May 3, 2016).

7. Petitioner explained he cannot afford the following medications: [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. Additionally, the petitioner explained that due to not being able to afford his medications, he has experienced changes in his conditions such as fainting which caused a concussion on one occasion.

8. The record was left open for the petitioner's SSA's denial decision notice. Petitioner presented a recent SSA denial letter which indicated that on July 8, 2016, SSA took another look at the petitioner's case. Based on this review, the SSA denial decision remained the same (May 3, 2016).

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 application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. SSA denied the petitioner's disability claim on May 3, 2016 because it determined he was not disabled under its rules.

14. Petitioner argued he needs Medicaid due to the fact that he is not able to afford his medications and doctor visits. Changes in his condition have occurred such as fainting.

The prescribed medications relieve the pain. The petitioner has reported all of his disabling conditions to SSA. On July 8, 2016, SSA reconsidered the petitioner's disability claim and determined the May 3, 2016 denial decision was correct. The petitioner has filed an appeal with SSA, which is still pending.

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 May 3, 2016 and denying the petitioner's Medicaid disability applications.

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 07 day of October, 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

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

FILED

Oct 05, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05219

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Marion
UNIT: 88007

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:00 a.m. on August 19, 2016.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant

STATEMENT OF ISSUE

At issue is whether the respondent's 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. The respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on August 19, 2016.

FINDINGS OF FACT

1. On May 3, 2016, the petitioner (age 52) submitted a Food Assistance and SSI-Related Medicaid application for himself. Medicaid is the only issue.
2. To be eligible for SSI-Related Medicaid, the petitioner must be, age 65 or older, considered blind/disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD determines Medicaid disability 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 with the SSA in 2015. The SSA denied the petitioner disability in September 2015. Petitioner is appealing the SSA denial through an attorney, an appeal date has not been set.
5. On June 2, 2016, the Department electronically sent DDD the petitioner's Disability Report.
6. On June 9, 2016, DDD denied the petitioner disability, due to adopting the SSA disability denial.
7. On June 9, 2016, the Department mailed the petitioner a Notice of Case Action, denying the petitioner's May 3, 2016 Medicaid application, due to not meeting the disability requirement.
8. Petitioner described his disabilities as [REDACTED]

[REDACTED]

[REDACTED]

9. Petitioner believes the SSA is aware of all his medical conditions; however, the SSA has not reviewed all his medical records. His attorney has all his medical records and will present them at the SSA 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. 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 the SSA determination is binding on the Department.

14. In accordance with the above authority, the Department denied the petitioner's May 3, 2016 SSI-Related Medicaid application, due to adopting the SSA September 2015 denial decision.

15. The above authority also states that the Department must make a determination of disability if the individual "Alleges a disabling condition different from, or in addition to, that considered by the SSA in making its determination...Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations."

16. Petitioner is appealing the September 2015 SSA denial decision. Petitioner believes that the SSA is aware of all his medical conditions. Although, all of the

petitioner's medical records have not been presented to the SSA and will be presented at the hearing.

17. In careful review of the cited authority and evidence, 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 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 05 day of October, 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

FILED

Sep 30, 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-05225

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88601

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 24, 2016 at 10:17 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Kenesha Hanley,
Operations Management Consultant I

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for Medicaid at application due to being over the asset limit. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted no exhibits. The respondent submitted 70 pages of evidence, which were marked and entered as Respondent's Composite Exhibit "1". The record was left open for additional exhibits through August 29, 2016 including the paystubs used by the respondent and an updated bank statement from the petitioner. On August 24, 2016, the petitioner provided an updated [REDACTED] bank statement which was entered as Petitioner's Exhibit 1. The respondent provided paystubs on August 24, 2016, however, the paystubs were not used in the action taken. The undersigned determined the information was not necessary and was not entered into the record. The record was closed the same day.

FINDINGS OF FACT

1. The petitioner submitted an application for SSI-Related Medicaid on June 27, 2016.
2. The petitioner is the only household member. He has been determined disabled by the Social Security Administration (SSA).
3. The petitioner receives \$927 Social Security Disability Income (SSDI) per month. The petitioner is currently ineligible for Medicare Part A and B.
4. The petitioner incurs a rental expense of \$825 per month. The petitioner also pays additional out of pocket prescription expenses of \$165, \$115, and \$105 each month.
5. The petitioner is employed with Impact Computers, working 50 hours per month earning \$17 per hour.
6. On July 1, 2016, the respondent received a response from the Data Exchange System used to verify asset ownership for the petitioner indicating the petitioner was the owner of a checking account ending in 5362 at [REDACTED] with a balance of

\$5,362.19 through the month of June 2016.

7. The respondent explained that the SSI-Related Medically Needy program has an asset limit of \$5,000 for an individual. The account balance of \$5,362.19 exceeds the asset limit.

8. On July 5, 2016, the respondent mailed the petitioner a Notice of Case Action (NOCA) informing him his request for Medicaid was denied as follows: "Reason: The value of your assets is too high for this program."

9. On July 12, 2016, the petitioner submitted an application requesting SSI-Related Medicaid.

10. On July 5, 2016, the petitioner submitted verification of the balance of his checking account. The account was verified at \$4,870.10 as of July 5, 2016.

11. On July 25, 2016 the respondent mailed the petitioner a Notice of Case Action (NOCA) informing him his request for Medicaid was denied as follows: "Reason: The value of your assets is too high for this program."

12. The petitioner timely requested the hearing.

13. The respondent asserts the transfer of assets within the bank statement are questionable. The respondent further states no attempt to address the discrepancy of the new account balance was made with the petitioner.

14. The petitioner used the funds in his account to pay his living expenses and prescription medications.

15. The petitioner asserts he no longer has \$5,000 in his bank account and he should be eligible as he has been honest about his income and assets.

CONCLUSIONS OF LAW

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

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

...(3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, **either party may present new or additional evidence not previously considered by the department in making its decision.** (*emphasis added*)

18. Fla. Admin. Code R. 65A-1.701, defines resources:

(28) Resources: Cash or other liquid assets, or any real or personal property that an individual owns and could convert to cash to be used for their support and maintenance. Resources is synonymous with assets.

19. Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant part:

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

(a) For Medicaid for the Aged or Disabled Demonstration Waiver (MEDS-AD), an individual whose income is equal to or below 88 percent of the federal poverty level must not have resources exceeding the current Medically Needy resource limit specified in Rule 65A-1.716, F.A.C.

20. Fla. Admin. Code R. 65A-1.303, Assets, states in part:

(1) Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.

(2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.

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

21. The above cited authorities define assets and further establishes rules set for determining availability of assets and where it is considered countable in determining eligibility. The petitioner does not dispute being the owner of the account at issue. The petitioner also does not dispute having full access to the account. The undersigned concludes the petitioner is the sole owner of the account and has ready access to all assets in the account.

22. Fla. Admin. Code R.65- 1.205 Eligibility Determination Process. States in the pertinent part:

...(5) The Department can substantiate, verify or document information provided by the applicant/recipient as part of each determination of eligibility. For any program, when there is a question about the validity of the information provided, the Department will ask for additional documentation or verification as required. The term verification is used generically to represent this process.

(a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.

(b) Verification confirms the accuracy of information through a source(s) other than the individual. The Department can secure verification electronically, telephonically, in writing, or by personal contact.

(c) Documentation establishes the accuracy of information by obtaining and including in the case record an official document, official paper or a

photocopy of such document or paper or electronic source that supports the statement(s) made by the individual.

(6) The Department conducts data exchanges with other agencies and systems to obtain information on each applicant and recipient. It uses data exchanges to validate or identify social security numbers, verify the receipt of benefits from other sources, verify reported information, and obtain previously unreported information...

(b) The Department compares information found through the data exchanges with the information already on file. If the data exchange identifies new or different information than was previously available, the Department conducts a partial eligibility review to determine whether it must change benefit levels.

23. The Department's Policy Manual (The Policy Manual), at Passage 0240.0108 MEDS-Aged/Disabled (MSSI) defines the asset limit for a household of one as \$5,000.

24. In accordance with the above cited authority and policy manual, the respondent used an electronic Data Exchange to verify the petitioner's asset value in his checking account. The Data Exchange was received on July 1, 2016 showing account balances through June 2016. The respondent determined the petitioner's asset value as over the asset limit. The petitioner provided an updated account balance verification from his bank dated July 5, 2016 showing a more current balance of \$4,870.10.

25. During the hearing, the petitioner provided additional information as to how the money in his account was used based on the July 1, 2016 withdrawal. The petitioner's reported expenses are approximately equal to the amount of withdrawal; therefore, not considered a questionable transfer of assets. Under a de novo review, the undersigned concludes that the petitioner's checking account balance is less than the asset limit for a household of one.

26. After careful review of the evidence and cited authorities, the undersigned concludes, the respondent's action to deny the petitioner's request for SSI-Related Medicaid was not within the rules of the program.

27. Fla. Admin. Code R.65-1.702 Special Provisions states in the pertinent 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...

(a) Good cause exists if evidence is presented which shows any of the following:..

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...

(e) If a case is re-opened and the department discovers that an error was made in the eligibility determination, benefits must be provided retroactively as follows:

1. If an application was denied, benefits will be awarded back to the date of eligibility provided all other eligibility requirements are satisfied.

28. In accordance with the above cited authority, the respondent must determine eligibility for the petitioner back to the date of eligibility provided all other eligibility requirements are satisfied.

29. Based on the evidence and cited authorities, the undersigned remands the respondent for corrective action to determine eligibility for the petitioner with an effective date of July 1, 2016, considering the assets for the bank account to be within the allowable limit.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and the department is hereby ordered to determine eligibility for the petitioner with an effective date of July 1, 2016 as outlined in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 30 day of September, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Oct 05, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05235

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Hernando
UNIT: 09DDD

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:45 a.m. on August 22, 2016.

APPEARANCES

For the Petitioner: Beverly Rutherford, pro se

For the Respondent: [REDACTED]
[REDACTED]

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Michelle Aguilar, the petitioner's daughter, appeared as the petitioner's witness. 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 August 22, 2016.

FINDINGS OF FACT

1. On June 1, 2016, the petitioner (age 45) submitted a Food Assistance and SSI-Related Medicaid application. Medicaid is the only issue.
2. For the petitioner to be eligible for SSI-Related Medicaid, she must be, age 65 or older, considered blind/disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD determines Medicaid Disability 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 in August 2015. In November 2015, the SSA denied the petitioner disability. The petitioner is appealing the SSA denial through an attorney, a hearing date has not been scheduled.
5. Petitioner "thinks" that the SSA is aware of all her medical disabilities. Petitioner's attorney has all of her medical records, which will be addressed at the SSA hearing.
6. On July 6, 2016, the Department mailed the petitioner a Notice of Case Action (NOCA), denying her June 1, 2016 Medicaid application with an incorrect denial reason; "You failed to complete an interview necessary for us to determine you eligibility for this program."
7. The Department did not request that DDD complete a disability review on the petitioner.

8. The Department denied the petitioner disability, due to adopting the November 2015 SSA denial decision.

9. On August 10, 2016, the Department mailed the petitioner another NOCA denying her June 1, 2016 Medicaid application with the correct reason, "You or a member(s) of your household do not met the disability requirement."

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 June 1, 2016 Medicaid application, due to adopting the SSA November 2015 denial decision.

15. The above authority also states that the Department must make a determination of disability if the individual "(i) Alleges a disabling condition different from, or in addition to, that considered by the SSA in making its determination...(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations."

16. Petitioner is appealing the November 2015 SSA denial through an attorney, a hearing date has not been scheduled. Petitioner “thinks” the SSA is aware of all her medical disabilities. Petitioner’s attorney has all of her medical records, which will be addressed at the SSA hearing.

17. In careful review of 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 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 October, 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 [REDACTED], Petitioner
Office of Economic Self Sufficiency

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

FILED

Sep 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05267

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 31, 2016 at 1:30 p.m.

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Monica Otalora
Senior Program Specialist

ISSUE

At issue is whether the respondent's denial of the prescription drug Harvoni was proper. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as witnesses for the respondent were Kimberly Lewis, Director of Grievances/Appeals, and Dr. Fred Hill, Medical Director, from Prestige Health Choice, which is the petitioner's managed health care plan.

The respondent submitted the following documents into evidence for the hearing: Exhibit 1 – Statement of Matters; Exhibit 2 – Denial Notice; Exhibit 3 – Prior Authorization Request, with attached medical records.

FINDINGS OF FACT

1. The petitioner is a sixty (60) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. He receives services under the plan from Prestige Health Choice.
2. On or about June 1, 2016, the petitioner's treating physician submitted a prior authorization request to Prestige Health Choice for the prescription drug [REDACTED].
3. On June 3, 2016, Prestige denied the request for [REDACTED]. The denial notice stated the following:

Your request does not meet pharmacy coverage guidelines. Florida Medicaid/AHCA criteria has not been met. Criteria requires the use of Viekira pak and documentation of patient's commitment to treatment. Criteria also requires a negative alcohol and drug screen collected within the past 30 days.

4. The petitioner testified he needs this medication because he has [REDACTED] and suffers from [REDACTED]. He also stated he had negative drug test results in April and May, 2016.
5. The respondent's witness, Ms. Lewis, stated that the petitioner must use the medication on the Medicaid Preferred Drug List (PDL), which is [REDACTED] unless there has already been a trial and failure of [REDACTED] or unless the prescribing physician indicates that [REDACTED] is contra-indicated for the patient.
6. Dr. Hill from Prestige stated that the petitioner did present a negative drug/alcohol screen, so the lack of a negative screening should no longer be considered a basis for the denial.

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 Section 120.80, Fla. Statutes.
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.

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, Prestige Health Choice is the health maintenance organization 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 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.

Page 2-5:

Approval of reimbursement for alternative medications that are not listed on the preferred drug list shall be considered if listed products have been tried without success within the previous twelve months. The step-therapy prior authorization may require the prescriber to use medications in a similar drug class or that are indicated for a similar medical indication unless contraindicated in the Food and Drug Administration labeling. The trial period between the specified steps may vary according to the medical indication. A drug product may be approved without meeting the step-therapy prior authorization criteria if the prescribing physician provides the agency with additional written medical or clinical documentation that the product is medically necessary because:

- There is not a drug on the preferred drug list which is an acceptable clinical alternative to treat the disease or medical condition; or
- The alternatives have been ineffective in the treatment of the beneficiary's disease; or
- Based on historic evidence and known characteristics of the patient and the drug, the drug is likely to be ineffective; or
- The number of doses has been ineffective.

19. The Findings of Fact establish that [REDACTED] is not included on the respondent's PDL.

20. Clinical evidence was not presented demonstrating PDL medications were attempted in the last year and found to be ineffective. As such, it was not demonstrated that the above step therapy process was addressed.

21. The petitioner has not established that the following conditions of medical necessity have been satisfied:

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;

22. The greater weight of evidence in this matter does not establish that the respondent's denial of Harvoni was improper. The petitioner should consult with his physician concerning the medication listed on the PDL, [REDACTED].

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)

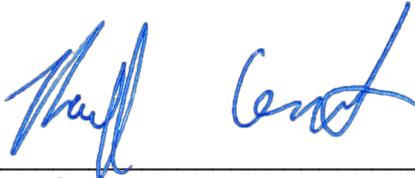
16F-05267

PAGE - 8

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

DONE and ORDERED this 27 day of September, 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
PRESTIGE HEARINGS UNIT
AHCA HEARINGS UNIT

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

FILED

Oct 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05268

PETITIONER,

Vs.

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

And

AMERIGROUP,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 6, 2016 at 8:30 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 custom shoe inserts was correct. The petitioner bears the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a physician's letter and photographs as evidence for the hearing, which were marked as Petitioner composite Exhibit 1.

Appearing as witnesses for the respondent were Lisa Williams, Quality Operations Nurse, and Dr. Lynn Berger, Medical Director, from Amerigroup, which is the petitioner's managed health care plan. Amerigroup was included as an additional respondent in this proceeding pursuant to its request to be added as a party.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Hearing Summary, Authorization Request, Medical Records, Denial Notice, and Medical Criteria.

Also present for the hearing was a Spanish language interpreter, [REDACTED]

[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 Amerigroup.
2. On or about June 30, 2016, the petitioner's treating physician (hereafter referred to as "the provider"), requested prior authorization from Amerigroup for approval of custom shoe inserts (foot orthotics). On July 6, 2016, Amerigroup denied the request based on medical necessity considerations and Medicaid guidelines.
3. The denial notice contained the following reason for the denial:

We cannot approve your child's foot inserts (custom foot supports). We know your child has [REDACTED]. These supports can only be approved when the child is less than 18 months old. These can be approved if an older child cannot walk. These supports are not being used in a special leg brace. There are other items her doctor can ask for (non-custom foot supports).

4. The petitioner's mother stated her daughter needs the shoe inserts because she has pain in her feet when she walks. She also stated her daughter's doctor would not have requested the inserts if they were not needed.

5. The respondent's witness, Dr. Berger, stated there was no indication from the petitioner's physician describing why a non-custom shoe insert would be inadequate in this case. She stated the petitioner has [REDACTED] which was diagnosed years ago, but the petitioner recently began experiencing pain due to her activities. She also stated that x-rays were not submitted as part of the authorization request.

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. Durable medical equipment, including orthopedic footwear devices, is also addressed in the Florida Durable Medical Equipment and Medical Supply Services Handbook ("DME Handbook"), effective July, 2010.

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. 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. Orthopedic footwear for children is a covered service under the Florida Medicaid Program. This service is addressed in the DME Handbook, which states as follows on page 2-56:

Orthopedic footwear includes orthopedic shoes, shoe modifications, wedges, heels, and miscellaneous shoe additions.

Foot orthotics are for congenital forefoot deformities in children who are under 18 months of age, unless determined medically necessary for an older child who is not yet walking.

15. After considering the evidence and testimony presented, the undersigned concludes the petitioner has not established by a preponderance of the evidence that the requested custom shoe inserts should have been approved by Amerigroup. The medical records submitted do not indicate why the petitioner cannot utilize a non-custom insert. Therefore, the medical necessity requirement that there is "no equally effective and more conservative or less costly treatment available" has not been met in this case.

DECISION

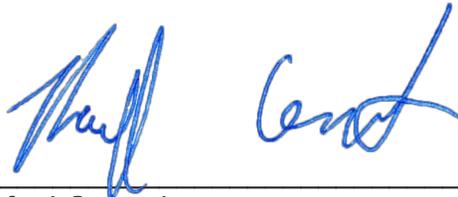
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED.

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 October, 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

Oct 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05272

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 14 Washington
UNIT:

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 14, 2016 at 1:51 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

[REDACTED]

[REDACTED]

Prestige Health Choice

STATEMENT OF ISSUE

Petitioner is appealing the July 7, 2016 denial of orthodontic treatment by the respondent. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The matter was originally scheduled as a telephonic hearing on September 1, 2016. The petitioner requested a face-to-face hearing, which was held on September 14, 2016.

██████████ treatment coordinator with Coast Dental, appeared as a witness for the petitioner. The petitioner also issued a subpoena to ██████████ ██████████ ██████████ was unable to appear due to previously scheduled patients in a private practice.

Melissa Stevens, Grievance and Appeals Coordinator, and Dr. Eric Stumpf, Chief Medical Officer, both from Prestige Health Choice appeared as witnesses for the respondent. Ann Gable, VP of Clinical Operations, and Debra Heil, Utilization Management Review, both with Argus Dental, appeared as witnesses for the respondent.

Diane Soderlind, Registered Nurse Specialist, and Cindy Henline, Medical Health Program Analyst, both with Agency for Health Care Administration, appeared as observers with no objection from the Department.

The petitioner submitted documents at hearing which were entered as Petitioner's Exhibit 1. The respondent submitted two evidence packets, which were entered as Respondent's Exhibits 1 and 2.

The record closed on September 14, 2016.

FINDINGS OF FACT

1. The petitioner became a member with Prestige Health Choice (PHC) on October 1, 2015.

2. Prestige Health Choice subcontracts with Argus Dental on dental services covered by Medicaid.

3. The petitioner was referred for evaluation of crowding/malalignment and open bite on January 20, 2016.

4. The petitioner visited Coast Dental on May 6, 2016 for an evaluation for orthodontics.

5. Coast Dental submitted a dental claim for preauthorization on May 23, 2016. Attached to the claim form was Appendix A – Medicaid Orthodontic Initial Assessment Form (IAF). The IAF total score was 19.

6. On the IAF scored by Dr. Fields: The petitioner has a 1mm mandibular protrusion, which allows five points of his score. The petitioner also has a 1mm open bite, which accounts for four points of the score. Dr. Fields found anterior crowding on the maxilla and mandible, which attributed 10 points to the score. (5 + 4 + 10 = 19)

7. ██████████ completed the initial paperwork at the beginning of the visit prior to the petitioner meeting with the orthodontist, Dr. Fields. She advised the visit was a “no charge” evaluation visit.

8. ██████████ confirmed no x-rays were completed, as the petitioner’s teeth were his permanent teeth. She further stated, to the best of her knowledge, all actions necessary to make the determination regarding orthodontics were completed.

9. ██████████ explained she could not opine on the information on the pre-authorization form as Dr. Fields completed it.

10. Argus Dental and Prestige Health Choice issued a Notice of Action on July 7, 2016 and denied eligibility for orthodontic treatment (5 codes) due to not meeting clinical criteria based on Orthodontic IAF metrics.

11. Argus Dental and Prestige Health Choice issued a Notice of Action on July 18, 2016 that denied eligibility for orthodontic treatment (5 codes) due to not meeting clinical criteria based on Orthodontic IAF metrics.

12. Prestige Health Choice issued a Resolution of Appeal-Unfavorable to the petitioner on July 19, 2016. In this letter, Prestige indicates the petitioner does not meet the clinical criteria based on Orthodontic IAF metrics.

13. Prestige issued the petitioner a Resolution of Grievance Letter on July 12, 2016. This letter informed the petitioner a review/investigation of Coast Dental Tallahassee was completed. The letter also reminded of a change of providers and an appointment on August 4, 2016 with [REDACTED]

14. [REDACTED] saw the petitioner for a second opinion on August 4, 2016.

15. [REDACTED] completed an IAF to submit for pre-authorization, which had a total score of 14. The form includes the following scores: The petitioner has anterior crowding on the maxilla and mandible, which attributed 10 points to the score. The petitioner has posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar) which adds four points to the score.

16. An orthodontic evaluation at Buttram Orthodontics on August 10, 2016, showed the petitioner's upper and lower teeth have crowding issues, his wisdom teeth

are impacted, and he has an open bite. A recommendation was made for comprehensive orthodontic treatment at that time.

17. The respondent explained that a referral to an orthodontist by a dentist does not alone mean the consumer meets the requirements for braces to be covered by Medicaid. The respondent further explained simply because an orthodontist concurs that a consumer may benefit from braces, does not mean the consumer meets the requirements to be covered under Medicaid. Orthodontic care is only approved for consumers with an Orthodontic IAF score of 26 or higher.

18. The respondent explained the Orthodontic IAF scoring sheet includes identification of cleft palate deformities, deep impinging overbite, crossbite of individual anterior teeth where destruction of soft tissue is present, severe traumatic deviations, overjet greater than 9mm or reverse overjet greater than 3.5 mm. The above conditions would automatically qualify a consumer for orthodontic care.

19. The respondent explained the Orthodontic IAF scoring sheet also identifies malocclusions (in mm) of overjet, overbite, mandibular protrusion, ectopic eruption or anterior crowding, labio-lingual spread and posterior unilateral crossbite. The respondent explained the severity of these conditions must reach a point total of 26 to qualify for orthodontic care under Medicaid.

20. The petitioner believes the referral for orthodontics or braces by the dentist would be sufficient. The petitioner has visited multiple orthodontists, who confirmed his need for braces to prevent future health problems.

21. The petitioner cannot find reference in the Medicaid Handbook to show that they must have a certain score to be approved to receive orthodontic treatment.

The petitioner does not believe the IAF scores are relevant in determination of eligibility for orthodontics.

22. The petitioner does not believe that proper procedure was followed at Coast Dental in determination of eligibility for orthodontic treatment. The petitioner believes the treatment at Coast Dental was incomplete and racially biased.

23. The respondent did refer the petitioner to Dr. Kovaleski following the complaint regarding Coast Dental. The respondent notes the score on the Orthodontic IAF completed by [REDACTED] is lower than the score from Coast Dental.

24. The petitioner explained he does not chew his food properly. The petitioner believes some of his speech and stuttering issues are directly related to his dental condition.

25. The petitioner did not present evidence to show that the petitioner does not properly chew his food, that proper chewing of his food is directly related to the placement of his teeth alone.

26. The petitioner provided no evidence to show his speech and stuttering issues were related to dental problems and not related to other possible health conditions.

27. The petitioner did not report an extreme weight loss between May 2016 and the hearing.

CONCLUSIONS OF LAW

28. 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. This order is the final administrative decision of the Department of Children and Families under Section 120.80, Florida Statutes.

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

30. 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).

31. 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.

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

33. 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.”

34. 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>.

35. On page 5 of the Policy, the following exclusions are listed:

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Anesthesia for restorative services, billed separately
- Dental screening and assessment performed by an RDH (D0190 and D0191) on the same date of service as an evaluation performed by a dentist
- Fixed partial dentures (except for procedure code D6985)
- Individual periapical radiograph(s) on the same date of service when the reimbursement amount exceeds that of a complete series (D0210)
- Intraoral-complete series and a panoramic film on the same date of service
- Partial dentures where there are eight or more posterior teeth in occlusion
- Partial dentures for single tooth replacement, except anterior teeth
- Periodontal scaling and root planing on the same date of service as debridement
- Relines and denture adjustments on the same date of service
- Repairs and denture adjustments on the same date of service
- Restoration on deciduous teeth, when loss is expected within six months
- Sealants applied to deciduous teeth
- Sedation on the same date of service as behavior management
- Services for cosmetic purposes
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy
- The use of general anesthesia procedure code, D9223, for either intravenous or nonintravenous sedation modalities

36. Pages 3-4 of the Policy, section 4.2.4 explains Orthodontic Services

allowances:

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

37. Pages 4-5 of the Policy, section 4.3 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.

38. Title 19 of the Social Security Act, section 1905 (r) states in relevant part:

(r) The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

...

(3) Dental services—

(A) which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

39. The Florida Medicaid Dental Fee Schedule, effective January 1, 2016, lists procedure codes D8670 and D8070 as covered services for those under age 21. Both procedures require prior authorization.

40. The above controlling authorities allows recipients under age 21 receive orthodontic treatment if they have a **handicapping malocclusion**. The petitioner

maintains he qualifies for orthodontics based on referral to orthodontists and the recommendation for braces by the orthodontists. The petitioner offered no evidence that he has a handicapping malocclusion. The respondent maintains use of the Orthodontic IAF is to determine if the petitioner meets the criteria for a handicapping malocclusion. The undersigned concludes the scoring of a consumer's condition allows a consistent method to determine the severity of a malocclusion.

41. The findings show that no cleft palate, deep impinging overbite, crossbite of individual anterior teeth causing destruction of soft tissue, severe traumatic deviations, or overjet greater than 9mm or reverse overjet greater than 3.5 mm was reported on either IAF. The undersigned concludes an automatically qualifying handicapping malocclusion was not identified. The undersigned concludes further review of the petitioner's teeth and bite pattern would be necessary to determine if a handicapping malocclusion existed.

42. The findings show both orthodontists scored the petitioner as having anterior crowding on both the maxilla and the mandible, which accounts for 10 points of the score. The findings show Dr. Fields found mandibular protrusion of 1mm, which added five points to his score and 1mm of open bite, which added four points to the score. The findings also show [REDACTED] found posterior unilateral crossbite, which added four points to the score. The findings also show the respondent requires 26 points or more to be considered as having handicapping malocclusion. The undersigned considered the anterior crowding on both maxilla and mandible (10 points) added with the 1mm of protrusion (5 points), 1 mm of open bite (4 points) and the unilateral crossbite (4 points) which would total 23 points ($10 + 5 + 4 + 4 = 23$). The

undersigned concludes the petitioner still does not rise to the score of 26, which would qualify the petitioner as having a handicapping malocclusion under the respondent's reported rule.

43. 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:

(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.

44. The undersigned further considered the petitioner's reported problems from not chewing his food properly as well as speech and stuttering problems. The findings show the petitioner did not provide any documentation to support his claims of these activities being directly related to the dental situation. The above controlling authority discusses medical necessity as a requirement for approval. The undersigned found no evidence presented to show that orthodontic treatment in this case is necessary to protect life or prevent significant illness or disability. The undersigned

concludes the requested orthodontic treatment does not rise to meet the definition of medical necessity.

45. The undersigned considered the case a final time under the EPSDT rule. The undersigned further concludes the petitioner's situation does not rise to the level of the definition of medically necessary for correcting or ameliorate a defect or condition.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24 day of October, 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-05272

PAGE - 13

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

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

FILED

Oct 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05273

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND
AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 14 Washington
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 14, 2016 at 1:51 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Robert Walker, Staywell

STATEMENT OF ISSUE

Petitioner is appealing the May 24, 2016 denial of orthodontic treatment by the respondent. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The matter was originally scheduled as a telephonic hearing on September 1, 2016. The petitioner requested a face-to-face hearing, which was scheduled and completed on September 14, 2016.

██████████, orthodontic assistance with ██████████, appeared as a witness for the petitioner.

Michelle Hadley, National Ancillary Department of Staywell and Dr. Andrea Spur, Liberty Dental appeared as witnesses for the respondent.

Diane Soderlind, Registered Nurse Specialist, and Cindy Henline, Medical Health Program Analyst, both with Agency for Health Care Administration, appeared as observers with no objection from the Department.

The petitioner submitted documents at hearing which were entered as Petitioner's Exhibit 1. The respondent submitted evidence on August 31, 2016, which was entered as Respondent's Exhibit 1.

The record remained open through September 21, 2016 for Staywell and Liberty Dental to review the additional evidence presented at hearing and submit a written statement regarding these documents. The respondent submitted the written response to the documentation on September 19, 2016, which was entered as Respondent's Exhibit 2.

The record closed on September 21, 2016.

The petitioner submitted additional information on October 11, 2016. The cover sheet did not indicate the petitioner provided the same information to the respondent.

The information was considered an attempted ex parte communication after the record closed. The undersigned did not reviewed for substance or considered in completion of this order.

FINDINGS OF FACT

1. The petitioner was enrolled with Staywell on March 1, 2015.
2. Staywell subcontracts with Liberty Dental on dental services covered by Medicaid.
3. The petitioner received a referral for evaluation of crowding/malalignment and open bite on January 20, 2016.
4. The petitioner had an orthodontic evaluation at [REDACTED] on May 6, 2016.
5. The petitioner contacted Staywell on May 23, 2016 regarding orthodontic denial.
6. The respondent issued a Notice of Action on May 24, 2016 informing the petitioner the denial of the claim for:
 1. panoramic radiographic image
 2. 2D cephalometric radiographic image, measurement and analysis
 3. 2D oral/facial photographic image, intra-orally/extra-orally,
 4. diagnostic casts,
 5. comprehensive orthodontic treatment of the adolescent dentation,
 6. periodic orthodontic treatment visit,
 7. orthodontic retention (removal of appliances, construction and placement of retainer(s)), and
 8. unspecified orthodontic procedure, by report was partially denied.

The letter indicated the need for a pre-authorization treatment request form to be submitted on items five, six, and eight above. The letter indicates all items required submission of oral/facial photographic images, panoramic ex-ray, and diagnostic casts.

Items one through four were denied as the procedure described in them is considered to be part of and included in a more inclusive procedure and no additional payment was available. Item seven was denied as a procedure not covered by the plan.

9. The respondent issued a second letter on May 24, 2016 informing the petitioner the pre-orthodontic treatment evaluation to monitor growth and development was approved.

10. The respondent issued a letter to the petitioner on May 31, 2016. The letter indicated Liberty Dental approved the consultation on May 6, 2016. The letter also indicated the orthodontic treatment pre-authorization form had not been received by Liberty Dental to evaluate and determine if the orthodontic services would be approved or not.

11. The petitioner provided a copy of Appendix A – Medicaid Orthodontic Initial Assessment Form (IAF). The petitioner indicated this was completed by Dr. Fields at Coast Dental. The IAF total score was 14.

12. The IAF did not reflect any of the following conditions a cleft palate, deep impinging overbite with destruction of the soft tissue, crossbite of individual anterior teeth with destruction of the soft tissue, severe traumatic deviations, or overjet greater than 9mm or reverse overjet greater than 3.5 mm.

13. The IAF did reflect the following conditions: The petitioner has 1mm of mandibular protrusion multiplied by five and attributing five points to the score. The petitioner has 1mm of open bite multiplied by four and attributing four points to the total score. The form requires the petitioner be scored either on ectopic eruptions **or** on anterior crowding. The petitioner was scored zero on ectopic eruption (excluding third

molars). The petitioner was scored anterior crowding on one row of teeth, which was multiplied by five to attribute five points to the total score. The petitioner did not have labio-lingual spread or posterior unilateral crossbite identified.

14. [REDACTED] completed the initial paperwork at the beginning of the visit prior to the petitioner meeting with the orthodontist, Dr. Fields. She advised the visit was a “no charge” evaluation visit.

15. [REDACTED] confirmed no x-rays were completed, as the petitioner’s teeth were his permanent teeth. She further stated, to the best of her knowledge, all actions necessary to make the determination regarding orthodontics were completed.

16. [REDACTED] explained she could not opine on the information on the pre-authorization form as Dr. Fields completed it.

17. An orthodontic evaluation was completed on August 10, 2016 at Buttram Orthodontics for the petitioner. The evaluation shows upper teeth are spaced, lower teeth are crowded, and there is an impacted tooth. A recommendation was made for comprehensive orthodontic treatment including full upper and lower braces, uncovering the tooth, bring in elastics as needed and retain.

18. The petitioner’s father submitted a hand written letter from “Brandon” which has faint print. The letter indicates he has pain in his jaw and teeth. It does not indicate the level, severity, or impact of the pain in his jaw or teeth.

19. The respondent explained that a referral to an orthodontist by a dentist does not alone mean the consumer meets the requirements for braces to be covered by Medicaid. The respondent further explained simply because an orthodontist concurs that a consumer may benefit from braces, does not mean the consumer meets the

requirements to be covered under Medicaid. The Orthodontic IAF scoring sheet is used to calculate the severity and need for orthodontic treatment.

20. The respondent explained the Orthodontic IAF scoring sheet includes identification of cleft palate deformities, deep impinging overbite, crossbite of individual anterior teeth where destruction of soft tissue is present, severe traumatic deviations, overjet greater than 9mm or reverse overjet greater than 3.5 mm. The above conditions would automatically qualify a consumer for orthodontic care.

21. The respondent explained the Orthodontic IAF scoring sheet also identifies malocclusions (in mm) of overjet, overbite, mandibular protrusion, ectopic eruption or anterior crowding, labio-lingual spread and posterior unilateral crossbite. The respondent explained the severity of these conditions must reach a point total of 26 to qualify for orthodontic care under Medicaid.

22. The petitioner complains to his father that his mouth is bothering him.

23. The petitioner reports the concern for the necessity of braces was found during his physical.

24. The petitioner believes the referral for orthodontics or braces by the dentist would be sufficient. The petitioner has visited multiple orthodontists, who confirmed his need for braces to prevent future health problems.

25. The petitioner cannot find reference in the Medicaid Handbook to show that they must have a certain score to be approved to receive orthodontic treatment. The petitioner does not believe the IAF scores are relevant in determination of eligibility for orthodontics.

26. The petitioner does not believe that proper procedure was followed at Coast Dental in determination of eligibility for orthodontic treatment. The petitioner believes the treatment at Coast Dental was incomplete and racially biased. The petitioner reports that Coast Dental told him that his son was not going to qualify for orthodontic treatment without even submitting the paperwork and documentation necessary for determination.

27. The respondent offered during hearing to assist the petitioner in location of another provider to obtain additional documentation necessary for the review for orthodontic treatment. The respondent noted that the petitioner has been approved for pre-orthodontic monitoring.

28. The respondent reported on September 19, 2016, two orthodontic consultants from Liberty Dental reviewed this case based on the documentation provided by the petitioner. The IAF scores reported by these consultants follows.

29. Dr. William Kochenour completed one review and an IAF form with a total score of five. The consultant found no mandibular protrusion or open bite. The consultant found one ectopic eruption, which multiplied by three contributes three points to the score. In regards to anterior crowding, the consultant reported the crowding is not present and explained that to qualify for crowding, you need more than 3.5mm of crowding with the front six teeth and that is not present. The consultant did find 2mm of labio-lingual spread for two points of the score.

30. Dr. Kochenour documented the following in his assessment: "Provider claims an IAF score of 14 points. Rescored IAF results in a score of five. According to the Medicaid Orthodontic Assessment form, you need an auto qualifier or 26 points to

qualify for orthodontic benefits. The intent of the program is to provide orthodontic care to recipients with handicapping malocclusion to improve function. Although aesthetics is an important part of self-esteem, services that are primarily aesthetics are not within the scope of benefits of this program. Patient at this time does not meet Medicaid's requirement for most severely handicapped."

31. The second consultant found a total score of six. This consultant also found no mandibular protrusion or open bite. This consultant concurred on one ectopic eruption multiplied by three to contribute three points to the score. This consultant notes the upper arch is not crowded. The consultant noted the maximum score for the impacted cuspid would be three points (already shown in the ectopic eruption), and the impacted tooth would come in when the primary tooth is extracted. This consultant differed from the first consultant in finding 3mm of labio-lingual spread, which accounts for three points of the score.

32. Appendix A, How to Score the Initial Assessment Form were included with the respondent's evidence. The scoring sheet explains "The case must be considered dysfunctional and have a minimum of 26 points on the IAF to qualify for any orthodontic care other than crossbite correction." Providers are also given opportunity to provide a brief narrative when submitted a case if attaining the qualifying score of 26 points is uncertain.

CONCLUSIONS OF LAW

33. 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. This order is the final administrative decision of the Department of Children and Families under Section 120.80, Florida Statutes.

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

35. 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).

36. 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.

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

38. 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.”

39. 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:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

...

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

40. The 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>.

41. On page 5 of the Policy, the following exclusions are listed:

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Anesthesia for restorative services, billed separately
- Dental screening and assessment performed by an RDH (D0190 and D0191) on the same date of service as an evaluation performed by a dentist
- Fixed partial dentures (except for procedure code D6985)
- Individual periapical radiograph(s) on the same date of service when the reimbursement amount exceeds that of a complete series (D0210)
- Intraoral-complete series and a panoramic film on the same date of service
- Partial dentures where there are eight or more posterior teeth in occlusion

- Partial dentures for single tooth replacement, except anterior teeth
- Periodontal scaling and root planing on the same date of service as debridement
- Relines and denture adjustments on the same date of service
- Repairs and denture adjustments on the same date of service
- Restoration on deciduous teeth, when loss is expected within six months
- Sealants applied to deciduous teeth
- Sedation on the same date of service as behavior management
- Services for cosmetic purposes
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy
- The use of general anesthesia procedure code, D9223, for either intravenous or nonintravenous sedation modalities

42. Pages 4-5 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** (emphasis added). For more information, please refer to Florida Medicaid's authorization requirements policy.

43. The Florida Medicaid Dental Fee Schedule, effective January 1, 2016, lists procedure codes D8670 and D8070 as covered services for those under age 21. Both procedures require prior authorization.

44. The above controlling authorities allows recipients under age 21 receive orthodontic treatment if they have a **handicapping malocclusion**. The petitioner maintains he qualifies for orthodontics based on referral to orthodontists and the

recommendation for braces by the orthodontists. The petitioner offered no evidence that he has a handicapping malocclusion. The respondent maintains use of the Orthodontic IAF is to determine if the petitioner meets the criteria for a handicapping malocclusion. The undersigned concludes the scoring of a consumer's condition allows a consistent method to determine the severity of a malocclusion.

45. The findings show that no cleft palate, deep impinging overbite, crossbite of individual anterior teeth causing destruction of soft tissue, severe traumatic deviations, or overjet greater than 9mm or reverse overjet greater than 3.5 mm was reported on either IAF. The undersigned concludes an automatic qualifying handicapping malocclusion was not identified. The undersigned concludes further review of the petitioner's teeth and bite pattern would be necessary to determine if a severe handicapping malocclusion existed.

46. The findings shows the orthodontist scored the petitioner as having anterior crowding on both one level of teeth, which accounts for five points of the score. The findings show Dr. Fields found mandibular protrusion of 1mm, which added five points to his score and 1mm of open bite, which added four points to the score. The findings show both consultants did not find mandibular protrusion or open bite. Dr. Fields also found anterior crowding allowing adding an additional five points to the score which totals to 14. The findings also show the consultants scored the petitioner under ectopic eruption rather than anterior crowding. Dr. Kochenour explained to qualify for crowding you need more than 3.5mm of crowding with the front six teeth, which is not present to explain the scoring of 3 points for the ectopic eruption rather than anterior crowding of 5. The consultants also each scored the petitioner for labio-lingual spread

in mm as a two or three. The findings also show the respondent requires 26 points or more to be considered as having handicapping malocclusion. The undersigned considered **if** the most liberal scoring was utilized in this case, the petitioner could score five for mandibular protrusion, four for open bite, five for anterior crowding and three for labio-lingual spread. This would give a total points scored as 17 ($5 + 4 + 5 + 3 = 17$). The undersigned concludes the petitioner still does not rise to the score of 26, which would qualify the petitioner as having a handicapping malocclusion under the respondent's instruction sheet.

47. 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:

(a) Meet the following conditions:

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

...

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

48. The undersigned considered the petitioner's reported pain in his jaw and teeth. The petitioner did not provide any testimony to explain the severity of the pain felt or what treatment alleviated the pain. The above controlling authority discusses

medical necessity as a requirement for approval. The undersigned found no evidence presented to show that the pain is severe enough to consider it medically necessary.

The undersigned concludes the requested orthodontic treatment does not rise to meet the definition of medical necessity.

49. The undersigned considered the case a final time under the EPSDT rule. The undersigned further concludes the petitioner's situation does not rise to the level of the definition of medically necessary for correcting or ameliorate a defect or condition.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24 day of October, 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
Staywell Hearings Unit

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

FILED

Oct 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05274

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 19 INDIAN RIVER
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 24, 2016, 2016 at 10:04 a.m. in [REDACTED]

[REDACTED]

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Jerome Hill, Supervisor for the Medicaid Fair Hearing Unit,
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 and partial days, Monday through Friday, for the certification period of July 7, 2016 to January 2, 2017, is 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 the Respondent was Dr. Darlene Calhoun, Physician Reviewer with eQHealth Solutions.

Appearing as witnesses for the Petitioner were Juan R. Garcia, father of petitioner, and Maria De Pick, Nursing Director with Kids & Nurses PPEC Center.

Respondent's composite Exhibit 1 was entered into evidence.

FINDINGS OF FACT

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

1. Petitioner is a two year-old male Medicaid recipient. He is diagnosed with [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

2. Petitioner's medications include Diastat (as needed), Dilantin, Taurine, and Pulmicort.

3. Petitioner is able to sit unassisted but is unable to crawl. He is able to eat pureed food by mouth, but only takes up to 10 ounces of fluid per day. Petitioner is dependent for all his activities of daily living (ADLs) and transfers. He is also incontinent of bowel and bladder, which is appropriate for his age.

4. The Agency for Healthcare Administration (Agency or AHCA) 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 prior authorization request for service is submitted by a provider along with information and documentation necessary for the QIO to make a determination of medical necessity. A review is conducted for every new certification period. If necessary, a request for modification may be submitted by the provider during the certification period.

6. The Petitioner continues to receive PPEC services five days per week, Monday through Friday, pending the outcome of this appeal. Full day services are no more than ten and a half hours in a day and partial day services are up to five hours of care in a day.

7. On July 5, 2016, the provider submitted a request for PPEC full and partial day services, Monday through Friday, for the certification period spanning from July 7, 2016 to January 2, 2017.

8. On July 8, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. On July 11, 2016, a "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner informing him that PPEC full and partial day 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.

9. On July 11, 2016, a "Notice of Outcome" was issued to Petitioner's provider and provided the clinical rationale as:

The patient is a 17 month old with [REDACTED]
[REDACTED] The patient has poor muscle tone and is unable to crawl. The patient has had no recent hospitalizations or emergency room visits. The patient was receiving PT and OT at home. The patient receives as needed nebulizer treatments. 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. A reconsideration review was not requested by the Petitioner

11. On July 12, 2016, Petitioner's mother timely requested a fair hearing.

12. Petitioner had surgery in February 2016 and has had no seizures since the surgery. The physician consultant noted the Petitioner did not have a need for skilled nursing services. She explained that the occupational therapy, physical therapy, and speech therapy the Petitioner receives at the PPEC center can be provided at other locations by different providers. She stated Petitioner's medications could be administered to him before and after school.

13. Petitioner's mother explained most daycare centers will not or cannot accept her son because they do not have trained staff who are able to provide him care or respond if he has a seizure. She feels the safest place for her son is PPEC. She also wants her son to continue receiving his occupational therapy, physical therapy, and speech therapy so he does not get behind other children his age.

14. The Nursing Director stated Petitioner has developed some behaviors that may be related to his seizures. The director opined Petitioner continued to need skilled nursing care, for a while, to prevent a setback.

15. Petitioner's mother explained since his surgery, her son suddenly cries for a few seconds then, as suddenly, stops. He also bangs his head against any object behind his head and will slap his head with his hand. The mother is maintaining a log of these incidents for future neurological assessment.

16. The physician consultant explained monitoring alone could not be a basis for approving PPEC services. She stated PPEC services were terminated because Petitioner no longer needs skilled nursing intervention. She explained the therapy services Petitioner receives at the PPEC center can be provided at other locations, and his medications can be given before and after he goes to school.

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 (F.A.C.) 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 follows:

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 the 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. The Agency offers PPEC services as an EPSDT service to Medicaid-eligible recipients less than twenty-one years of age. The agency has not approved ongoing PPEC services but is providing PPEC services to the Petitioner administratively, pending outcome of this appeal. Therefore, the undersigned needs to determine that PPEC services are not medically necessary in order to be in compliance with EPSDT requirements.

26. The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook- September 2013 ("PPEC Handbook") is incorporated by reference in Rule 59G-4.260, Florida Administrative Code.

27. On page 1-1, the PPEC Handbook provides the following purpose and definition of PPEC:

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.

28. 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.

29. 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 [emphasis added].

30. Petitioner asserts PPEC services are necessary to administer his medications and ensure he does not experience a setback with his seizures. Petitioner wishes to continue his therapies at the PPEC center and does not believe daycare centers are able to provide the level of care he needs.

31. Respondent's witness explained that PPEC services cannot be approved because the child must need skilled nursing interventions. Petitioner's medical conditions do not require ongoing skilled nursing intervention. There is no evidence to suggest that Petitioner is dependent upon 24-hour per day medical or nursing care, or that he is dependent upon life-sustaining medical intervention or equipment. Petitioner's level of illness does not meet the definition of "medically complex" or "medically fragile," as defined in the Florida Administrative Code. The therapy services he receives can be provided at other locations.

32. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes Respondent has met its burden of proof. PPEC services are not medically necessary.

DECISION

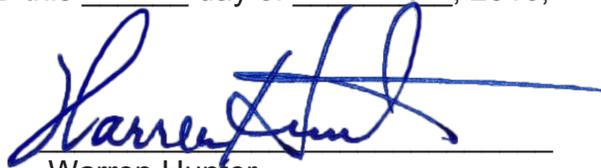
Based upon the foregoing Findings of Fact and Conclusions of Law, Petitioner's appeal is DENIED and the Respondent's action is AFFIRMED.

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 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 October, 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

Oct 20, 2016

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-05278

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pasco
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above referenced matter telephonically on September 6, 2016, at 4:10 p.m.

APPEARANCES

For the petitioner:



For the respondent:

Lisa Williams, R.N.
Quality Operations Nurse
Amerigroup

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for replacement of his partial lower dentures?

PRELIMINARY STATEMENT

Jackelyn Salcedo, Grievances and Appeals Specialist at DentaQuest, appeared as a witness for the 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 the purpose of observation.

The petitioner introduced Exhibits “1” and “2”, inclusive, at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits ‘1” through “10”, 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 May 9, 2016 to allow the petitioner to submit a letter from his dentist and for the respondent to supply the statutes and rules applicable to this case. The petitioner did not submit any additional information. Once the information was received from the respondent, it was accepted into evidence and marked as respondent’s Exhibit “11”. The hearing record was then closed.

FINDINGS OF FACT

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

1. The petitioner is a 52-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 Amerigroup Florida (“Amerigroup”). Amerigroup is a health maintenance organization (“HMO”) contracted by the Agency for

Health Care Administration to provide services to certain Medicaid eligible recipients in Florida. The petitioner's effective date of enrollment with Amerigroup was April 1, 2015.

4. Amerigroup provides certain dental benefits to its members. Amerigroup has contracted DentaQuest to review prior authorization requests for dental services.

5. The petitioner received lower partial dentures approved by DentaQuest and paid for by Amerigroup on or about February 15, 2016.¹

6. The petitioner was experiencing pain in his lower jaw while eating after he received the dentures. Consequently, he removed his lower partial dentures while eating at a fast-food restaurant shortly after he received them.

7. The petitioner accidentally lost his lower partial dentures.

8. On June 29, 2016, the petitioner's dentist submitted a prior authorization request to DentaQuest for replacement lower partial dentures.

9. In a Notice of Action dated June 30, 2016, DentaQuest informed the petitioner it was denying his request for replacement lower dentures on the basis that the requested service is not a covered benefit.

10. The DentaQuest representative appearing at the hearing testified that the claim was denied because the petitioner was previously provided lower partial dentures.

11. It was the petitioner's contention at the hearing that additional teeth need to be removed from his lower arch. Hence, the petitioner asserts, since the lower partial dentures would have to be modified to accommodate the removal of the additional teeth, the dentures provided to him were temporary in nature and not permanent. Therefore,

¹ The petitioner also received full upper dentures at the same time he received his lower partial dentures. However, the upper dentures are not at issue in this appeal.

the petitioner reasons, the replacement lower partial dentures should be approved by the respondent.

12. The petitioner's dentist has also submitted a prior authorization request to DentaQuest for the removal of an additional tooth from the petitioner's lower arch and the addition of this tooth to the petitioner's lower partial dentures.

13. The DentaQuest representative appearing at the hearing testified temporary dentures are designed to be used for a period not to exceed 60 days. She also testified that the petitioner was provided permanent resin-based partial lower dentures which are designed to be modified as additional teeth are extracted.

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.

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

17. 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.

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

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

20. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan and explains as follows:

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...

21. 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.

22. 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.

23. 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....”

24. 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.”

25. The Florida Medicaid Dental Services Coverage Policy, May 2016 is promulgated into rule by Rule 59G-4.060, Fla. Admin. Code.

26. The Florida Medicaid Dental Services Coverage Policy in Section 4.2.7 entitled Prosthodontic Services explains:

Florida Medicaid reimburses for prosthodontic services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:

- One upper, lower, or complete set for full or removable partial dentures per recipient
- One reline, per denture, per 366 days, per recipient
- One all-acrylic interim partial (flipper) for the anterior teeth, per recipient under the age of 21 years.

27. Amerigroup Adult SSI Medicaid covered benefits published by DentaQuest include complete maxillary dentures for individuals age 21 and older but place a limit on this benefit to one time per lifetime.

28. Amerigroup policy regarding dentures for individuals age 21 and older is identical to that of the Agency for Health Care Administration.

29. In the present case, both the Agency for Health Care Administration and Amerigroup limit the receipt of dentures to once per lifetime per arch per recipient. Since the petitioner received lower partial dentures paid for by the respondent earlier this year, the respondent correctly denied his request for a replacement of the dentures.

30. The hearing officer is not in agreement with petitioner's argument that since the lower dentures were partial and could be modified to add additional teeth, that they were temporary and not permanent in nature. The respondent's witness provided credible testimony that the dentures provided were permanent partial dentures.

31. Pursuant to the above, the petitioner has not met his burden of proof to demonstrate that the respondent incorrectly denied his request for replacement of his lower partial dentures.

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 20 day of October, 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
AHCA, Medicaid Fair Hearings Unit
Amerigroup Hearings Unit

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

FILED

Sep 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05341

PETITIONER,

Vs.

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

CO-RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, a telephonic administrative hearing was convened in this matter before the undersigned hearing officer on September 7, 2016 at 10:05 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

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 Argus Dental & Vision, to deny his request for dental procedure D8070-comprehensive orthodontic treatment (braces) of the transitional dentition and D8670-periodic orthodontic treatment (monthly visits for the braces). Because the issue under appeal involves a request for services, Petitioner bears the burden of proof.

PRELIMINARY STATEMENT

Sharon Burgher, Grievance and Appeals Coordinator, appeared as Respondents' witness from the Petitioner's managed care plan Prestige Health Choice. Dr. Nick Kavouklis, Dental Consultant, and Anne Gable, Vice-President of Clinical Operations, appeared as Respondents' witnesses from Argus Dental & Vision (Argus).

██████████, Interpreter from ██████████, provided Spanish translation for Petitioner's mother.

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 an eight year-old Medicaid recipient enrolled with Prestige Health Choice (Prestige), a Florida Health Managed Care provider.
2. Prestige requires prior authorization for services related to dental care and has subcontracted with Argus to review prior authorization requests.
3. Petitioner's dentist sent a prior authorization request for dental procedure D8070: comprehensive orthodontic treatment of the transitional dentition (braces); and D8670: periodic orthodontic treatment visit. Argus received the request on June 28, 2016.
4. Argus made its determination on July 6, 2016 denying procedures D8070 and D8670. Notice was sent to the Petitioner providing the denial reason: The requested service is not a covered benefit.
5. Petitioner filed a timely fair hearing request on July 14, 2016.

6. Petitioner experiences pain when eating. His upper front teeth are permanent (adult teeth) and protrude over his bottom front teeth. As a result, his bottom teeth irritate his upper palate. Petitioner states braces are needed to align his teeth so he can have a normal bite. Braces will relieve the pain he experiences when chewing.

7. Respondent's dentist explained the request for braces was denied for two primary reasons: (1) Petitioner only has 50% of his adult teeth; 50% of his adult teeth still need to erupt. He explained Petitioner would be 12-14 years old when he received his remaining adult teeth. (2) Petitioner is in the middle of his split phase dentition. Petitioner has some adult teeth and some baby teeth. Respondent's dentist cited the Medicaid handbook that states split dentition is not covered except for cleft palate.

8. Respondent's dentist stated the photos of Petitioner's mouth do not show any damage or inflammation of the mouth, as described by the mother. He explained Petitioner is still growing and undergoing changes, including head size. He encouraged the mother to be patient during this growth period.

CONCLUSIONS OF LAW

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

10. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 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. 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.

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

14. 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.”

15. 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** (emphasis added);
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

16. 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>.

17. On page 5 of the Policy, the following exclusions are listed:

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Anesthesia for restorative services, billed separately
- Dental screening and assessment performed by an RDH (D0190 and D0191) on the same date of service as an evaluation performed by a dentist
- Fixed partial dentures (except for procedure code D6985)
- Individual periapical radiograph(s) on the same date of service when the reimbursement amount exceeds that of a complete series (D0210)
- Intraoral-complete series and a panoramic film on the same date of service
- Partial dentures where there are eight or more posterior teeth in occlusion
- Partial dentures for single tooth replacement, except anterior teeth
- Periodontal scaling and root planning on the same date of service as debridement
- Relines and denture adjustments on the same date of service
- Repairs and denture adjustments on the same date of service

- Restoration on deciduous teeth, when loss is expected within six months
- Sealants applied to deciduous teeth
- Sedation on the same date of service as behavior management
- Services for cosmetic purposes
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy
- The use of general anesthesia procedure code, D9223, for either intravenous or non-intravenous sedation modalities

18. Pages 4-5 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** (emphasis added). For more information, please refer to Florida Medicaid's authorization requirements policy.

19. The Florida Medicaid Dental Fee Schedule, effective January 1, 2016, lists procedure codes D8670 and D8070 as covered services for those under age 21. Both procedures require prior authorization.

20. Petitioner asserts he needs braces to realign his upper front teeth. The braces will create a normal bite and eliminate the pain he currently experiences while eating.

21. Respondent explained Petitioner has only half his adult teeth, no documented inflammation, and will not have all his adult teeth until he reaches 12-14 years of age.

22. It is not disputed Petitioner has upper front teeth protruding over his lower teeth. However, Respondent did not address the pain the eight-year old petitioner is suffering.

23. Respondent's notice of denial stated the requested services are not a covered benefit. The Florida Medicaid Dental Fee Schedule, however, shows both dental procedures are covered services requiring prior authorization. Moreover, EPSDT requirements, as cited above, allow for exceeding coverage limitations when medically necessary.

24. The pain Petitioner is experiencing meets the first criteria listed for medical necessity in Fla. Admin. Code R. 59G-1.010 (166)(a)(1). (See paragraph 15 above.)

25. While Petitioner will not have all his adult teeth until he reaches 12-14 years of age, the undersigned finds he has established the medical necessity for braces at this time to relieve the pain he experiences when eating. The monthly follow-up visits should help the dentist address any changes in Petitioner's mouth due to his growth and/or eruption of other adult teeth.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)

16F-05341

PAGE - 8

DONE and ORDERED this 27 day of September, 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
Prestige Hearings Unit

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

FILED

Oct 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05342

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 30, 2016 at 1:36 p.m. in [REDACTED].

APPEARANCES

For Petitioner: [REDACTED]

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 initial request for Prescribed Pediatric Extended Care (PPEC) services for full and partial days, Monday through Friday for the certification period of June 15, 2016 to November 13, 2016, was correct. Because the matter under appeal involves an initial request for PPEC services, the burden of proof is assigned to the Petitioner.

PRELIMINARY STATEMENT

Appearing as a witness for Respondent was Dr. Rakesh Mittal, Board-Certified Pediatrician and Physician Consultant for eQHealth Solutions.

Appearing as witnesses for Petitioner were [REDACTED], [REDACTED] with Broward PPEC; [REDACTED]; and [REDACTED]

[REDACTED]

Respondent submitted a 155-page document, which was marked and entered into evidence as Respondent Exhibit 1.

FINDINGS OF FACT

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

1. The Petitioner is a 1 year-old male Medicaid recipient. He is diagnosed with

[REDACTED]

[REDACTED]

2. Petitioner lives with his parents and sibling. Both parents work.
3. Petitioner's medications include [REDACTED] (daily), [REDACTED] (daily), [REDACTED] (daily), [REDACTED] (before bed), [REDACTED] (twice a day) and [REDACTED] (as needed).

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 June 24, 2016, a request for PPEC full and partial day services, Monday through Friday, was submitted by the provider on behalf of Petitioner for the certification period June 15, 2016 to November 13, 2016. The request represents an initial request for PPEC services.

7. On June 29, 2016, an eQHealth Solutions physician consultant reviewed the request and denied the PPEC services. A "Notice of Outcome-Denial Prescribed Pediatric Extended Care Services" was issued to Petitioner on June 30, 2016, which notified Petitioner that PPEC full and partial day 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 June 30, 2016, a "Notice of Outcome-Denial" was issued to Petitioner's provider and provided the clinical rationale as:

[REDACTED]

[REDACTED] The patient has had no recent hospitalizations or emergency room visits. The patient was receiving PT and OT at home. The patient receives as needed nebulizer treatments. 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. No reconsideration review was requested by the Petitioner.

10. On July 12, 2016, Petitioner timely requested a fair hearing.

11. Petitioner's witness explained Petitioner has difficulty swallowing. Because of a protruding tongue, he breaths through his mouth, which exposes him to respiratory problems. He frequently vomits through his nose which puts him at risk for aspiration. Because of these conditions, he has to be monitored all the time. In October 2015, Petitioner was admitted to the hospital and was diagnosed with respiratory syncytial virus (RSV).

12. Petitioner's witness opined Petitioner will not do well in a regular day care. He needs to be monitored to identify symptoms of distress and to have his medications administered.

13. The Respondent's physician consultant reviewed the information submitted for Petitioner's PPEC request. He explained Petitioner's medications can be given at home in the morning and evening. Skilled nursing cannot be provided to administer Petitioner's [REDACTED] because it is given as needed, not daily.

14. The physician consultant explained Petitioner's swallowing difficulty needs to be documented by a speech therapist which he did not find in Petitioner's submitted documentation. He noted physical therapy and speech therapy services can be provided outside a PPEC center. The physician consultant stated Petitioner's needs do not require skilled nursing care in a PPEC setting.

CONCLUSIONS OF LAW

15. By agreement between the Agency for Health Care Administration (AHCA) and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office

of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80, Florida Statutes. This is a final order pursuant to §§ 120.569 and 120.57, Florida Statutes.

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

17. 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).

18. 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.

19. 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.”

20. 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.

21. 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.

22. 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.

23. In reviewing the appeal for compliance with EPSDT requirements, PPEC services are part of Florida's Medicaid State Plan of services. The agency has not approved ongoing PPEC services. Respondent would need to determine PPEC services are not medically necessary, in order to be in compliance with EPSDT requirements.

24. 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.

25. 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.

26. 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.

27. Petitioner's request for PPEC services is primarily for administering medications and monitoring for possible aspiration. Petitioner requires monitoring for administration of albuterol, when needed.

28. Respondent's witness explained PPEC services cannot be approved for the petitioner because he does not need skilled nursing. Petitioner's medications can be

administered at home in the morning and evening. Respondent asserted full-time skilled staff cannot be provided for administration of albuterol on an as needed basis.

29. There is no evidence to suggest Petitioner is dependent upon 24-hour per day medical or nursing care or that he is dependent upon life-sustaining medical intervention or equipment. Therefore, Petitioner's level of illness does not meet the definition of "medically complex" or "medically fragile," as defined by the above cited authority.

30. The Petitioner has failed to prove, by a preponderance of evidence, that PPEC services are medically necessary. The Respondent has provided documentation and testimony that Petitioner does not need skilled nursing care.

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-05342

PAGE - 9

DONE and ORDERED this 13 day of October, 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

Oct 26, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05384

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Escambia
UNIT: 88630

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 12, 2016 at 9:06 a.m.

APPEARANCES

For the Petitioner: [REDACTED]
[REDACTED]

For the Respondent: Tanya Layton, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of July 1, 2016 enrolling them in Medically Needy and denying eligibility for Qualifying Individuals 1 (QI 1) Medicare Buy-In. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was scheduled for September 1, 2016, however, the office was closed this date for Hurricane Hermine. The hearing was rescheduled for September 12, 2016.

The Department submitted evidence on August 29, 2016. This was entered as Respondent's Exhibit 1. The record remained open for additional evidence from the petitioner through September 19, 2016. The petitioner submitted the evidence to the Department who forwarded to the undersigned on September 20, 2016. This was entered as Petitioner's Exhibit 2.

FINDINGS OF FACT

1. The petitioner submitted an application for Medicaid/Medicare Buy-In on June 28, 2016.
2. The household consists of the petitioner, her husband and her minor daughter.
3. The household's income consists of Social Security (SS) disability for the petitioner in the gross amount of \$381.80, Social Security retirement for her husband in the gross amount of \$413.50, Veteran's Affairs (VA) Income in the gross amount of \$1,072. The petitioner's daughter also receives Social Security income from her father's record in the monthly gross amount of \$1,282.
4. The petitioner and her husband both receive Medicare Parts A & B.
5. The Department issued a Notice of Case Action on July 1, 2016 informing the petitioner that she and her husband continue to qualify for Medically Needy. The

Notice also informed the petitioner the application for Qualifying Individuals 1 (QI 1) was denied, as the household's income is too high.

6. The Department explained the income limit for a couple to receive QI 1 is \$1,803. The Department further explained the gross income, before any deductions, is counted when determining eligibility for the Medicare buy-in program. The only allowable deduction is a \$20 unearned income disregard.

7. The Department explained the total income included was the petitioner's SS of \$381, her husband's SS of \$413, and her husband's VA income of \$1,072. These income total \$1,866. The Department further explained the total income less the \$20 disregard leaves \$1,846, which is more than the income limit of \$1,803.

8. The petitioner believed the Department was including her daughter's income in the determination of eligibility for them for Medically Needy and for the buy-in. The petitioner and her husband explained they do not use the daughter's income to support the household in any way.

9. The petitioner advised each of their SS checks reduced by Social Security to \$98.

10. The petitioner's evidence reflects the petitioner's SS check of \$381.80 was reduced for two reasons. First, it was reduced due to the Medicare Part B premium of \$121.80 being deducted. Second, it was being deferred due back pay of an overpayment on record. Her check will resume in October 2016.

11. The petitioner's evidence reflects her husband's SS check of \$413.50 was reduced due to payment of his Medicare Part B premium of \$104.90. This letter indicates his current net monthly SS payment is \$308.

CONCLUSIONS OF LAW

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

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

14. Fla. Admin. Code R. 65A-1.702 "Special Provisions" states in part: "(12) (d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)"

15. Fla. Admin. Code R. 65A-1.713 "SSI-Related Medicaid Income Eligibility Criteria states in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

16. Federal Regulations at 20 C.F.R. § 416.1121 "Types of unearned income" states in relevant part:

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

17. 20 C.F.R. § 416.1123 "How we count unearned income" states in relevant part:

(b) Amount considered as income. We may include more or less of your unearned income than you actually receive.

(1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see §416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. Exception: We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

...

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums.

18. 20 C.F.R. § 416.1124 "Unearned income we do not count" states in relevant part:

(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the \$20 general exclusion described in paragraph (c)(12) of this section.

...

(c) Other unearned income we do not count. We do not count as unearned income—

...

(12) The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility.

19. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, lists the income limit for a couple to receive MEDS-AD (full Medicaid) effective April 1, 2016 as \$1,175. This limit did not change with the July 1, 2016 update. Appendix A-9 also lists the income limit for a couple to receive QI 1 as \$1,803. This income limit did not change with the July 1, 2016 update.

20. The findings show the petitioner and her husband receive income from Social Security and Veteran's Affairs. The above controlling authorities describe these income sources as unearned income. The undersigned concludes the Department correctly included these income sources as unearned income.

21. The findings show the petitioner and her husband have their SS checks reduced due to payment of their Medicare premium. The findings also show the petitioner's SS check is further reduced due to back pay on an overpayment. In accordance with the above controlling authorities, the undersigned concludes the gross amount of the SS checks is the correct amount to include in the benefit calculations.

22. The findings show the petitioner's gross SS income is \$381. The findings also show the petitioner's husband has gross SS income of \$413 and VA income of \$1,072. The total of this income is \$1,866 ($\$381 + 413 + \$1,072 = \$1,866$). The above controlling authority lists the income limit for a couple to receive MEDS-AD as \$1,175. The undersigned concludes the petitioner and her husband's income is greater than the

couple income limit for MEDS-AD. The authority also lists the income limit for a couple for a couple to receive QI 1 is \$1,803. The undersigned concludes the petitioner and her husband's total gross income exceeds the couple income limit for QI 1. The undersigned concludes the Department correctly enrolled the petitioner and her husband in Medically Needy and denied the QI 1 program.

23. The undersigned reviewed the rules and regulations and found no program, administered by the Department, with a higher income limit, which would pay the Medicare premiums for the petitioner and her husband.

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 26 day of October, 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]
Office of Economic Self Sufficiency

FILED

Oct 17, 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-05405

PETITIONER,

Vs.

CASE [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 55106

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 30, 2016 at 1:00 p.m.

APPEARANCES

For the petitioner: [REDACTED]

[REDACTED]

For the respondent: Stan Jones, ACCESS Economic Self-Sufficiency
Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner submitted one exhibit at the hearing, entered as Petitioner's Exhibit "1". Respondent submitted four exhibits, entered as Respondent's Exhibits "1" through "4".

FINDINGS OF FACT

1. The petitioner (32) applied for disability Medicaid for himself on April 15, 2016. Petitioner reported on his application that he is disabled. Petitioner is not age 65 or older and does not have any minor children.
2. Petitioner's disabling conditions include: [REDACTED]
[REDACTED]
[REDACTED]
3. Petitioner applied for disability with Social Security Administration (SSA) on April 18, 2016. Petitioner reported all of his disabling conditions to SSA. Petitioner was denied disability benefits through SSA on June 23, 2016 with a denial code N-32. N-32 means "Non-pay- Capacity for substantial gainful activity-other work, no visual impairment". On July 12, 2016, the petitioner appealed SSA's denial decision through an attorney.
4. The Division of Disability Determination (DDD) is responsible for making a State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. Petitioner's application was referred to DDD on May 23, 2016.
5. DDD did not conduct an independent review; instead, it denied the petitioner's disability claim by adopting the SSA denial decision (June 23, 2016). On June 28, 2016, DDD electronically forwarded the Disability Determination and Transmittal form to the respondent.

6. On June 28, 2016, the respondent mailed the petitioner a Notice of Case Action, denying his Medicaid application; due to not meeting the disability requirements.
7. Petitioner's mother explained her son needs treatment and medication. She indicated that on or about June 2016, the petitioner was supposed to be baker acted but instead, he was incarcerated as there were no beds available at the facility. On July 3, 2016, the petitioner was baker acted due to threat of self-harm and hospitalized at [REDACTED]; he was released on July 4, 2016. Petitioner submitted this additional information to SSA when he appealed its 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 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
10. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905, "Basic definition of disability for adults". The regulation states, in part:
 - (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s)

that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy...

11. The Code of Federal Regulations at 42 C.F.R. § 435.541 addresses determinations of disability and states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations.

(1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA. [emphasis added]

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section. [emphasis added]

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

...

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

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

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

- (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
- (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

12. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner reported all his disabling conditions to SSA. SSA denied the petitioner's disability claim on June 23, 2016 because it determined he was not disabled under its rules.

13. Petitioner's mother argued her son needs Medicaid benefits in order to receive treatment and medication. The petitioner was baker acted on July 3, 2016 and released on July 4, 2016. The petitioner submitted this additional information to SSA when he appealed its denial decision on July 12, 2016.

14. The respondent denied the petitioner's April 15, 2016 Medicaid application; due to adopting the SSA June 23, 2016 denial decision.

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 23, 2016 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 17 day of October, 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]
Office of Economic Self Sufficiency

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

FILED

Oct 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05430

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Hernando
UNIT: 88007

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:47 a.m. on September 9, 2016.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner Medicaid Disability is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was scheduled to convene on August 22, 2016. The hearing was rescheduled and convened on September 9, 2016, due to the petitioner not receiving the Department's evidence.

The petitioner did not submit exhibits. The respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on September 9, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received full Medicaid benefits.
2. Respondent's representative stated that the Department incorrectly approved the petitioner Medicaid from June 2015 through June 2016.
3. On April 21, 2016, the petitioner (age 52) submitted a recertification application for Food Assistance and SSI-Related Medicaid for herself. Medicaid is the only issue.
4. 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 for the Department.
5. Petitioner is not age 65 or older and has not been considered blind or disabled by the SSA or DDD.
6. The SSA denied the petitioner disability in February 2015. Petitioner appealed the SSA denial through an attorney, a SSA hearing is scheduled to convene on September 21, 2016.

7. Petitioner described her disability as [REDACTED], which has resulted in [REDACTED]. [REDACTED]. Petitioner said that the SSA is aware of all her medical conditions. And her attorney will present all her medical records to the SSA on September 21, 2016.

8. DDD received the petitioner's documents from the Department on June 14, 2016. And on June 21, 2016, DDD denied the petitioner disability, due to adopting the SSA denial decision.

9. On June 23, 2016, the Department mailed the petitioner a Notice of Case Action, notifying she was ineligible for Medicaid effective July 2016.

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 April 21, 2016 Medicaid application, due to adopting the SSA denial decision.

15. Petitioner appealed the SSA 2015 denial decision, a SSA hearing is scheduled to convene on September 21, 2016. The petitioner testified that the SSA is aware of all

her medical conditions. And her attorney will present all her medical records to the SSA at the September 21, 2016 appeal hearing.

16. In careful review of the cited authority and evidence, the undersigned concludes that the Department met its burden of proof. The undersigned concludes the Department's denial of the petitioner's Medicaid Disability is proper.

DECISION

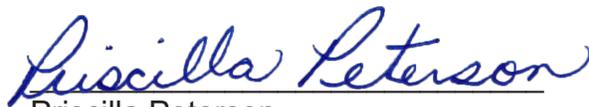
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

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 07 day of October, 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

Sep 29, 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-05431

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 883DT

B - Benefit Recovery (BR)

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 11, 2016 at approximately 1:01 p.m. CDT. The hearing was reconvened on August 25, 2016 at approximately 2:29 p.m. CDT.

APPEARANCES August 11, 2016

For the Petitioner: [REDACTED] [REDACTED] [REDACTED]

For the Respondent: Nicole Nuriddin, economic self-sufficiency specialist II

APPEARANCES August 25, 2016

For the Petitioner: Randy Lovelace, *pro se*

For the Respondent: Nicole Nuriddin, economic self-sufficiency specialist II
Liesta Sykes, call center director
Goodluck Owi, operations management consultant

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of July 7, 2016 when a customer call center call agent instructed him to ignore a notice of case action (NOCA) mailed on June 29, 2016; told him that the "benefit was active till October 31, 2016," and that a letter verifying that statement would be mailed to him in two days. The petitioner called this a denial of benefits as he is not in receipt of the benefit allegedly discussed by the call agent. 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 "13". The respondent also submitted into evidence a .wav formatted recording of a customer call center call made on July 7, 2016 by the petitioner. This recording was played into the record during the August 25, 2016 hearing, entered into evidence and marked as Respondent's Exhibit "14".

FINDINGS OF FACT

1. The petitioner is enrolled in the Medically Needy Program with a \$701 share of cost (SOC). The enrollment period lasts through October 31, 2016.
2. On April 1, 2016, petitioner submitted an application requesting food assistance (FA), family Medicaid, and SSI-Related Medicaid for a household of two.
3. On June 22, 2016, the respondent received by fax from (727) 587-7537, a medical bill from Largo Medical Center in the amount of \$1,237.80 with a date of service of March 7, 2016.

4. On June 29, 2016, respondent mailed a NOCA informing the petitioner that he met his Medically Needy SOC and was Medicaid eligible for the period of March 7, through March 31, 2016.
5. On July 7, 2016, the petitioner called the customer call center to inquire about the nature of the NOCA mailed June 29, 2016, asking "Why did you send me the letter?" Upon inquiry, he added, "I'm eligible for Medicaid from March 7 to March 31st 2016. You sent me this letter June 29th. Do you see where I'm going with this?"
6. The call agent responded that he should "disregard the letter...You have the benefit till October 31st 2016; the benefit is active through October 31, 2016."
7. The call center agent and petitioner agreed that a letter stating as much would be in the mail to the petitioner in two days and petitioner's address was confirmed.
8. On July 5, 2016, a South Florida customer call center agent recorded in the case narrative that the petitioner had called inquiring about the eligibility review period and that the information was explained. There is no reference in the case narrative to the call made July 7, 2016.
9. On July 13, 2016, the petitioner called the customer call center to discuss the NOCA again. It was explained that the respondent had received a medical bill on June 22, 2016 for the date of service of March 7, 2016. The SOC was met effective March 7, 2016 and the petitioner was therefore notified of the Medicaid eligibility by NOCA. The petitioner argued that it was unfair to send a notice of eligibility for March in June, as he cannot use it and that the respondent should have some allowance for these cases. Petitioner was informed that bills can only be tracked after they are received. The petitioner explained that on a recent customer call center call, he had

been informed that his Medicaid was open until October 2016. The respondent explained the Medically Needy program and SOC commenting that the petitioner will only be Medicaid eligible if the SOC is met each month. Petitioner's response was to request an administrative hearing. On the record, a call center director assured the petitioner that his concern over being misinformed would be investigated and necessary action taken.

10. What benefits the petitioner was eligible for or how that determination was made are not in question outside the context of the customer call center conversation. No concerns were raised about household size (two), income amounts being used (\$1,088 for him and \$544 for his daughter), or deductions included in the budgeting process.

CONCLUSIONS OF LAW

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

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

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

14. 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.

15. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at

2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU. For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school fulltime.

16. In accordance with the above controlling authorities, the Medicaid household group is the petitioner and his daughter (two members). The findings show the Department determined the petitioner's eligibility with a household size of two for Medicaid.

17. 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 I 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 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).

19. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for the parent in a household of two as \$241 and a Standard Disregard of \$146 for parents. It also indicates the MNIL to be \$387.

20. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. Step 1: The total income counted in the budget is \$1088. Step 2: There are no deductions. Step 3: The total income of \$1088 less the standard disregard of \$146 is \$942. Step 4: The balance of \$942 is greater than the income limit of \$241 for a parent in a household of two. Step 5: The balance of \$942 less the MAGI disregard of \$67 is \$875. This amount is greater than the income limit of \$241. The undersigned concludes that the petitioner is ineligible for Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.

21. 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.

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. To determine the petitioner SOC, the respondent determined the petitioner's household income to be \$1,088. The medically Needy Income Level of \$387 for a standard filing unit size of two was subtracted resulting an on-going SOC of \$701.

24. The hearing officer found no exception to these calculations. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found.

25. The Policy Manual at passage 2630.0500 SHARE OF COST (MFAM) states:

The Share of Cost (SOC) refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.

Eligibility must be determined for Medically Needy any time the assistance group meets all technical factors but the income exceeds the appropriate income limit for Medicaid.

To calculate the share of cost, compare the countable net income to the Medically Needy Income Level based on the size of the standard filing unit. The difference is the assistance group's share of cost.

26. The Policy Manual at passage 2630.0502, Enrollment (MFAM) states in relevant part "An individual is eligible from the day their SOC is met through the end of the month."

27. The Policy Manual at passage 2630.0507.02, Tracking Medical Expenses (MFAM), states in part: "Allowable medical expenses must be tracked on a monthly basis for each individual/family with a different assistance group and share of cost. Allowable medical expenses whether paid or unpaid must be tracked in chronological order by date incurred (date of service to the individual)."

28. The medical bill received June 22, 2016 with the date of service March 7, 2016 was compared to the petitioner's SOC (\$1,237.80 > \$701) resulting in the SOC being met and the petitioner determined and informed of his Medicaid eligibility effective March 7 through 31, 2016. The hearing officer found no exception to these calculations. It is concluded that a more favorable outcome could not be determined.

29. As to the petitioner's statement that he never submitted a bill to be tracked, it is appropriate for the respondent to track a bill received no matter the sender as service is done for both the applicant and the medical provider. In this instant case, the ability of the provider to now bill Medicaid for payment of the petitioner's bill incurred on March 7, 2016 is advantageous to both parties.

30. Misinformation was provided to the petitioner from the customer call center. An apology from call center management and their assertion that appropriate action will be taken was offered to the petitioner on record. The statement, "The benefit is active through October 31, 2016," mentioned by the call agent is the petitioner's enrollment in the Medically Needy Program, which was possibly misconstrued by both parties to be a Medicaid eligibility period. As concluded above, eligibility, enrollment and share of cost were determined correctly. No evidence or testimony was offered that there was any loss of benefits or coverage due to the misinformation. As there were no stated damages there is nothing to be resolved by the undersigned. The undersigned concludes the issue of the content of the customer call center call moot.

31. Understanding that there was an error made in the handling of and follow-through of a call made by the petitioner to the call center, and having been assured there will be follow-up about the call, the undersigned concludes that other than the

handling of the call the respondent's actions as reviewed above are correct concerning eligibility and benefits made available. As eligibility, enrollment and share of cost are correct, the undersigned sees nothing within his authority to resolve.

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 29 day of September, 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

Sep 13, 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-05434
16F-05435

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88694

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 31, 2016 at 10:04 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Bertha Diaz, Economic Self-Sufficiency Supervisor

STATEMENT OF ISSUE

At issue is the respondent's action to approve \$122 in Food Assistance Program (FAP) benefits for the petitioner and enroll her daughter in Medically Needy (MN) with a \$1,376 Share of Cost (SOC) at recertification. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted no exhibits. The respondent submitted a 67 page exhibit, which was marked and entered as Respondent's Composite Exhibit "1".

FINDINGS OF FACT

1. On April 27, 2016, the petitioner submitted an application for recertification of Food Assistance Program (FAP) and Medicaid benefits for her household.
2. The petitioner's household consists of the petitioner (52 years old) and her daughter (18 years old). They incur shelter and utility expenses. The petitioner does not intend to file taxes and her daughter is not tax dependent on her.
3. The petitioner receives \$440 per month in child support (CS) income. The petitioner's daughter works at [REDACTED] and is paid biweekly.
4. The respondent determined the petitioner's household income for the FAP budget as \$2,003.24 (\$1,563.24 + \$440.00).
5. The respondent calculated the petitioner's FAP budget as follows:

\$2,003.24	total gross income
- 312.64	earned income deduction
- 155.00	standard deduction
<hr/>	
\$1,535.60	adjusted income
\$ 959.33	shelter cost
+ 345.00	utility standard
<hr/>	
\$1,304.33	shelter/utility costs
- 767.80	shelter standard (50% of adjusted income)
<hr/>	
\$ 536.53	excess shelter/deduction
\$1,535.60	adjusted income
- 504.00	shelter deduction (capped at \$504)
<hr/>	
\$ 1,031.60	food stamp adjusted income
\$ 357	thrifty food plan (for household of two)
- 310	benefit reduction (30% of \$1,031.60)
<hr/>	
\$ 47	FAP monthly allotment

6. The respondent determined the petitioner's income for the Medicaid budget as \$1,563.24 per month based on SWICA verified earned income. The Medicaid income limit for a Standard Filing Unit (SFU) of 1 is \$1,317.
7. The petitioner's daughter is over the income limit for full Medicaid.
8. The respondent then determined the petitioner's Share of Cost for the Medically Needy (MN) program by subtracting the Medically Needy Income limit for a household of one \$289 from the SWICA verified income.
9. On May 3, 2016 the respondent mailed the petitioner a Notice of Case Action (NOCA) informing the petitioner the household was eligible for \$47 FAP benefits beginning June 1, 2016 through November 30, 2016 and her daughter was enrolled in Medically Needy (MN) with a \$1,274 Share of Cost (SOC) beginning June 1, 2016 and ongoing.
10. On July 19, 2016 the petitioner contacted the Customer Call Center (CCC) to report a decrease in her CS received. The respondent determined the petitioner's CS income as \$170.36. The petitioner also provided two paystubs to verify the earned income in the household.
11. The respondent determined the petitioner's total gross income for the FAP budget as \$1,960.29 (\$1,789.92 + \$170.37). The petitioner's FAP budget was calculated using the above FAP budgeting methodology.
12. The respondent determined the petitioner's total gross income for the Medicaid budget as \$1,665.04. Using the above mentioned MN budget methodology, the respondent recalculated the petitioner's SOC.

13. On July 20, 2016 the respondent mailed the petitioner a NOCA informing the petitioner the household FAP benefit increased to \$74 beginning August 1, 2016 through November 30, 2016 and her daughter's SOC would increase from \$1,274 to \$1,376 beginning August 1, 2016.

14. The petitioner timely requested the hearing.

15. On July 20, 2016, the petitioner contacted the CCC and reported her CS income as \$4.62 per week for the last four weeks. The respondent determined the petitioner's CS income as \$79.46 per month and the total gross household income as \$1,869.38 (\$1,789.92 +\$79.46).

16. On July 21, 2016, the respondent mailed the petitioner a NOCA informing the petitioner the household FAP benefit would increase to \$101 beginning August 1, 2016 through November 30, 2016 and no change reported to the SOC amount.

17. On August 8, 2016, the respondent recalculated the petitioner's CS income as \$9.93 per month. The respondent determined the petitioner's total gross income as \$1,799.85. The FAP was recalculated using the above mentioned FAP methodology.

18. On August 9, 2016 the respondent mailed the petitioner a NOCA informing the petitioner the household FAP benefit would increase to \$121 beginning September 1, 2016 through November 30, 2016 and no change to the SOC amount.

19. The petitioner feels her daughter is entitled to full Medicaid. The petitioner also states her daughter has become a student and her income has decreased.

20. During the hearing, the respondent advised the petitioner to report her change in income and provide updated paystubs in order to receive a possible increase in her FAP benefit and potential full Medicaid eligibility for her daughter.

CONCLUSIONS OF LAW

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

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

The FAP eligibility will be reviewed first:

23. Federal Regulations at 7 C.F.R. § 273.9 define income and allowable deductions in the Food Assistance Program (FAP) and in part states:

(a) Income eligibility standards...

(1) The gross income eligibility standards for the Food Stamp Program...

(b) Definition of income. Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.

(1) Earned income shall include: (i) All wages and salaries of an employee...

(2) Unearned income shall include, but not be limited to:...

(iii) Support or alimony payments made directly to the household from nonhousehold members.

24. The above authority explains the respondent must include all wages and salaries of an employee and all support payments made directly to the household in order to determine the gross income. In accordance with the authority, the respondent included all the wages of the daughter and the child support income received in the household.

25. Federal Regulations at 7 C.F.R. § 273.10 Determining household eligibility and benefit levels states in pertinent part:

(c) Determining income—(1) Anticipating income. (i) For the purpose of determining the household's eligibility and level of benefits, the State agency shall take into account the income already received by the household during the certification period and any anticipated income the household...

(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...

(d) Determining deductions. Deductible expenses include only certain dependent care, shelter, medical and, at State agency option, child support costs as described in §273.9.

26. In accordance with the above authority and the policy manual, the department must convert the biweekly income received by the petitioner's daughter and multiply the average biweekly amount by 2.15. The respondent correctly converted the petitioner's biweekly income to a gross monthly amount earned income.

27. Federal Regulations at 7 C.F.R. § 273.9, Income and Deductions states in the pertinent part:

...(d) Income deductions. Deductions shall be allowed only for the following household expenses:

(1) Standard deduction...

(2) Earned income deduction. Twenty percent of gross earned income as defined in paragraph (b)(1) of this section. Earnings excluded in paragraph (c) of this section shall not be included in gross earned income for purposes of computing the earned income deduction,...

(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...

28. Federal Regulations at 7 C.F.R. § 273.10 – Calculating net income and benefit

levels states in the pertinent part:

- (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...
 - (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...
 - (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)...
 - (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 ...

29. The Department Program Policy Manual (The Policy Manual), CF-OP 165-22, Appendix A-1 effective October 1, 2015, sets forth for a household size of two as the following:

- \$357 maximum FAP benefit
- \$155 standard deduction
- \$345 standard utility allowance

30. The above cited regulations and policy manual defines allowable deductions in the FAP budget and further establishes the calculations of the net monthly income. In accordance with the regulation, the respondent utilized the petitioner's gross household

income and any allowable deduction in calculating the net income and benefit level for a household size of two.

31. In review of the petitioner's July 2016 FAP budget, the undersigned has completed a recalculation. The petitioner's earned income of \$1,789.92 was reduced by 20% ($\$1,789.92 \times .20$) to arrive at a subtotal of \$1,431.94. The petitioner's weekly child support income was calculated as \$19.86 per month ($\$4.62 \times 4.3 = \19.86). The petitioner's total income of \$1,451.80 ($\$1,431.94 + \19.86) reduced by a \$155 standard deduction to arrive at the \$1,296.80 adjusted income, 50% of which becomes the shelter standard (\$648.40). With total shelter/utility cost at \$1,304.33, the petitioner was allowed \$504 (capped) in excess shelter deduction, resulting in the Food Stamp adjusted income to \$792.80 ($\$1,296.80 - \504). A 30% benefit reduction occurred in the amount of \$238 ($\$792.80 \times 30\%$), resulting in the petitioner's household being eligible for \$119 in FAP benefits ($\$357 - \238) when subtracted from the maximum allotment.

32. Federal Regulations at 7 C.F.R. § 273.12 Requirements for change reporting households, states in the pertinent part:

(c) State agency action on changes. The State agency shall take prompt action on all changes to determine if the change affects the household's eligibility or allotment...

(1) Increase in benefits. (i) For changes which result in an increase in a household's benefits, other than changes described in paragraph (c)(1)(ii) of this section, the State agency shall make the change effective no later than the first allotment issued 10 days after the date the change was reported to the State agency.

33. In accordance with the above authority, the petitioner's reported change of decrease in her CS income was acted upon by the respondent within 10 days of the

petitioner's issuance date. The petitioner's changes were acted upon in a timely manner.

34. In review of the respondent's FAP budget calculations, the undersigned reviewed the petitioner's earned and unearned income using the rules cited above and determined the petitioner was eligible for \$119 in FAP for August 2016. The department has issued \$101 to the household and is ordered to supplement the remaining \$18 (\$119 - \$101) in FAP benefits to the household for the month of August 2016. In review of the September 2016 and ongoing FAP budget, the undersigned did not find a more favorable outcome than \$121 FAP benefits approved by the respondent.

Full Medicaid eligibility will now be addressed:

35. 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.

36. The Policy Manual at passage 1830.0101 Support Payments (MFAM) states:

Taxable Earned income is the receipt of wages, salary, commission, or profit from an individual's performance of work or services or a self-employment enterprise.

Taxable Unearned income is income for which there is no performance of work or services. Taxable unearned income may include:

1. retirement, disability payments, unemployment compensation;
2. annuities, pensions, and other regular payments;
3. alimony and spousal support payments;
4. dividends, interest, and royalties;
5. prizes and awards; or
6. Social Security income.

Excluded income is income (earned or unearned) that is not counted when determining eligibility.

37. The Policy Manual at passage 1830.0101 Support Payments (MFAM) states:

Support payments are funds paid by a non-custodial parent or spouse intended for the support or maintenance of a member of the household. Support paid by a non-custodial parent is considered child support to the child for whom the payment is intended and is excluded. All child support received, including delinquency or arrearages, is excluded unearned income.

38. 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).

39. The petitioner does not intend to file taxes and her daughter is not tax dependent upon her. The petitioner's daughter is then considered in a Standard Filing Unit (SFU) of one. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a child age 8 through 18 in a household size of one as \$1,317, the Medically Needy Income Limit (MNIL) as \$289 and the MAGI Disregard as \$50.

40. In accordance with the above cited controlling authorities, the undersigned calculated the Medicaid eligibility for the petitioner's daughter. Step 1: The total income counted in the budget is \$1,665.04. Step 2: There were no deductions provided. Step 3: There is no standard disregard provided for children six through 18. Step 4: The balance of \$1,665.04 is greater than the income limit of \$1,317 for a child six through 18 in a household of one. Step 5: The income of \$1,665.04 less the Magi disregard of \$50 is \$1,615.04. The amount is greater than the income limit of \$1,317. The undersigned concludes the petitioner's daughter is ineligible for full Medicaid. The undersigned concludes Medically Needy (MN) eligibility must be explored.

Enrollment in Medically Needy and Share of Cost amount will now be addressed:

41. 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.

42. 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".

43. 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.

44. The Policy Manual at 2230.0400 Standard Filing Unit (MFAM) states:

The SFU is determined for each individual by following one of three rules based on intended tax filing status for the upcoming tax year as reported by the applicant/recipient. Individuals cannot receive Medicaid benefits under more than one assistance group, but can have their income included in more than one assistance group.

Filer Rule: If the individual being tested for eligibility expects to file a tax return for the tax year in which eligibility is being determined and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

- 1. individual,**
- 2. individual's spouse, if any, even if the individual and the individual's spouse are living separately and filing a joint tax return, and**
- 3. all claimed tax dependents of the individual living inside or outside of the household. (*emphasis added*)**

Tax Dependent Rule: If the individual being tested for eligibility expects to be claimed as a tax dependent for the tax year in which eligibility is being determined, the SFU includes the:

1. individual,
2. individual's spouse, even if the individual and the individual's spouse are living separately and filing a joint return,
3. tax filer,
4. tax filer's spouse, if any, even if the tax filer and tax filer's spouse are living separately and filing a joint return, and
5. all claimed tax dependents of the tax filer living inside or outside of the household.

45. In accordance with the above controlling authorities, the respondent determined the petitioner's SFU as a household of one based on her tax filing status.

46. In accordance with the above controlling authorities, the respondent determined the petitioner's daughter's countable household income to be \$1,665.04. The MNIL of \$289 was subtracted from the income to determine SOC of \$1,376.

47. The undersigned found no exception to these calculations. It is concluded that a more favorable SOC could not be determined.

48. Based on the evidence and a review of the respondent's budget calculations, the undersigned has concluded the respondent's action to deny the petitioner's daughter full Medicaid and enroll her in the Medically Needy program with a \$1,376 SOC was proper.

DECISION

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

It is granted and remanded for corrective action. The petitioner is eligible for \$119 in FAP for August 2016. The department has issued \$101 FAP benefits to the household and is ordered to supplement the remaining \$18 (\$119 - \$101) in FAP benefits to the household for the month of August 2016, not duplicating any benefits already received.

It is denied as the department correctly denied full Medicaid benefits and properly enrolled the petitioner's daughter in the Medically Needy Program with a share of cost.

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.

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 September, 2016,

in Tallahassee, Florida.



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

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

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

FILED

Oct 10, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05443

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:52 p.m. on August 31, 2016.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Marsha Shearer, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's husband full Medicaid and instead approve Medically Needy (MN) with a \$1,495 Share of Cost (SOC) is proper. The respondent 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 Exhibits "1" through "5". The record remained open through end of business day on August 31, 2016, for the respondent to submit additional exhibits. The exhibits were received timely and entered as Respondent Exhibits "6" and "7". The record was closed on August 31, 2016.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner's husband received full Medicaid. The Department did not include the husband's income in the previous Medicaid certification determination.
2. On May 26, 2016, the petitioner submitted a web recertification application for Food Assistance and SSI-Related Medicaid benefits for herself and her husband. The application lists income from the Social Security Administration for both the petitioner (\$947) and her husband (\$914). Medicaid for the petitioner's husband is the only issue.
3. The Department verified that the petitioner receives \$947 Social Security Disability Income (SSDI) and her husband receives \$914 SSDI, totaling \$1,861 household income.
4. For the petitioner's husband to be eligible for full SSI-Related Medicaid, the household income for a couple cannot exceed the \$1,175 Medicaid income standard. Petitioner and her husband's \$1,861 household SSDI exceeds the \$1,175 Medicaid income standard. The next available Medicaid program is the MN with a SOC.

5. The Department determined the petitioner's husband's SOC as follows:

\$ 947	petitioner's SSDI
+\$ 914	petitioner's husband's SSDI
<hr/>	
\$1,861	total household income
-\$ 20	unearned income disregard
-\$ 241	MN income level (MNIL) for a household size of two
-\$ 104	petitioner's Medicare premium (cents dropped)
<hr/>	
\$1,495	SOC

6. On June 6, 2016, the Department mailed the petitioner a Notice of Case Action, notifying the petitioner's husband was approved MN with a \$1,495 SOC. The notice indicates that the petitioner's husband's MN SOC would increase from \$686 to \$1,495.

7. Respondent's representative was unsure why the notice stated that the petitioner's husband's MN SOC would increase, because he was previously receiving full Medicaid. The record remained open for the respondent's representative to submit verification that the petitioner's husband received full Medicaid through June 2016.

8. After the hearing, the respondent's representative submitted verification showing that the petitioner's husband received full Medicaid through June 2016.

9. Petitioner disagrees with the Department's termination of full Medicaid for her husband. Petitioner stated that her husband is suffering from [REDACTED] and is in need of full Medicaid.

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 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...

13. 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.

14. The Department's Program Policy Manual, CFOP 165-22, appendix A-9 (July 2016), identifies \$1,175 as 88 percent of the FPL for a couple.

15. Petitioner's \$1,861 household SSDI exceeds the \$1,175 income limit for her husband to be eligible for full Medicaid.

16. 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...”

17. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$241 for a family size of two.

18. Federal Regulations at 42 C.F.R. § 436.831 explain Medicare premium deduction and in part states, “(e) Determination of deductible incurred expenses (1) Expenses for Medicare and other health insurance premiums...”

19. In accordance with the cited authorities, the Department deducted \$20 unearned income, \$241 MNIL and \$104 petitioner’s Medicare premium from the petitioner’s \$1,861 household income, to arrive at \$1,495 SOC.

20. In carefully review of the cited authorities and evidence, the undersigned concludes that the respondent met its burden of proof. The undersigned concludes the respondent’s action to approve the petitioner’s husband MN with a \$1,495 SOC is proper.

DECISION

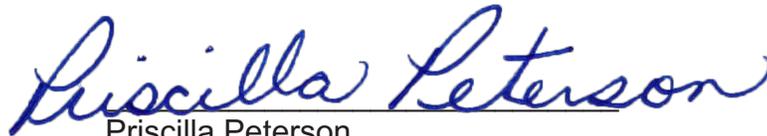
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent’s action is affirmed.

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 10 day of October, 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

Oct 05, 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]
[REDACTED]

APPEAL NO. 16F-05459

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Duval
UNIT:

RESPONDENT.
_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 24, 2016 at 1:25 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Sheila Broderick, registered nurse specialist with AHCA

STATEMENT OF ISSUE

Whether it is medically necessary for the petitioner to continue to receive Prescribed Pediatric Extended Care (PPEC) services through Medicaid. 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 several Medicaid services, including PPEC services.

By notice dated July 14, 2016, eQ informed the petitioner that her request for continued PPEC services for the certification period July 17, 2016 – January 12, 2017 was denied. The notice reads in part: “the services are not medically necessary.”

The petitioner timely requested a hearing to challenge the denial decision on July 18, 2016. The petitioner’s PPEC services have been continued pending the outcome of the hearing.

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

Present as a witness for the respondent from eQ: Dr. Rakesh Mittal, physician reviewer. The respondent submitted documentary evidence which was admitted into the record as Respondent’s Composite Exhibit 1. The record was closed on August 24, 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 4) is a Florida Medicaid recipient.

2. The petitioner's diagnoses includes [REDACTED]

[REDACTED]-not otherwise specified.

3. In 2014, the petitioner was approved for eight hours (9am to 6pm) of PPEC services (specialized medical daycare for children with complex medical needs) daily, Monday – Friday for six months, due to serious coexisting medical issues, including full body seizure activity.

4. Continued eligibility for PPEC service must be reviewed every six months. The petitioner was recertified for PPEC services at each six month review over the last two years.

5. On July 10 2016, the petitioner's treating physician submitted a request for continued PPEC services to eQ (AHCA's contracted review agent) for another six month certification.

6. All Medicaid services must be medically necessary as determined through a prior service authorization process. eQ reviews the authorization request form and all supporting documentation during the review process. eQ has no direct contact with the child or child's family.

7. In the instant case, eQ reviewed the request form and petitioner's Plan of Care (a document which defines the patient's need for Medicaid services and service goals), Home Health Assessment (a document which describes household composition, member's medical condition, and functioning level) and PPEC notes to make the eligibility decision.

8. The Plan of Care is dated July 23, 2015 describes the petitioner as follows:

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED] Mom states that he has frequent seizures throughout the day that you notice by the twitching in his right arm. He is walking independently now. He needs assistance with walking up and down stairs as well as when there is a change in surface. He can sit or crawl. He still wears diapers and only bubbles with his verbalization. He does yell and scream throughout the day. Parents feel he yells for no reason. He is currently receiving OT, ST and PT at the PPEC 2x/week. He was also found to be 10% blind in his left vision. He has had two outpatient surgical procedures. He had a [REDACTED] in August 2015 and [REDACTED] repair December 2015. He is followed by Neurology and Ophthalmology. He will be seeing Orthopedics in the near future regarding leg discrepancy. He has outgrown his ankle braces.

9. The clinical notes from the petitioner's PPEC record incontinence, total need for assistance with the activities of daily living, administration of medications, physical therapy, speech therapy, and occupational therapy. PPEC records note a discussion with the petitioner's mother regarding transitioning him to elementary school.

10. The petitioner lives in the family home with his parents, older sibling, and maternal grandmother. The other family members have no disabling conditions. The parents work outside the home 30 to 40 hours weekly. The grandmother does not work outside the home. The family is the only source of natural support.

11. eQ concluded that the petitioner's medical condition had stabilized since birth; he has medical needs, but no longer requires continuous skilled nursing care.

The clinical rationale section of eQ's evaluation explains the denial decision:

[REDACTED]. The patient's last seizure was 3 years ago. The patient is on one scheduled medication. The patient has had no recent hospitalizations or emergency room visits. The patient continues to have some developmental delays.

The clinical information does not support the medical necessity of the requested services. There no longer appears to be any skilled needs.

12. Dr. Rakesh Mittal, physician reviewer with eQ, appeared as a respondent witness during the hearing. Dr. Mittal questioned the petitioner's mother regarding his seizure activity because PPEC records contain conflicting notes: one note states that the petitioner has not had a seizure in three years. Another note states daily seizure activity. The petitioner's mother explained that he has not had a full body seizure in three years. The prescribed medications have successfully controlled full body seizure activity. However, he continues to have chronic isolated seizures in the right arm, noted by twitching of the arm.

13. Dr. Mittal opined that the petitioner's care needs do not require the services of skilled nurse staff because he does not suffer severe, full body seizure activity nor does he require mechanical devices (G-tube for feedings, ventilator, or IV for medications) to maintain life. Dr. Mittal opined that it is not medically necessary for the petitioner to continue to receive PPEC services.

14. The petitioner's mother argued that his medical condition has improved, but he is still non-verbal and unable to communicate his needs like an average four year old child. He is incontinent and needs total assistance with the activities of daily living. In addition, he needs speech, occupational and physical therapies, these services are received at the PPEC; cessation of the therapies would be detrimental to the petitioner's development.

15. In rebuttal, the respondent explained that a responsible adult can address the services needs described by the petitioner's mother, skilled nursing care is not required. Regarding the therapy services the petitioner receives at PPEC, the respondent explained that these services can be received on an outpatient basis.

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 respondent.

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 and therapeutic 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, through its agent eQ, denied the petitioner's request for ongoing PPEC services. The respondent determined that the services were no longer medically necessary; the petitioner's care needs can be addressed by a responsible adult and does not required continuous skilled nursing care.

29. The petitioner's mother argued that he is significantly, developmentally delayed and requires specialized care.

30. The petitioner's medical condition was not stable at birth; he was [REDACTED] [REDACTED]) and suffered from severe full body seizure activity. Skilled nursing care was required at that time. The evidence proves that the petitioner's medical condition has improved significantly over the past four years. He no longer experiences full body seizures. He is developmentally delay and requires assistance with the activities of daily living, as well as administration of medications. However, the petitioner does not require G-tube feedings; he is not ventilator dependent; he does not require a medical apparatus to maintain life. The petitioner does not require continuous skilled nursing care to ensure his health and safety.

31. 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 05 day of October, 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]
AHCA, Medicaid Fair Hearings Unit

FILED

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

Oct 26, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05468

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 10 Polk
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above referenced matter telephonically on September 12, 2016, at 4:10 p.m.

APPEARANCES

For the petitioner: [REDACTED]
[REDACTED]

For the respondent: Sarah Macdonald
Case Manager Supervisor
Prestige Health Choice

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied his request for reimbursement of his out-of-pocket costs associated with the use of an out-of-network provider for a circumcision?

PRELIMINARY STATEMENT

The following individuals appeared as witnesses on behalf of the respondent: Michael O'Donnell, Grievance and Appeals Coordinator at Prestige Health Choice; and Erik Stumpf, M.D., Medical Director for Prestige Health Choice. Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Coordinator at the Agency for Health Care Administration ("AHCA" or "Agency"), was present solely for observation.

The respondent introduced Exhibit "1," inclusive, at the hearing, which was accepted into evidence and marked accordingly. The hearing record in this matter was left open until the close of business on September 19, 2016 for the respondent to provide additional information including, but not limited to, the relevant portions of the member handbook and contractual provisions relating to the use of out-of-network physicians. Once received, this information was accepted into evidence and marked as respondent's Exhibit "2." The hearing record was then closed.

FINDINGS OF FACT

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

1. The petitioner is an infant male. He was born earlier this year.
2. Petitioner was eligible to receive Medicaid services at all times relevant to this proceeding.
3. Petitioner was an enrolled member of Prestige Health Choice at the time the services were rendered. Prestige Health Choice 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 effective date of enrollment of the petitioner's mother with Prestige Health Choice was October 1, 2015.

5. At the time the petitioner's mother became an enrolled member of Prestige Health Choice, she was already pregnant with the petitioner and under the care of an Obstetrics and Gynecology ("OBGYN") provider, Heart of Florida OBGYN.

6. Heart of Florida OBGYN is outside the Prestige Health Choice provider network. They are an out-of-network provider.

7. In order to provide continuity of care, Prestige Health Choice allowed the petitioner's mother to continue receiving obstetric and gynecological care at Heart of Florida OBGYN.

8. Prior to the petitioner's birth, the petitioner's mother was advised by a case manager at Prestige Health Choice that circumcision is a covered benefit up until an infant is three months old, but that the petitioner's mother needs to ensure she selects a doctor who accepts Prestige Health Choice insurance.

9. The petitioner received a circumcision by an out-of-network provider at [REDACTED] on or about April 15, 2016.

10. The petitioner's mother paid [REDACTED] \$250.00 directly for the petitioner's circumcision.

11. The petitioner's mother thereafter submitted the receipt for the circumcision to Prestige Health Choice along with a request for reimbursement.

12. Prestige Health Choice denied the mother's request for reimbursement because the service was performed by an out-of-network provider.

13. The petitioner's mother requested a fair hearing and this proceeding ensued.

14. The petitioner was residing in or around Winter Haven, Florida at the time his circumcision was performed.

15. A circumcision may be performed by either an OBGYN or a pediatrician.

16. Prestige Health Choice has 21 in-network pediatricians in the [REDACTED] area. It is unclear how many of these pediatricians perform circumcisions.

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.

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

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

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

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

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

23. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan and explains as follows:

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

24. The definition of medically necessary is found in 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.

25. 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.

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:

[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. 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.

....

HMO Coverage

When a provider verifies a recipient’s eligibility for Medicaid, he must also verify whether the recipient is enrolled in an HMO. If a recipient is an HMO

member, the provider must seek authorization from the HMO in which the recipient is currently enrolled prior to providing services covered by the HMO, unless it is an emergency.

If the recipient is in an HMO, Medicaid will not pay a provider for any HMO-covered services. Providers must seek authorization and reimbursement from the HMO for services the HMO covers for its members.

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

59G-5.110 Direct Reimbursement to Recipients.

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

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

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

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

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

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

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

30. The Prestige Health Choice member handbook, in the section entitled Services covered by Prestige and what to do, on Page 13, explains as follows: “you may be responsible to pay for services if you find out ahead of time that Prestige does not cover the services. You may also have to pay for the services if you go to a provider that is not in the Prestige network.”

31. The Prestige Health Choice member handbook, in the section entitled Services Prestige Excludes/Does Not Cover, on Page 20, states as follows:

Prestige excludes, or doesn't cover, some services. Always contact Prestige if you have questions about your benefits. These are the types of services not covered:

...

Services provided by an out of network physician. We make exceptions for emergency services, family planning services or when the requested service is not available through Prestige. You can see an out of network provider during your Continuity of Care time when you first join Prestige....

32. AHCA Contract No. FP017, Attachment II, Exhibit II-A, Effective 08/15/16, the Contract between the Agency for Health Care Administration and Prestige Health Choice, on Page 28 of 115, states the following:

The Managed Care Plan shall provide timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval. The Managed Care Plan may not require paper authorization as a condition of receiving treatment. Written follow-up documentation of the approval must be provided to the non-participating provider within one (1) business day after the approval. Enrollees shall be liable for the cost of such unauthorized use of covered services from non-participating providers.

33. In the present case, no evidence was presented indicating the petitioner's reimbursement request involves an erroneous denial or termination of eligibility.

Additionally, the petitioner's mother chose to have the petitioner's circumcision performed by an out-of-network provider. Testimony at the hearing and evidence provided afterwards indicates there were a number of local in-network providers within relatively close proximity to the petitioner who could have performed the surgery. The above authorities are clear that a plan recipient is responsible for any charges incurred as the result of having a service performed by an out-of-network provider when that service has not been authorized by the Plan. Accordingly, the respondent correctly denied the petitioner's request for the charges he incurred for the procedure.

34. Pursuant to the above, the petitioner has not met his burden of proof to demonstrate by a preponderance of the evidence that the respondent incorrectly denied his request for reimbursement of the procedure performed by an out-of-network provider.

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 26 day of October, 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:


AHCA, Medicaid Fair Hearings Unit
Prestige Hearings Unit

FILED

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

Oct 18, 2016
Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05472

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pinellas
UNIT: AHCA

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 20, 2016 at 10:39 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]
[REDACTED]

For the Respondent:

Stephanie Lang, R.N.
Registered Nurse Specialist/Fair Hearing Coordinator
Agency for Health Care Administration

STATEMENT OF ISSUE

The Petitioner is appealing the denial of her initial request for Prescribed Pediatric Extended Care (PPEC) services. The Petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The Petitioner's evidence packet discussed on the record is entered into evidence as Composite Petitioner Exhibit "1."

Dr. Rakesh Mittal, M.D., Physician Reviewer with eQHealth Solutions, appeared as a witness on behalf of the Agency for Health Care Administration ("AHCA").

The Respondent introduced Exhibits "1" through "5," inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

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

- Florida Statute section 409.905
- Florida Administrative Code Rules 59G-1.001, 59G-1.010, and 59G-4.260
- Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, September 2013

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceedings, the following findings of fact are made:

1. The Petitioner is a 2-year-old female diagnosed with [REDACTED].
2. The Petitioner lives in the family home with her mother, older sibling who is 14 years-old, and father. The mother does not work because of her disability. The older sibling is diagnosed with [REDACTED] the father is frequently out of town for work.

3. The Petitioner was eligible to receive Medicaid at all times relevant to this proceeding.
4. The Petitioner has limited verbal ability.
5. The Petitioner has simple seizures that do not alter mental status.
6. The Petitioner is incontinent of both bladder and bowel, which is age-appropriate.
7. The Petitioner is ambulatory.
8. The Petitioner is on a regular, age-appropriate diet but requires assistance with meal preparation and feeding.
9. The Petitioner has no documented respiratory issues. However, the Petitioner is at risk for aspiration due to [REDACTED].
10. The Petitioner's Pediatrician referred her to a Neurologist for abnormal behaviors.
11. The Petitioner had a neurological consultation on May 12, 2016. The Neurologist had two abnormal EEG in February 2016 and April 2016. The mother reported that Petitioner appears to walk around like she is blind, has frequent temper tantrum, speaks her own language, has developmental delays, and an inability to control anger.
12. The mother explained since the Petitioner's last evaluation she had two additional seizures in July 2016 and August 2016.
13. The Petitioner is not on a complex medication regimen for prolonged seizures. She is on one scheduled seizure medication, [REDACTED]. The Petitioner takes

additional [REDACTED] [REDACTED] and [REDACTED], which treats her other diagnosis. The Petitioner explained the medications are working.

14. The Petitioner does not have a gastrostomy tube ("G-tube) or any other feeding tube.
15. The Petitioner does not use a ventilator for assistance with breathing nor is she connected to any other medical equipment.
16. The mother received referrals for speech therapy, behavior therapy, and occupational therapy for the Petitioner. She has not set up the Petitioner's appointments for the referrals because PPEC offers these services in one location.
17. Petitioner's mother believes she belongs in the PPEC program because it's the Petitioner's right as a special needs child.
18. The mother explained PPEC has professional nurses and she is not a professional. The Petitioner's seizures should be monitored by professionals.
19. 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.
20. On May 27, 2016, a request for PPEC for full or partial day services from Monday to Saturday for six months was submitted by the provider on behalf of the Petitioner for the certification period June 13, 2016 to December 9, 2016. The request represents an initial request for PPEC services.

21. eQHealth Solutions is the Quality Improvement Organization contracted by AHCA to review requests by Medicaid recipients in the State of Florida for PPEC services.
22. 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 AHCA.
23. The Petitioner's request was reviewed by an eQHealth Solutions Physician Reviewer on June 17, 2016. The Physician Reviewer determined PPEC is not medically necessary for the Petitioner and denied all of the requested services.
24. eQHealth Solutions Physician Reviewer sent the denial form to the Petitioner's provider on June 20, 2016. The Physician Reviewer provided the following clinical rational for the decision:

[REDACTED]

25. The Respondent's witness Dr. Mittal stated PPEC is designed for children that are medically complex and who require skilled nursing care. He testified PPEC services are generally for children who require ventilators for breath assistance,

gastrostomy tubes (“G-tubes”), or are dependent on the use of medical equipment to which they are attached. The Respondent’s witness explained 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 used to monitor and supervise for potential seizure activity. He also explained the parents can be trained to care for seizures at home. The Respondent’s witness stated the mother can receive behavior therapy, occupational therapy, and speech therapy services outside of PPEC.

CONCLUSIONS OF LAW

26. 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 Florida Statutes section 120.80.
27. The Florida Medicaid Program is authorized by Florida Statutes Chapter 409 and Chapter 59G, Florida Administrative Code. The Program is administered by AHCA.
28. This proceeding is a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.
29. This is a Final Order, pursuant to Florida Statutes sections 120.569 and 120.57.
30. The standard of proof in an administrative hearing is a preponderance of the evidence pursuant to Florida Administrative Code Rule 65-2.060(1).
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. Although the terms medically necessary and medical necessity are often interchangeable 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" and "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

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

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

33. Since Petitioner is under 21, a broader definition of medically necessary applies to include the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) requirements. Florida Statutes, section 409.905 (2), Mandatory Medicaid Services defines Medicaid services for children to include:

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

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

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

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

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

appropriate in a particular case” and a treating physician is “required to operate within such reasonable limitations as the state may impose.”

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

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

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

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or

infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice ...

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

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

37. Section 409.913(1)(d), Florida Statutes, highlights that the Agency makes the final decision regarding whether or not a requested service is medically necessary; however, the hearing officer is the final decision making authority for the Agency according to Florida Statutes section 120.80.
38. 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.
39. The purpose of PPEC on page 1-1 of the PPEC Handbook states that, “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 non-residential pediatric center.” (emphasis added)
40. The PPEC Handbook on pages 2-1 lists the criteria a recipient must meet to receive PPEC services. The criteria are:
- Be Medicaid eligible
 - **Diagnosed with a medically-complex or medically fragile condition** as defined in Rule 59G-1.010, F.A.C.

- Be under the age of 21 years
- Be medically stable and not present significant risk to other children or personnel at the center
- **Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care due to a medically complex condition.** (emphasis added)

41. Florida Administrative Code Rule 59G-1.010 defines “medically complex” and “medically fragile” as follows:

(164) “Medically complex” means that a person has a 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 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. (emphasis added).

42. In the instant case, PPEC is requested to treat and ameliorate the supervisory monitoring, and continuous therapy needs, which Petitioner’s health conditions require. As such, in a general sense, PPEC is in keeping with Florida Administrative Code Rule 59G-1.010(166)(1). Because PPEC is a recognized Medicaid service, it is consistent with generally accepted medical standards, pursuant to Florida Administrative Code Rule 59G-1.010(166)(3).

43. More specifically, however, Florida Administrative Code Rule 59G-1.010(166) (2),(4), and (5) also requires that any authorized service not be in excess of a

patient's needs, be furnished in a manner not intended for convenience, and be a service for which no equally effective and less-costly treatment is available. In order for PPEC to fulfill these criteria, the Petitioner must meet the requirements for PPEC, as provided in the PPEC Handbook.

44. There is little evidence to suggest that the Petitioner is dependent upon 24-hour per day medical or nursing care, or that she is dependent upon life-sustaining medical intervention or equipment. The Petitioner is not on a complex medication regimen. She is taking one medication that is controlling her seizures, even though she may have sporadic episodes it does not rise to the level that requires "short, long-term, or intermittent continuous therapeutic interventions or skilled nursing care." Her simple seizures require monitoring and supervision by her mother. However, Dr. Mittal explained the parent can be trained to look for seizure activity and respond accordingly.
45. The Petitioner's level of illness does not reach the level of "medically complex" or "medically fragile," as defined in the Florida Administrative Code Rule 59G-1.010. She is on a regular age-appropriate diet, has no documented respiratory issues, is ambulatory, has frequent temper tantrums, and simple seizures. She does not have a gastrostomy tube ("G-tube) or any other feeding tube; does not use a ventilator for assistance with breathing, nor is she connected to any other medical equipment.
46. Similarly, although the Petitioner clearly requires continued therapy services, these services can be provided outside of the PPEC setting. As such, the provision of PPEC is currently in excess of Petitioner's medical needs.

47. When jointly considering the requirements of both ESPDT and Medical Necessity, along with a review of the totality of the evidence and legal authority, the undersigned concludes that the Petitioner has not met her burden of proof by a preponderance of the evidence and the Respondent correctly denied the Petitioner's initial request for PPEC services.
48. The Petitioner's mother is encouraged to follow through with her child's therapy referrals and make the appropriate arrangements for her child.

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 18 day of October, 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
AHCA Hearings Unit

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

FILED

Oct 07, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05478
16F-05499

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 07 Volusia

And

UNITED HEALTHCARE

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 19, 2016 at 1:08 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Susan Frischman, senior compliance analyst

STATEMENT OF ISSUE

At issue is the respondent's decision denying the petitioner's request for a biopsy procedure through Medicaid. Also at issue is the denial of the petitioner's request to change health plans.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts the numerous Health Maintenance Organizations (HMOs) to provide services to Medicaid enrollees. United Healthcare (United) is the contracted HMO in the instant case.

By notice dated July 12, 2016, United informed the petitioner that his request for "a biopsy or excision of lymph node(s) with an out of network provider" was denied because [t]he requested service was not a covered benefit.

The petitioner timely requested a hearing on July 20, 2016 to challenge the denial decision.

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

Present as a witness from Sunshine: Dr. Eina Fishman, chief medical officer. The Respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

Present as observers: Selwyn Gossett, Medicaid healthcare analyst with AHCA and Stephanie Twomey, hearing officer with the Office of Appeal Hearings.

The record was held open until close of business on September 26, 2016 for the submission of additional evidence. Evidence was received from the respondent and admitted as Respondent's Composite Exhibit 2. The record was closed on September 26, 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 6) is a Florida Medicaid recipient. The petitioner is enrolled with United HMO.
2. The petitioner's treating physician discovered a lump on the side of his neck two years ago. The petitioner underwent quarterly ultrasounds to determine if there was a change in the size of the lump. The tests results showed continuous growth.
3. When medications failed to reduce or diminish the lump, the petitioner's treating physician referred him to an otolaryngologist, an ear, nose, and throat (ENT) specialist, Dr. Angela Baker.
4. Dr. Baker submitted a prior service authorization to United to conduct a biopsy or excision of lymph node(s) on the petitioner at [REDACTED].
5. United denied the petitioner's request because Baptist Medical Center does not accept United health insurance. United explored having the petitioner's preferred [REDACTED] perform the procedure at a United participating medical center, [REDACTED], but [REDACTED] does not having operating privileges at that

facility. United provided the petitioner with the name of another ENT specialist who could perform the biopsy at [REDACTED].

6. United witnesses explained that when the petitioner began seeing [REDACTED] two years ago, [REDACTED] was a participating provider. May 2016, two months before the petitioner's ENT submitted the authorization request, [REDACTED] terminated its relationship with United. United cannot require that a provider continue to accept its plan. Providers have the right to choose which plans or HMOs it will accept.

7. The petitioner's mother explained that she declined United's offer to have the procedure performed by another ENT at another medical center because the petitioner has been working the [REDACTED] for two years. He has a rapport with [REDACTED]. The mother feels for continuity of care, it is best that [REDACTED] perform the biopsy.

8. The hearing record was held open until close of business on September 26, 2016 because United requested another opportunity to reach out to [REDACTED] and determine if there was a possibility that the center wanted to become a participating provider again. The undersigned received an electronic communication from United on September 26, 2016 which stated that it had over turned the biopsy denial decision and approved the requested procedure. However, United was "still awaiting confirmation from [REDACTED] that they will accept United Healthcare's authorization." There has been no additional communication from United.

9. The petitioner's mother asserted that she contacted AHCA to inquire about changing to an HMO that Baptist Medical Center accepts and was told that the

petitioner could not change plans because he was not in an open enrollment period during which HMO changes are allowed. The petitioner's mother did not have a copy of a denial notice from AHCA, she stated the denial was verbal. AHCA did not have a participating witness at the hearing, only an observer who declined to testify in this matter. The record was held open until close of business on September 26, 2016 for the petitioner's mother to provide a denial notice from AHCA. No additional information was received from the petitioner's mother and she did not request a deadline extension.

CONCLUSIONS OF LAW

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

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

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

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

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

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

DENIAL OF REQUESTED MEDICAL PROCEDURE WILL BE ADDRESSED

FIRST

16. Section 409.902, Florida Statutes, addresses reimbursement of Medicaid providers reads in pertinent part:

(1) The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These **payments shall be made**, subject to any limitations or directions provided for in the General Appropriations Act, **only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law** [emphasis added]. This program of medical assistance is designated the “Medicaid program.”...

(2) Eligibility is restricted to United States citizens and to lawfully admitted noncitizens who meet the criteria provided in s. 414.095(3).

(a) Citizenship or immigration status must be verified. For noncitizens, this includes verification of the validity of documents with the United States Citizenship and Immigration Services using the federal SAVE verification process.

17. The cited authority explains that Medicaid payments can only be made to qualified (participating) providers.

18. United initially denied the petitioner’s request for a neck biopsy because the petitioner’s preferred provider, [REDACTED], does not accept United HMO health insurance. United later reversed its denial decision and approved the requested procedure. However, the petitioner’s preferred provider, [REDACTED], still does not accept United HMO health insurance. The undersigned found no regulation

which allows for payment to a provider that has chosen not to accept a patient's health insurance. The appeal is denied.

HMO PLAN CHANGE WILL NOW BE ADDRESSED

19. The petitioner asserted that the respondent denied his request to change HMOs. The record was held open for the petitioner to provide a denial notice which would establish an appealable adverse agency action. The petitioner did not provide a notice and did not contact the undersigned to request a deadline extension.

20. Fla. Admin. Code § 65-2.056 Basis of Hearings reads in pertinent part:

The Hearing shall include consideration of:

(1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on

eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.

(2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.

(3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision.

21. The cited authority explains that fair hearings are afforded to recipients involving the denial, termination or reduction of government benefits. The petitioner provided no evidence of a written notice denying his request to change HMO plans. This issue is not ripe for appeal and is hereby dismissed as non-jurisdictional.

DECISION

The medical procedure appeal is denied. The HMO plan change appeal is dismissed as non-jurisdictional.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 07 day of October, 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]
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

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

FILED

Oct 31, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05507

PETITIONER,

Vs.

CASE NO.

MANAGED CARE ORGANIZATION,
AND AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT:

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter telephonically on September 26, 2016, at 10:55 a.m.

APPEARANCES

For the petitioner:

[REDACTED]
[REDACTED]

For the Respondent:

Christian Laos
Senior Compliance Analyst
United Healthcare

STATEMENT OF ISSUE

Did the petitioner prove by a preponderance of the evidence that the respondent incorrectly denied her request for an automotive wheelchair lift?

PRELIMINARY STATEMENT

The petitioner's spouse and attorney-in-fact may sometimes hereinafter be referred to as the petitioner's "representative."

Sloan Karver, M.D., Long-Term Care Medical Director for United Healthcare, appeared as a witness on behalf of the respondent. Stephanie Lang, R.N., Registered Nurse Specialist and Fair Hearing Coordinator with the Agency for Health Care Administration ("AHCA" or "Agency"), was present solely for the purpose of observation.

The petitioner introduced Exhibits "1" and "2," inclusive, at the hearing, which were accepted into evidence and marked accordingly. The respondent introduced Exhibits "1" through "5", inclusive, at the hearing, which were accepted into evidence and marked accordingly.

The hearing record in this matter was left open until the close of business on September 30, 2016 for the respondent to provide additional information including, but not limited to, the applicable statutes and rules, the member handbook, and the relevant portions of the contract between the Agency for Health Care Administration and United Healthcare. Once received, this information was accepted into evidence and marked as respondent's Exhibit "6." The hearing record was then closed.

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 70-year-old female.
2. Petitioner was eligible to receive Medicaid benefits at all times relevant to these proceedings.

3. Petitioner is enrolled in the United Healthcare Community Plan. United Healthcare is a managed care organization (“MCO”) contracted by the Agency for Health Care Administration to provide services to certain Medicaid eligible recipients in the State of Florida.

4. Petitioner’s effective date of enrollment in United Healthcare Community Plan was August 1, 2014.

5. On or about July 7, 2016, the petitioner’s medical provider submitted a prior authorization request to United Healthcare Community Plan for an automotive wheelchair lift.

6. A wheelchair lift is a mechanical platform designed to raise and lower to allow an individual with a wheelchair to easily enter and exit a vehicle.

7. In a Notice of Action dated July 8, 2016, United Healthcare Community Plan notified the petitioner it was denying her request for a wheelchair lift.

8. The Notice of Action states: “The requested service is not a covered benefit.” It also goes on to explain: “The facts that we used to make our decision are: You asked for a car lift. The long term care health plan does not cover this. It is not a covered benefit. The request is not approved.”

9. On or about July 21, 2016, the petitioner requested an administrative hearing and this proceeding ensued.

10. The petitioner is diagnosed with [REDACTED].

11. The petitioner is confined to a wheelchair. She cannot stand independently.

12. The petitioner’s primary caregiver is her husband of over 50 years. The petitioner’s husband is 72-years-old.

13. The petitioner attends multiple medical and other appointments outside her home.

14. The petitioner's representative requested the wheelchair lift so it could be installed on his vehicle.

15. The petitioner presently requires the assistance of two individuals to be placed into and removed from the vehicle driven by the petitioner's representative.

16. The purpose of the petitioner's request for a wheelchair lift was to facilitate her placement in and removal from the vehicle without having to be removed from her wheelchair.

17. The United Healthcare Long-Term Care Medical Director at the hearing testified that a wheelchair lift is not a covered benefit under the petitioner's health plan.

18. The United Healthcare Long-Term Care Medical Director at the hearing also testified the petitioner may opt to use a medical transportation service that is able to accept recipients in wheelchairs. She explained such a service is a covered benefit under the petitioner's health plan.

19. The petitioner's representative provided an example of a transportation service with which he is familiar and explained that, although the service is good about picking up people on time for their appointments, the service may take as long as a few hours to pick up a patient after an appointment.

CONCLUSIONS OF LAW

20. 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 Section 120.80, Florida Statutes.

21. 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.

22. Goods and services requested under the Florida Medicaid Program must be shown to be medically necessary in order to be approved.

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

24. The petitioner in the present case 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.

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. Section 409.905, Florida Statutes, addresses mandatory Medicaid services under the State Medicaid Plan and explains as follows:

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...

(a) The agency shall require prior authorization of home health services....

(c) The agency may not pay for home health services unless the services are medically necessary ...

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

28. The Florida Medicaid Home Health Services Coverage and Limitations Handbook, on Page 2-27, states as follows: Home health agencies that provide DME must comply with the policies and procedures contained in this handbook and in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

29. The Florida Medicaid Provider General Handbook (July 2012) is incorporated by reference and promulgated into Rule by 59G-5.020, Florida Administrative Code. 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.

30. Page 1-28 of the Florida Medicaid Provider General Handbook provides a list of HMO covered services. These services include durable medical equipment.

31. 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.”

32. In order for durable medical equipment and supplies to be approved, the equipment and supplies must not only be medically necessary but must also meet all requirements set forth in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook.

33. Although the terms medically necessary and medical necessity are often used interchangeably and may be used in a variety of contexts, their definition for Florida Medicaid purposes is contained in 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.

(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.

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

“Medical necessity” or “medically necessary” means any goods or services necessary to palliate the effects of a terminal condition, or 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. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (July 2010) (“DME Handbook”) is incorporated by reference and promulgated into Rule by 59G-4.070, Florida Administrative Code.

37. The DME Handbook describes the covered services, limitations, and exclusions associated with the acquisition and reimbursement of durable medical equipment and medical supplies obtained through the Medicaid program.

38. The DME Handbook sets forth the definition of durable medical equipment on Page 1-2. "Durable medical equipment (DME) is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home as determined by the Agency for Health Care Administration (AHCA)."

39. The DME Handbook, on Page 2-98, lists a wheelchair lift as a non-covered item.

40. The United Healthcare Community Plan Health and Home Connection Enrollee Handbook, on Page 26, explains transportation services are a covered benefit. It defines transportation services as follows: "Non-emergency transportation is offered to and from services as described in the enrollee's plan of care."

41. In the present case, wheelchair lifts are specifically listed as non-covered items in the DME Handbook. The item is also not a covered item in the United Healthcare member handbook. Furthermore, the definition of medical necessity contained in Rule 59G-1.010, above, specifies that a service may not be approved if any equally effective and more conservative or less costly treatment is available and that a service must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. The transportation service offered by the respondent's witness during the hearing is an equally effective and less costly alternative to a wheelchair lift. Therefore, the respondent correctly denied the petitioner's request for the wheelchair lift.

42. After a careful evaluation of the facts in this case along with the authorities set forth above, the hearing officer concludes the petitioner has not met her burden of proof to demonstrate that the respondent incorrectly denied her request for a wheelchair lift.

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 31 day of October, 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:

████████████████████
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

FILED

Oct 17, 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-05585

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Citrus
UNIT: 88999

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:38 a.m. on August 31, 2016.

APPEARANCES

For the Petitioner: [REDACTED]
[REDACTED]

For the Respondent: Joyce Miller, Esq.
Department of Children and Families

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner Medicaid Institutional Care Program (ICP) benefits for March 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 legal counsel, who was also the petitioner's Attorney-in-fact. Appearing as witnesses for the respondent from the

Department of Children and Families, ACCESS were Stan Jones, Economic Self-Sufficiency Specialist II and Kane Lamberty (KL), Senior Human Services Program Specialist.

Petitioner submitted one exhibit, entered as Petitioner Exhibit "1". Respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The Hearing Officer requested that the parties submit Proposed Orders by September 12, 2016. Petitioner's counsel requested the date for Proposed Orders be extended because he was returning from vacation on September 12, 2016. Request was granted, the record remained open until September 19, 2016, for the parties to submit Proposed Orders. Neither party submitted Proposed Orders by the required September 19, 2016 date. The record was closed on September 19, 2016.

FINDINGS OF FACT

1. Petitioner was admitted to [REDACTED] on March 7, 2016. She remained at the Nursing Center until her death on [REDACTED].
2. On March 16, 2016, the petitioner's counsel submitted a "Statement In Support Of Claim" request to the Department of Veteran Affairs (VA). The request in part states:

The above [petitioner] mentioned ward is now a Medicaid patient in a Nursing Home. She is also under Hospice care and is 90 years of age. Therefore we request immediate attention. As the Fiduciary of the above mentioned, I request that immediate action be taken to reduce the beneficiary's Improved Pension to the \$90 Medicaid rate.

3. Petitioner's counsel received a letter from the VA, dated March 17, 2016, that states in part:

We have received your application for benefits. It is our sincere desire to decide your case promptly. However, as we have a great number of claims, action on yours may be delayed. We are now in the process of

deciding whether additional evidence or information is needed. If we need anything else from you, we will contact you...

4. On May 16, 2016, an ICP application was submitted on behalf of the petitioner. The application lists \$1,564.90 income from the VA and \$824.90 income from the Social Security Administration (SSA).
5. The Department verified that the petitioner received \$1,564.90 from the VA and \$986 from the SSA, totaling \$2,550 income, in March 2016.
6. Petitioner's counsel did not dispute the petitioner's income from the SSA. And agreed that the petitioner received \$1,564.90 from the VA in March 2016. Petitioner's counsel stated that the VA would take back the \$1,564.90 the petitioner received in March 2016, once they approved the \$90 Medicaid rate.
7. The income limit for the petitioner to be eligible for ICP benefits is \$2,199 monthly. Petitioner's \$2,550 March 2016 income exceeds the ICP income limit.
8. On June 16, 2016, the Department mailed Hospice of Citrus County a Notice of Case Action, notifying the May 16, 2016 Medicaid application was denied, "Reason: your household's income is too high to qualify for this program."
9. Statement from U.S. Department of the Treasury, dated June 16, 2016, shows the Government retrieved the petitioner's \$1,564.90 VA benefits for April 2016, May 2016 and June 2016. The statement states in part, "The Government has received information that the person named [petitioner] on this notice is deceased. The purpose of this notice is to inform you that by law entitlement to Government benefits of this person ended at death."

10. Petitioner's counsel opined that the petitioner would be under the ICP income limit, once the VA takes back the petitioner's \$1,564.90 VA benefits for March 2016.

11. KL, the respondent's witness, stated that the petitioner is not eligible for ICP benefits because she received \$2,550 income in March 2016. KL said that the only way the petitioner would have been eligible for ICP benefits in March 2016 is if an income trust had been created and funded.

12. Petitioner's counsel responded that he was unable to establish an income trust for the petitioner after her death because his Attorney-in-fact ended when the petitioner died.

13. Petitioner's counsel "believes" that in accordance with the Department's policy 1840.0108, the petitioner's \$1,564.90 VA income is unavailable to the petitioner.

CONCLUSIONS OF LAW

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

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

16. Federal Regulation at 20 C.F.R. § 416.1120 states, "Unearned income is all income that is not earned income. We describe some of the types of unearned income in §416.1121. We consider all of these items as unearned income, whether you receive them in cash or in kind."

17. Federal Regulation at 20 C.F.R. § 416.1121 Types of unearned income in part states:

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits...

e) Death benefits. We count payments you get which were occasioned by the death of another person...

18. In accordance with the above authority, the Department included the petitioner's \$986 unearned income from the SSA and \$1,564.90 unearned income from the VA in determining her ICP benefits eligibility.

19. Petitioner's counsel argued that the VA will take back the petitioner's \$1,564.90 VA income she received in March 2016, once the VA approves the \$90 Medicaid rate.

20. The evidence submitted establishes that the petitioner's counsel requested that the VA reduce the petitioner's \$1,564.90 VA compensation to the \$90 Medicaid rate on March 16, 2016.

21. The evidence submitted establishes that the U.S. Department of the Treasury, retrieved the petitioner's \$1,564.90 VA benefits for April 2016, May 2016 and June 2016. However, the petitioner's counsel did not submit evidence to support that the VA will take back the petitioner's \$1,564.90 VA benefits she received in March 2016.

22. Petitioner's counsel argued that in accordance with the Department's Policy Manual 1840.0108, the petitioner's \$1,564.90 VA income is not available to her.

23. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1840.0108, Available Income (MSSI, SFP) states:

Income must be available to meet the SFU's needs to be considered, except in the case of lump sum income. Generally, income is considered available when it is actually available and/or when the individual has the legal ability to make the income available.

Exceptions to the policy above:

Occasionally, a regular monthly payment (e.g., Title II or VA) is received in a month other than the month of normal receipt. As long as there is no interruption in the regular payment schedule, consider the funds to be income in the normal month of receipt. Examples of this situation are as follows:

1. Advance Dated Checks - When a payor advance dates a check because the regular payment date falls on a weekend or holiday, there is no intent to change the normal delivery date. Whenever such an advance dated check goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable.
2. Electronic Funds Transfer - When an individual's money goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable. Whenever this occurs, treat the electronically transferred funds as income in the month of normal receipt.
3. Florida State Retirement benefits are received the last workday of the month. The payment is considered income in the following month for SSI-Related Programs.
4. Income may be unavailable due to legal restrictions or factors beyond the control of the individual. In both these situations, the eligibility specialist must request supporting evidence and make an independent assessment regarding availability based on the evidence presented. Additional guidance may be requested from the Region or Circuit Program Office, Headquarters, or Circuit Legal Counsel.

24. The evidence submitted establishes that the petitioner received \$1,564.90 from the VA and \$986 from the SSA in March 2016. Evidence was not presented that the \$2,550 income the petitioner received in March 2016 was unavailable to the petitioner.

25. Federal Regulation at 20 C.F.R. § 416 1124 Unearned income we do not count states in part:

(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your

unearned income below zero or apply any unused unearned income exclusion to earned income except for the \$20 general exclusion described in paragraph (c)(12) of this section...

(c) Other unearned income we do not count. We do not count as unearned income—

- (1) Any public agency's refund of taxes on real property or food;
- (2) Assistance based on need which is wholly funded by a State or one of its political subdivisions...
- (3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses...
- (4) Food which you or your spouse raise if it is consumed by you or your household;
- (5) Assistance received under the Disaster Relief and Emergency Assistance Act...
- (6) The first \$60 of unearned income received in a calendar quarter if you receive it infrequently or irregularly...
- (7) Alaska Longevity Bonus payments...
- (8) Payments for providing foster care to an ineligible child...
- (9) Any interest earned on excluded burial funds...
- (10) Certain support and maintenance assistance...
- (11) One-third of support payments made to or for you by an absent parent if you are a child...
- (12) The first \$20 of any unearned income...
- (13) Any unearned income you receive and use to fulfill an approved plan to achieve self-support if you are blind or disabled...
- (14) The value of any assistance paid with respect to a dwelling unit under...
- (15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement...
- (16) The value of any commercial transportation ticket...
- (17) Payments received by you from a fund established by a State to aid victims of crime...
- (18) Relocation assistance provided you by a State or local government that is comparable to assistance provided under title II of the Uniform...
- (19) Special pay received from one of the uniformed services...
- (20) Interest or other earnings on a dedicated account...
- (21) Gifts from an organization...
- (22) Interest and dividend income from a countable...
- (23) AmeriCorps State and National and AmeriCorps National Civilian Community Corps cash or in-kind payments to AmeriCorps participants or on AmeriCorps participants' behalf...
- (24) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:
 - (i) A veteran (as defined in 38 U.S.C. 101); and
 - (ii) Blind, disabled, or aged.

26. The above authority lists unearned income not counted by the Department in determining eligibility, none of which apply to the petitioner.

27. 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...

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate (emphasis added) after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C...

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP...(emphasis added)

(e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional programs.

(3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individual's account, or when it is set aside for their use, whichever is earlier. (emphasis added)

(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...

28. The above authority explains that gross income cannot exceed 300% of the SSI federal benefit rate to be eligible for ICP benefits. And an income trust may be established for those that exceed the income standard.

29. Policy Manual, Appendix A-10 (January 2016), sets the federal benefit rate for an individual at \$733 (300% of \$733 = \$2,199).

30. Policy Manual, Appendix A-9 (July 2015), sets \$2,199 as the ICP income standard for an individual.

31. The findings show that an income trust was not established for the petitioner. Therefore, the petitioner's total income was available to be counted in the ICP eligibility determination for March 2016.

32. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the respondent's action to deny the petitioner Medicaid ICP benefits for March 2016 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 17 day of October, 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
[REDACTED]
Joyce Miller, Esq.

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

FILED

Oct 13, 2016

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-05617

PETITIONER,
VS.

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

AND

COVENTRY HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on August 30, 2016 at 3:00 p.m.

APPEARANCES

For Petitioner:



For Respondent: Fathima Leyva, Senior Program Specialist
Agency for Health Care Administration

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for a power scooter was proper. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted as evidence for the hearing her own letter and a letter from her physician, which were marked as Petitioner composite Exhibit 1. The petitioner also submitted a CD containing an image of an x-ray of her leg, which was marked Petitioner Exhibit 2.

Appearing as witnesses for the respondent were Dr. Jorge Cabrera, Medical Director, Maureen McNamara, Grievance and Appeals Manager, and Summer Brooks, Contract Manager, from Coventry Healthcare, which is the petitioner's managed care health plan. Coventry Healthcare was included as an additional respondent in this proceeding pursuant to its request to be added as a party

The Respondent submitted the authorization request, denial notice, and medical records as evidence for the hearing, which were marked as Respondent composite Exhibit 1.

FINDINGS OF FACT

1. The petitioner is a fifty-four (54) 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 Coventry Healthcare.

2. On or about July 13, 2016, the petitioner submitted a request to Coventry for approval of a power scooter (power operated vehicle). Coventry denied this request on July 14, 2016.

3. The denial notice stated the power scooter was denied as not being medically necessary. This denial notice also stated the following regarding the reason for the denial:

Per Medicaid rules (Florida Medicaid DME Handbook, pages 2-91, 2-92), a wheelchair or power operated vehicle is medically necessary when the patient cannot walk (non-ambulatory) or has a severe limited mobility problem and needs this type of equipment in order to complete his/her activities of daily living in the home. These activities include bathing, eating, toileting, dressing, and transferring in and out of a bed or chair as well as moving around inside the home. Based on the medical notes we received, you are able to move around using a cane and only need the scooter for long distances outside of your home

4. The petitioner stated she sustained compound leg fractures in a prior car accident and she had 3 inches of bone removed from her leg. She previously had a power scooter which broke down in 2015 and it could not be repaired due to a lack of parts. She was given a temporary replacement scooter but it was too big for her and it was eventually taken away. She also stated her records may reflect she was issued a new scooter in 2014, but she never received a scooter at that time.

5. The petitioner also stated she is able to walk short distances (about a half block), but needs the scooter for longer distances. She has [REDACTED] in her hand and she states she cannot use a manual wheelchair.

6. The respondent's witness, Dr. Cabrera, stated the petitioner does not qualify for a power scooter because she does not need it for mobility in her home since she uses a cane to ambulate indoors. He also stated the purpose of a power scooter is not for long-distance ambulation or for convenience. There must also be some upper extremity weakness to qualify for a power scooter. The existence of [REDACTED]

not necessarily mean an individual cannot operate a manual wheelchair. He stated Coventry never approved a new scooter for the petitioner but Coventry may be able to assist with repairs to her existing scooter.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

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

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

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

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

(a) Meet the following conditions:

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

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

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

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

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

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

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

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

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

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

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

Has demonstrated that he possesses sufficient eye and hand perceptual capabilities and the cognitive skills necessary to safely operate and guide the chair or POV independently, and is capable of evacuating a residence or building with minimal or no verbal prompting in case of an emergency; and
Currently resides in or will primarily use the equipment in an environment conducive to the use of a motorized wheelchair of the type and size wheelchair requested.

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

Recipient's medical necessity requires the use of a POV to independently move around his residence; and
Recipient is physically unable to operate a manual wheelchair; and
Recipient is capable of safely and independently operating the controls for the POV requested; and
Recipient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV; and
An independent licensed physical therapist, occupational therapist or physiatrist has determined and documented his recommendation of the most appropriate and medically-necessary POV to meet the recipient's individual mobility needs; and
The recipient does not have a wheelchair that was purchased by Medicaid within the past five years.

21. The petitioner believes the power scooter should be approved because she needs it for long distances. She also stated she cannot use a manual wheelchair due to her [REDACTED]

22. The respondent's position is that the petitioner does not qualify for a power scooter since she can ambulate with a cane inside her home and there is no indication of upper extremity weakness.

23. After considering the evidence and testimony presented, the undersigned concludes that the petitioner has not met her burden of proof in demonstrating that the

power scooter should have been approved. According to the DME Handbook provisions, an individual must demonstrate "severe abnormal upper extremity dysfunction or weakness" and must need the power scooter to "independently move around [the] residence." Neither of these requirements was met in this case since the petitioner is able to ambulate short distances with a cane.

DECISION

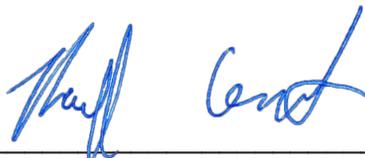
Based upon the foregoing Findings of Fact and Conclusions of Law, the Petitioner's appeal is hereby DENIED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 13 day of October, 2016,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

16F-05617

Page 9 of 9

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

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

FILED

Oct 07, 2016

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-05621
16F-05622

PETITIONER,

Vs.

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

And

SIMPLY HEALTHCARE,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 31, 2016 at 11:30 a.m.

APPEARANCES

For the Petitioner:



For the Respondent:

Monica Otalora, Senior Program Specialist
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's request for wisdom teeth extractions (appeal number 16F-5621) and denial of a dental crown (16F-5622)

were correct. The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing in this matter was originally scheduled for August 30, 2016, but was rescheduled to August 31, 2016 upon verbal notice to the parties since the respondents did not receive one of the hearing notices.

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 is the petitioner's dental services review organization. Also present as witnesses for the respondent were Debra Zamora, Grievance and Appeals Specialist, 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 pursuant to its request to be added as a party.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Exhibits: Exhibit 1 – Statement of Matters and Authorization Request; Exhibit 2 – Denial Notice; Exhibit 3 – Dental Review and Dental Criteria.

Also present for the hearing was a Spanish language interpreter, [REDACTED]

[REDACTED].

FINDINGS OF FACT

1. The petitioner is a seventeen (17) year-old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Managed Medical Assistance (MMA) plan. She receives services under the plan from Simply Healthcare, which utilizes DentaQuest for review and approval of dental services.
2. On or about July 14, 2016, the petitioner’s treating dentist (hereafter referred to as “the provider”), requested prior authorization from DentaQuest to perform extractions of four wisdom teeth (Teeth 1, 16, 17, and 32). DentaQuest denied this request on July 15, 2016.
3. The denial notice stated the extractions were denied as not being medically necessary. This denial notice also stated the following regarding the reason for the denial:

The information your dentist sent shows your tooth does not need to be removed. Your tooth has no sign of infection and your dentist has not told us that you are in pain.
4. The petitioner also requested approval of a dental crown. That request was initially denied by DentaQuest, but subsequently approved prior to the hearing. Therefore, the issue of the dental crown became moot and was not addressed during the hearing.
5. The petitioner’s mother stated her daughter has swelling and inflammation in the back of her mouth and her dentist told her the wisdom teeth need to be removed. The dentist told her it is better to remove the teeth now to avoid complications later. She also stated the wisdom teeth are pushing the adjacent teeth out of position.

6. The respondent's expert witness, Dr. Dorrego, stated that the extraction of the wisdom teeth was denied since the information submitted did not indicate infection, pain, or aberrant position. The pain must be something beyond the normal pain associated with erupting teeth, and this was not described in the provider's narrative. The prophylactic removal of wisdom teeth is not considered a covered benefit. Dr. Dorrego also stated the submitted x-rays showed the wisdom teeth in a normal relationship to the adjacent teeth and the wisdom teeth should erupt in a normal manner.

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 and Limitations Handbook ("Dental Handbook"), effective November 2011.

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. The Medicaid Handbook and the Dental Handbook 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 denied the request for extractions due to medical necessity considerations.

15. The petitioner's mother believes the extractions should have been approved because her daughter has pain and inflammation and she does not want the condition to worsen.

16. The respondent's witness stated that the denial of the extractions was appropriate because there was no infection, abnormal pain, or aberrant position.

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).

18. 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. Although the petitioner has symptoms of pain and inflammation, the provider's narrative does not establish that those symptoms are beyond what is associated with normal tooth eruptions. In addition, the x-rays showed the wisdom teeth in a normal position relative to the adjacent teeth.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, appeal number 16F-5621 is DENIED. Appeal number 16F-5622 is DIMISSED as moot as described above.

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 October, 2016,

in Tallahassee, Florida.



Rafael Centulion
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
AHCA, MEDICAID FAIR HEARINGS UNIT
SIMPLY HEARINGS UNIT

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

FILED

Oct 12, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05635

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88287

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 23, 2016 at approximately 10:00 a.m. CDT. The hearing was reconvened on September 27, 2016 at approximately 8:30 a.m. CDT.

APPEARANCES - August 23, 2016

For the Petitioner: [REDACTED] [REDACTED]
[REDACTED]

For the Respondent: Nicole Nuriddin, economic self-sufficiency specialist II
Mike Basdeo, Division of Disability Determination unit supervisor

APPEARANCES - September 27, 2016

For the Petitioner: [REDACTED] [REDACTED]
[REDACTED]

For the Respondent: Nicole Nuriddin, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of April 29, 2016 denying Medicaid based on the decision that the petitioner does not meet disability criteria. 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 as marked as Respondent's Exhibits "1" through "8".

The record was left open on August 23, 2016 for the petitioner to submit the disability decision made by an Administrative Law Judge (ALJ). It was received on September 7, 2016 and admitted into evidence and marked as Petitioner's Exhibit "1".

The hearing reconvened on September 27, 2016 allowing both parties the opportunity to comment on the content of the decision. The record was closed on September 27, 2016.

FINDINGS OF FACT

1. On January 19, 2016, the petitioner submitted an application to the respondent requesting SSI-Related Medicaid (Respondent's Exhibit 2).
2. On February 29, 2016, a disability determination packet was sent to DDD, the Division of Disability Determinations, for them to complete a determination of disability (Respondent's Exhibit 1).
3. The petitioner's household consists of herself (age 46) and her husband, DD, (age 62). The household's total monthly income is \$2,112.88, consisting of DD's earned income (\$1,390.88) from [REDACTED] and his \$722 from Social Security (Respondent's Exhibit 1).

4. The disability determination was received by the respondent on April 29, 2016. The petitioner was determined not to meet disability criteria. The denial reason code was N-32 (Non-pay—Capacity for substantial gainful activity – other work, no visual impairment) (Respondent's Exhibit 1). This determination included case analysis containing a summary of the decision made by the DDD (Respondent's Exhibit 5).

5. On December 28, 2012, the petitioner applied with the Social Security Administration (SSA) for Social Security Disability Insurance and Supplemental Security Income (Respondent's Exhibit 6). ON February 11, 2016, the petitioner received notification from the SSA Office of Disability Adjudication and Review that the decision was unfavorable (Petitioner's Exhibit 1). The most recent denial from SSA was received by a notice mailed on July 13, 2016. The petitioner is in the process of preparing to take the issue before the federal court.

6. The conditions considered in the DDD decision include; [REDACTED]
[REDACTED]
[REDACTED] (Respondent's Exhibit 5).

7. The conditions considered in the decision of the ALJ include; [REDACTED];
[REDACTED]
[REDACTED]

8. The petitioner's representative asserts that the petitioner's conditions of [REDACTED]s,
[REDACTED]
and vision were not considered in the ALJ's decision (Petitioner's Exhibit 1).

9. Upon further review on the record of the ALJ's decision, it was agreed that the only conditions on the petitioner's list that may not have been directly or indirectly

considered by the ALJ were [REDACTED]. Upon inquiry, it was determined that the petitioner's [REDACTED] was diagnosed two or three years ago and the petitioner has had a breathing machine for the condition since 2014; that there is no diagnosis of [REDACTED], rather a physician commented in 2005 or 2006, that there were some symptoms that may indicate [REDACTED]; and that the petitioner has not had a stroke after the medical information was submitted to the ALJ. Petitioner also reported that she has "always had [REDACTED]." The hearing officers finds no new conditions to be considered in a disability determination.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.
11. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
12. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
13. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determination 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...

14. In accordance with the above authority, the respondent submitted the application to DDD as it states the Department must make a determination of disability if the individual "alleges a disabling condition different from, or in addition to, that considered by the SSA in making its determination". On April 29, 2016, DDD submitted to the

respondent, a decision of Not Disabled. The petitioner requests that the hearing officer complete an independent determination of her disability.

15. The hearing officer concludes that the petitioner does not have different medical conditions that have not been reported to the SSA and understands that the petitioner is pursuing the possibility of taking the failed SSA appeal to the federal court. The hearing officer also concludes that all pertinent conditions were considered by DDD in its recent review; therefore, reevaluation of the disability determination would conclude with the same result.

16. In careful review of the cited authority and evidence, the hearing officer agrees with the respondent's action to deny petitioner Medicaid based on the decision of DDD.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 12 day of October, 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]
Office of Economic Self Sufficiency
[REDACTED]

FILED

Sep 26, 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]

PETITIONER,

Vs.

APPEAL NO. 16F-05652
16F-05653

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88006

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 23, 2016 at 8:30 a.m.

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the following:

I. The amount of Food Assistance Program (FAP) benefits she is eligible to receive beginning June 2016. She is seeking an increase. The petitioner carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to terminate full Medicaid benefits for herself and her minor son, and instead; enroll them in the Medically Needy (MN) Program with a share

of cost (SOC). Petitioner is seeking full Medicaid for her and her minor son. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any exhibits. The respondent submitted five exhibits, entered as Respondent's Exhibits "1" through "5".

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving full Medicaid and \$511.00 in FAP benefits for herself and her sons JC (age 21) and KC (age 14). The petitioner was certified for FAP benefits for a six-month period, from December 2015 through May 31, 2016. Medicaid benefits were certified from June 2015 through July 2016.
2. On May 26, 2016, the petitioner reported to the Department her adult son JC moved out of the home. No action was taken on the FAP benefits because the certification period was ending on May 31, 2016.
3. JC was removed from the Medicaid benefits on June 3, 2016. On June 6, 2016, the respondent sent a Notice of Case Action notifying the petitioner that her Medicaid benefits were ending on June 30, 2016 and that she was enrolled in the MN Program with a \$1,511.00 SOC beginning July 2016. Said notice also notified the petitioner that JC's Medicaid benefits were ending on June 30, 2016 and that KC was eligible for continued Medicaid coverage.
4. On June 3, 2016, the petitioner submitted an application to recertify her Medicaid and FAP benefits for June 2016. On this application she listed herself and her two

sons. The petitioner listed her monthly expenses as rent of \$1,295.00, water, and electricity. Petitioner listed her monthly sources of income as her long term disability (LTD) benefits and child support income for KC.

5. The petitioner completed a phone interview on June 3, 2016. During the interview, the petitioner reported her LTD benefits and child support income are irregular. She also explained JC was in the household and employed; however, she did not want to include him in her case.

6. On June 6, 2016, the respondent sent a pending notice to the petitioner requesting proof of her LTD benefits and child support income. On June 29, 2016, the petitioner submitted to the respondent her LTD statement from Sun Life Financial which shows she started to receive \$2,053.86 a month beginning January 2016. She also provided a payment history report from ██████████ County Child Support Enforcement Agency which indicates the petitioner received child support income on June 6, 2016 for \$67.60, June 13, 2016 for \$56.34 and June 20, 2016 for \$56.34. The respondent added these child support checks to calculate the petitioner's monthly child support income of \$180.28 ($\$67.60 + \$56.34 + \$56.34 = \180.28); no conversion factor was used to calculate the monthly child support income.

7. The combined household income was \$2,234.14. However, the respondent determined the income calculation as \$2,234.06. The respondent determined the petitioner was eligible for \$14.00 in FAP benefits for June 2016 and \$16.00 for July 2016 through November 2016. The respondent calculated the petitioner's FAP benefits for June 2016 and ongoing as follows:

ABFN FOOD STAMP NET INCOME BUDGET

		TOTAL GROSS INCOME:	2234.06
		EARNED INCOME DEDUCTION:	- .00
		STANDARD DEDUCTION:	- 155.00
TOTAL MEDICAL COSTS:	.00		
MEDICAL DEDUCTION:	- .00		
EXCESS MEDICAL EXPENSES:	= .00	EXCESS MEDICAL EXPENSES:	- .00
		DEPENDENT CARE DEDUCTION:	- .00
SHELTER COSTS:	1295.00	CHILD SUP PAYMENT DEDUCT:	- .00
UTILITY STD. (SUA/ BUA/ PH) :	+ 345.00	HOMELESS INCM DEDUCTION:	- .00
SHELTER/UTILITY COSTS:	= 1640.00	ADJUSTED INCOME:	= 2079.06
SHELTER STD (50% ADJ NET INC):	- 1039.53		
EXCESS SHELTER/DEDUCTION:	= 600.47	SHELTER DEDUCTION:	- 504.00
		FOOD STAMP ADJ INCOME:	= 1575.06
ASSISTANCE GROUP SIZE:	2	MAX NET MONTHLY INCOME:	1328.00

8. The maximum monthly allotment of FAP benefits for a household size of two is \$357.00. To determine the petitioner's FAP benefits amount, the Department took 30% of \$1,575.06 (Adjusted income after deductions) to calculate the benefit reduction of \$473.00. The benefit reduction exceeds the maximum FAP benefits amount; however, the respondent determined the petitioner is eligible to receive the minimum monthly allotment of \$16.00.

9. On June 30, 2016, the respondent mailed a Notice of Case Action to the petitioner informing her she was approved for \$14.00 in FAP benefits for June 2016 and \$16.00 per month in FAP benefits for July 2016 through November 30, 2016.

10. The respondent explained that in the previous FAP budget, the petitioner's LTD benefits were not included in the FAP eligibility determination. The Department was not aware of the petitioner's LTD benefits until she submitted her application on June 3, 2016.

11. JC is under 22 years of age, employed, and is a mandatory member in the FAP benefits. It is unknown why JC was not included in the petitioner's FAP eligibility determination.

12. The respondent also terminated full Medicaid benefits for the petitioner and her minor son KC. The respondent excluded the child support income from the Medicaid budget. The respondent first determined KC's Medicaid eligibility. The countable household income of \$2,053.86 was compared to the Medicaid income limit for a child between the ages of 6 through 18 in a household size of two (\$1,776.00), the respondent determined the petitioner's son KC was not eligible for full Medicaid benefits.

13. The respondent explained KC was not eligible for full Medicaid benefits because the household income exceeded the Medicaid income limits for his age group.

14. The respondent then determined Medicaid eligibility for the petitioner. The countable household income of \$2,053.86 was compared to the Medicaid income limit for a parent in a household size of two (\$241.00), the respondent determined the petitioner was not eligible for full Medicaid benefits as the household income exceeded the Medicaid income limits.

15. To determine the petitioner and KC's MN SOC amount, the respondent determined the Medically Needy Income Level (MNIL) for a household size of two was \$387.00. This amount was subtracted from the countable household income of \$2,053.86, resulting in a SOC amount of \$ 1,666.00. It is unknown how the respondent determined the petitioner's SOC of \$1,511.00 for June 2016.

CONCLUSIONS OF LAW

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

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

FOOD ASSISTANCE ISSUE

18. The Code of Federal Regulations 7 C.F.R. § 273.9 defines "Income" and "Deductions" 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; 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; strike benefits; foster care payments for children or adults who are considered members of the household; gross income minus the cost of doing business derived from rental property in which a household member is not actively engaged in the management of the property at least 20 hours a week.

(iii) Support or alimony payments made directly to the household from nonhousehold members.

...

(d) Income deductions. Deductions shall be allowed only for the following household expenses:

(1) Standard deduction...

(6) Shelter costs...

(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...

(iii) Standard utility allowances.

19. 7 C.F.R. § 273.10 addresses budgeting and benefit levels in the FAP and states in

relevant part:

(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...

(C) Subtract the standard deduction...

(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 up to the maximum amount allowed for the area... from the household's monthly income after all other applicable deductions... The household's net monthly income has been determined...

(2) Eligibility and benefits...

(ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:

(1) The State agency shall round the 30 percent of net income up to the nearest higher dollar; or

(2) The State agency shall not round the 30 percent of net income at all. Instead, after subtracting the 30 percent of net income from the appropriate Thrifty Food Plan, the State agency shall round the allotment down to the nearest lower dollar.

20. The Department's Program Policy Manual (Policy Manual) sets forth the following:

Appendix A-1	\$2,655.00 Gross Income Limit for a household size of two
	\$1,328.00 Net Income Limit for a household of size of two
	\$ 357.00 maximum FAP benefit for a household size of two
	\$ 345.00 standard utility allowance
	\$ 155.00 standard deduction for a household size of one-
	three
	\$16 minimum allotment for 1 or 2 member households

21. The Department's Program TRANSMITTAL NO.: C-13-10-0007, Food Assistance

Minimum Benefit, dated October 11, 2013, states in part:

...all one and two member assistance groups (AGs) are eligible for the minimum monthly food assistance benefit allotment, which is 8% of the maximum allotment for a one person household.

Minimum Benefit Policy

The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and:

- The AG has income less than or equal to the 200% gross income limit...

22. The above-cited regulations explain that participants in the FAP are required to meet income standards. The regulations also set forth income which must be included, deductions which are allowed in the FAP benefit determination as well as how the net income and FAP benefit amount are determined.

23. The respondent included the petitioner's LTD benefits, child support income and all allowable deductions in the FAP calculations, in accordance with the authorities. The respondent determined the petitioner's FAP eligibility based on a household size of two (the petitioner and her minor son KC) and excluded her son JC and his income from the FAP determination.

24. After careful review of the controlling legal authorities and evidence, the undersigned concludes the respondent erred in the petitioner's favor by not including her 21 year old son JC in the FAP eligibility determination; however, there is no better outcome the undersigned can provide to the petitioner.

MEDICAID ASSISTANCE ISSUE

25. Fla. Admin. Code R. 65A-1.707, Family-Related Medicaid Income and Resource

Criteria, states in part:

(1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows:

(a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.

...

(2) The department considers income in excess of the medically needy income level available to pay for medical care and services. Available income from a one month period is used to determine the amount of excess countable income available to meet medical care and services. To be allowable, a paid expense may not have been previously deducted from countable income during a period of eligibility.

26. 42 C.F.R. § 435.603 “Application of modified adjusted gross income (MAGI)” states

in part:

(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...

(3)(b) Family size means the number of persons counted as members of an individual's household...

(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...

27. 42 C.F.R. § 435.118 addresses income standards for children under age 19.

...

(b) Scope. The agency must provide Medicaid to children under age 19 whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) Income standard. (1) The minimum income standard is the higher of—

(i) 133 percent FPL for the applicable family size; or...

(2) The maximum income standard for each of the age groups of infants under age 1, children age 1 through age 5, and children age 6 through age 18 is the higher of—(emphasis added)

(i) 133 percent FPL;

9ii) The highest effective income level for each age group in effect under the Medicaid State plan for coverage under the applicable sections of the Act listed at paragraph (a) of this section or waiver of the State plan covering such age group as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issue by the Secretary under section 1902(e)(14)(A) and € of the Act...

28. 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.

29. According to the above-cited rules, the household's income must not exceed 133% of the Federal Poverty Level (FPL) for the petitioner's son KC to be eligible for full Medicaid. The Policy Manual, Appendix A-7, Family-Related Medicaid Income Limits, sets the income limit for a child 1 through 18 in a household size of two as \$1,776.00.

30. 42 C.F.R. § 435.110 sets forth the Medicaid budgeting criteria for parents:

- (a) Basis. This section implements sections 1931(b) and (d) of the Act.
- (b) Scope. The agency must provide Medicaid to parents and other caretaker relatives, as defined in § 435.4, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.
- (c) Income standard. The agency must establish in its State plan the income standard as follows:
 - (1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.
 - (2) The maximum income standard is the higher of—
 - (i) The effective income level in effect for section 1931 low-income families under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or
 - (ii) A State's AFDC income standard in effect as of July 16, 1996 for the applicable family size, increased by no more than the percentage increase in the Consumer Price Index for all urban consumers between July 16, 1996 and the effective date of such increase.

31. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria explains:

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

<u>Family Size</u>	<u>Income Level</u>
1	\$180
2	\$241

32. Pursuant to the above authority, the petitioner's \$2,053.86 countable household income is more than the \$241.00 income limit; therefore, she is not eligible for full Medicaid benefits.

33. The Policy Manual, Appendix A-7, Family-Related Medicaid Income Limits, sets forth the Medically Needy Income Level (MNIL) for a household size of two as \$387.00. It further indicates that the MNIL "includes the appropriate standard disregard. No additional disregards should be applied to establish a share of cost." The respondent subtracted the \$387.00 MNIL from \$2,053.86 (household income) to arrive at the \$1,666.00 SOC for the petitioner and her son KC.

34. After careful review of the controlling legal authorities and evidence, the undersigned concludes the respondent followed rule in terminating the petitioner and her minor son KC's full Medicaid benefits due to the household income exceeding the income limits for this program. Furthermore, the undersigned concludes the respondent correctly evaluated the petitioner and her son KC for the Medically Needy Program and determined the petitioner's SOC as \$1511.00 for July 2016 and the petitioner and her son KC's SOC as \$1,666.00 effective August 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and 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 26 day of September, 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

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

FILED

Oct 26, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05682
16F-05683

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88690

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 12, 2016 at 11:03 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Kenesha Hanley,
Operations Management Consultant I

STATEMENT OF ISSUE

At issue is the respondent's action to approve \$16 Food Assistance Program (FAP) benefits at recertification and deny the petitioner's request for Medicaid. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

A hearing was scheduled for September 6, 2016 at 3:15 p.m. On September 6, 2016 the petitioner requested to reschedule the hearing. The hearing was reset for September 12, 2016.

The petitioner provided no exhibits. The respondent submitted a 42 page exhibit which was marked and entered as Respondent's Composite Exhibit "1". The record was left open for additional evidence, including the policy related to the minimum benefit, through September 19, 2016. The above mentioned information was submitted on September 19, 2016, marked and entered as Respondent's Composite Exhibit "2". The record was closed the same day.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving \$16 in FAP benefits through June 30, 2016.
2. On May 16, 2016, the petitioner submitted an application for recertification of her FAP benefits and the additional benefit of Medicaid.
3. The petitioner (52 years old) is the only household member. The petitioner does not claim any disability.
4. The petitioner works at [REDACTED] and is paid bi-weekly. The petitioner incurs a rental expense of \$1,194, Section 8 pays \$807 of the rent. The petitioner incurs a heating and cooling expense.
5. The respondent determined the petitioner's earned income to be \$1,360 for the FAP budget based on the paystubs provided:

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

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

The FAP eligibility will be addressed first:

14. Federal Regulations at 7 C.F.R. § 273.9 define income and allowable deductions in the Food Assistance Program (FAP) and in part states:

(a) Income eligibility standards...

(1) The gross income eligibility standards for the Food Stamp Program...

(b) Definition of income. Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.

(1) Earned income shall include: (i) All wages and salaries of an employee...

(d) Income deductions. Deductions shall be allowed only for the following household expenses:

(1) Standard deduction...

(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...

15. The above authority explains the respondent must include all wages and salaries of an employee in order to determine the gross income and all allowable deductions in the

FAP budget. In accordance with the authority, the respondent included the petitioner's earned income wages and all allowable deductions in the petitioner's FAP budget.

16. Federal Regulations at 7 C.F.R. § 273.10, – Calculating net income and benefit levels states in the pertinent part:

- (d) Determining deductions. Deductible expenses include only certain dependent care, shelter, medical and, at State agency option, child support costs as described in §273.9.
- (1) Disallowed expenses.
 - (i) Any expense, in whole or part, covered by educational income which has been excluded pursuant to the provisions of §273.9(c)(3) shall not be deductible. For example, **the portion of rent covered by excluded vendor payments shall not be calculated as part of the household's shelter cost.** (*emphasis added*)
- (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...
 - (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...
 - (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 ...
 - (C) Except during an initial month, all eligible one- and two-person households shall receive minimum monthly allotments equal to the minimum benefit

17. The Department Program Policy Manual CF-OP 165-22, (The Policy Manual), at Appendix A-1 effective October 1, 2015, sets forth for a household size of one as the following:

\$194 maximum FAP benefit
\$ 16 minimum FAP benefit
\$155 standard deduction
\$345 standard utility allowance

18. Department Transmittal C-13-04-0002, Food Assistance Minimum Benefit, issued October 11, 2013, states in pertinent part:

...all one and two member assistance groups (AGs) are eligible for the minimum monthly food assistance benefit allotment, which is 8% of the maximum allotment for a one person household.

Minimum Benefit Policy

The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and:

The AG has income less than or equal to the 200% gross income limit...

19. The above cited authorities and department policy sets forth income and allowable deductions in the FAP benefit determination. In accordance with the authority and policy manual, the respondent included the petitioner's earned income and allowable deductions (earned income deduction, standard deduction, shelter costs, and utilities). The portion for rent covered by the excluded vendor payments was not calculated as a part of the shelter cost in the FAP benefit calculations. The respondent determined the petitioner is eligible to receive the \$16 minimum monthly FAP benefit.

20. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income and expenses using the rules cited above and did not find a more favorable outcome.

21. Based on the evidence and testimony, the undersigned concludes the respondent's action to approve \$16 in FAP benefits was within the rules of the Program.

Medicaid benefits will now be addressed:

22. 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) Adult-Related (referred to SSI-Related Medicaid) for disabled adults and adults 65 or older.

23. Fla. Admin. Code R. 65A-1.703 Family-Related Medicaid Coverage Groups in part states:

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

(5) Medicaid for pregnant women...

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

25. The evidence also establishes that the petitioner is not age 65 or older and the petitioner does not claim to be disabled. Therefore, the petitioner is not eligible for SSI-Related Medicaid.

26. In careful review of the cited authorities and evidence, the undersigned concludes the respondent is correct in denying the petitioner's application for Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, both 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 26 day of October, 2016,

in Tallahassee, Florida.



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

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

FILED

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

Oct 13, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05765

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER OF DISMISSAL

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 21, 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 hearing officer has jurisdiction to consider the denial of the petitioner's request for occupational therapy by the Florida Healthy Kids Program. The respondent filed a motion to dismiss and, therefore, the respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The respondent, AHCA, filed a motion to dismiss asserting the Office of Appeal Hearings lacks jurisdiction to hear this appeal since the petitioner is not a Medicaid recipient, but instead is covered by the Florida Health Kids Program.

The petitioner's managed health care plan, Amerigroup, submitted a packet of documents as evidence for the hearing, consisting of a hearing summary, medical records, and denial notices. These documents were marked as Respondent composite Exhibit 1. No one from Amerigroup appeared for the hearing.

FINDINGS OF FACT

1. The petitioner is a five (5) year old child who is a participant in the Florida Healthy Kids program. He receives services under the program from Amerigroup. He is not currently eligible for Medicaid and is not a Medicaid recipient.
2. On or about May 27, 2016, the petitioner made a request to Amerigroup for occupational therapy services. Amerigroup denied this request on June 6, 2016 and advised the petitioner of his right to file an internal appeal with Amerigroup to contest the denial.
3. The petitioner's mother initiated the internal appeal process with Amerigroup on June 9, 2016. Amerigroup issued a notice to the petitioner denying the appeal on July 8, 2016.
4. The July 8, 2016 denial notice from Amerigroup also advised the petitioner that he could request a Medicaid fair hearing to contest the denial by contacting the Office of

Appeal Hearings. The petitioner's mother thereafter requested a Medicaid fair hearing on July 26, 2016 and this proceeding followed.

5. The petitioner's mother stated she understands her son is not covered by Medicaid but she requested a fair hearing because she was directed to do so by Amerigroup and/or its representatives.

6. The AHCA representative stated the petitioner is not covered by Medicaid and, therefore, he must pursue whatever appeal rights are afforded under the Florida Healthy Kids program.

7. No representative from Amerigroup appeared for the hearing to explain how or why the petitioner was informed he could request a Medicaid fair hearing.

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 respondent since it filed a motion to dismiss. 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.

13. The Florida Healthy Kids program is part of the Florida Kidcare program, which is described in Fla. Stat. § 409.813. Section 409.814, Florida Statutes, provides as follows:

1) A child who is eligible for Medicaid coverage under s. 409.903 or s. 409.904 must be enrolled in Medicaid and is not eligible to receive health benefits under any other health benefits coverage authorized under the Florida Kidcare program.

(2) A child who is not eligible for Medicaid, but who is eligible for the Florida Kidcare program, may obtain health benefits coverage under any of the other components listed in s. 409.813 if such coverage is approved and available in the county in which the child resides.

14. The dispute review process for Florida Kidcare or Florida Healthy Kids participants is described in Florida Administrative Code Rule 59G-14.001. That dispute process is handled by the Florida Healthy Kids program rather than by any other outside agency. That process is not part of the Medicaid fair hearing procedure since that program is not a Medicaid program.

15. In this case, it is undisputed that the petitioner is not a Medicaid recipient. Unfortunately, the petitioner was misinformed by the Amerigroup denial notice which stated he could request a Medicaid fair hearing. The undersigned acknowledges that this erroneous information caused the petitioner's mother to expend time and effort in pursuing this course of action. The fact that the denial notice was erroneous, however, does not convey jurisdiction to the Office of Appeal Hearings to consider the petitioner's

request for a hearing. Since the petitioner is not a Medicaid recipient, he is not entitled to a Medicaid fair hearing.

16. The respondent, AHCA, should work with health plan providers such as Amerigroup to ensure plan participants are properly informed of their appeal or hearing rights in these types of cases so that this same error is not repeated in the future with other participants.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DISMISSED due to lack of jurisdiction.

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 13 day of October, 2016,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255

FINAL ORDER (Cont.)

16F-05765

PAGE - 6

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
AMERIGROUP HEARINGS UNIT

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

FILED

Oct 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05817

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Flagler
UNIT: 88372

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 27, 2016 at 9:24 a.m.

APPEARANCES

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

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

ISSUE

At issue is the Department's on July 18, 2016 to deny the petitioner's application for the Qualifying Individual 1 (QI1) program due to being over the income limit for the program.

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

PRELIMINARY STATEMENT

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

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. On July 12, 2016, the petitioner (age 59) applied for SSI-Related Medicaid and Medicaid Savings Plan (MSP). The petitioner listed on her application Social Security income in the amount of \$1383.

2. The Department calculated the Q11 budget by including the petitioner's income in the amount of \$1383. The \$20 unearned income disregard was subtracted from the total gross income which resulted in a countable income of \$1363.

3. The Department determined that the petitioner was ineligible for the Q11 program as the income exceeded the Q11 income standard for an individual in the amount of \$1337.

4. The petitioner disputes the denial because she and her son moved to Florida from California due to her son not being able to find a job in California; she and her son were invited by her sister to move to Florida. The petitioner explained that due to an abusive situation regarding her sister, she and her son were forced to move out of her sister's home. The petitioner argues that she was not able to save money as she was forced to get her own housing for her and her son. The petitioner contends that she

incurred outstanding bills and that her credit score went down because she had to use her credit cards to survive.

5. The petitioner argues that she borrowed \$1000 from a friend. The petitioner contends that her expenses are higher. The petitioner explained that she cannot afford to drive her car because she cannot afford to register her car in the state of Florida. The petitioner argues that the state of California has always paid her Medicare premium and believes that the state of Florida should also pay her premium.

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. Federal Regulations at 20 CFR § 416.1121 Types of unearned income states:

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

9. The above authority explains that unearned income, such as Social Security income, are included as income in determining eligibility for the Medicaid programs. The findings show that the petitioner is receiving Social Security income. Therefore, the

undersigned concludes that the Department was correct to include the petitioner's Social Security income in its calculations.

10. Fla. Admin. Code R. 65A-1.702 Special Provisions 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.)

11. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility

Criteria 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.

(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.

12. The above authority explains that an individual must have income that is within the income limits established by the federal and state law as well as the Medicaid State plan. An individual may qualify for the QMB program if her income is less than or equal to the federal poverty level after applying the exclusions to the income. The SLMB program requires income to be greater than 100% of the federal poverty level but equal to or less than 120% of the federal poverty level. An individual must have income greater than 120% of the federal poverty level but equal to or less than 135% of the federal poverty level to be eligible for QI1.

13. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the income standards for an individual effective July 2016 as \$990 for the QMB program, \$1188 for the SLMB program, and \$1337 for the QI 1 program. The income standards are a percentage of the Federal Poverty Level as explained above.

14. The petitioner's countable income was \$1363, which exceeds the income limit (\$1337) for an individual in the QI1 Program, which has the highest income limit of the MSP programs. Therefore, the undersigned concludes that the Department correctly denied QI1 program benefits.

DECISION

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

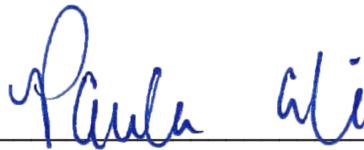
NOTICE OF RIGHT TO APPEAL

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 27 day of October, 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]

Office of Economic Self Sufficiency

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

FILED

Sep 22, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05836

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 LEE
UNIT: 883CF

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 20th, 2016 at 8:34 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Nicole Nuriddin, Economic Self-Sufficiency Specialist II for the Hearings Unit

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 petitioner's husband, [REDACTED], testified on the petitioner's behalf. The petitioner did not present any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 9 were admitted into evidence.

By way of a Notice of Case Action dated July 28th, 2016, the respondent informed the petitioner that her application for SSI-Related Medicaid dated June 29th, 2016, was denied because she did not meet the disability requirement. On August 5th, 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 June 29th, 2016. As part of the application process, the respondent is required to explore and verify all technical factors of eligibility.

2. The petitioner is married and was age 52 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 April 19th, 2016. SSA denied the petitioner on May 5th, 2016. The petitioner recently appealed the SSA denial through an attorney but was unsure of the appeal date. A hearing date has not yet been scheduled.

4. The petitioner's husband described the petitioner's conditions as an [REDACTED]. The petitioner's husband states the petitioner's [REDACTED] worsened on August 5th, 2016, resulting in an emergency room visit. The emergency room visit took place after the respondent denied the Medicaid application. The petitioner's husband states the August 5th episode has been reported to the petitioner's attorney.

5. On July 21st, 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 July 27th, 2016, due to adopting the previous SSA denial decision.

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

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

8. 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...

9. 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.

10. As established in the Findings of Fact, the petitioner's conditions are described as an [REDACTED]. According to the respondent's evidence (see R 3 p 16), DDD reviewed both conditions when making its determination and adopted SSA's denial. The petitioner acknowledged no new conditions and no worsening conditions until after the SSI-Related Medicaid application was denied. 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 22 day of September, 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

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

Oct 24, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-05837

PETITIONER,

Vs.

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

And

HUMANA,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 9, 2016 at 11:30 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 her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a handwritten note/letter as evidence for the hearing, which was marked as 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. Daniel Dorrego, Dental Consultant, from DentaQuest, which reviews dental claims on behalf of Humana. Humana was included as an additional respondent in this proceeding pursuant to its request to be added as a party.

The respondent, Humana, 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. Humana also submitted one page from its dental plan provisions, which was marked as Respondent Exhibit 2.

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 of requests for dental services.
2. On or about June 9, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Humana to perform deep dental cleaning of the upper and lower portions of her mouth (upper right,

upper left, lower right, lower left quadrants). On or about June 10, 2016, DentaQuest denied the request. 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. Our dentist looked at the information sent by your dentist. This service is not needed.

Your dentist needs to send us clear x-rays of your teeth. We have told your dentist this also. You may need to go back to your dentist to have the x-rays of your teeth done.

3. DentaQuest subsequently re-reviewed the requested services and approved the deep cleaning for the lower right and lower left quadrants. However, the service remained denied for the upper right and upper left quadrants. This determination was made on July 19, 2016.

4. The petitioner stated she had been previously approved in 2015 for the deep cleaning on all four quadrants, but she never had the services performed because she was dissatisfied with the dental office at that time and she thereafter sought to have the services performed by a different dentist. She also stated her dentist has submitted all required documentation.

5. The respondent's witness, Dr. Dorrego, stated the provider only submitted two x-rays, and more are needed to make a complete determination. He also stated the 2015 approval is no longer valid, and the new provider must submit all the pertinent information.

6. Ms. Salcedo from DentaQuest stated the petitioner's dental plan covers the deep cleaning of one quadrant once every 36 months.

7. 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

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 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.

15. 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.

16. After considering the evidence and testimony presented, the undersigned concludes that the petitioner has not demonstrated that the requested service (deep cleaning of the upper quadrants) should have been approved by Humana. Although this service was approved one year ago, the plan must review the current information to make a determination whether the service is needed at this time. Therefore, the

hearing officer cannot make a determination that this service must be covered by the petitioner's plan at the present time.

17. The plan provision purporting to limit this service to one quadrant once every three years should not preclude the petitioner from obtaining approval for the 2 upper quadrants once the plan receives the complete information to evaluate the need for the service. The plan provision states "one [deep cleaning] per 36 months per patient per quadrant." This indicates a patient can receive a deep cleaning on each quadrant once every 36 months, not that only one of the four quadrants can receive a deep cleaning every 36 months. To interpret this provision otherwise would mean an individual would need to wait 12 years for the entire mouth (all 4 quadrants) to receive a deep cleaning. In addition, the service limitation was not cited as a reason for denial in the Notice of Action, and the petitioner has already been approved for deep cleaning of 2 quadrants.

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

FINAL ORDER (Cont.)

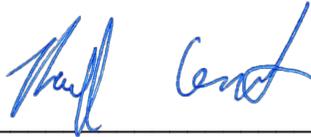
16F-05837

PAGE - 7

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

DONE and ORDERED this 24 day of October, 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 [REDACTED] PETITIONER
AHCA, MEDICAID FAIR HEARINGS UNIT
HUMANA HEARINGS UNIT

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

FILED

Oct 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05838

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 17 Broward

RESPONDENT

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 28, 2016 at 2:05 p.m. in [REDACTED], [REDACTED].

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Linda Latson, Registered Nurse Specialist,
Agency for Health Care Administration (AHCA)

STATEMENT OF ISSUE

Whether it was correct for Respondent to deny Petitioner's initial request for eight hours of personal care services (PCS) per day, seven days per week, for the certification period June 1, 2016 through November 30, 2016. Because the matter at issue is an initial request for services, Petitioner carries the burden of proof.

PRELIMINARY STATEMENT

AHCA has contracted with eQHealth Solutions, Inc. (eQHealth), as its 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.

Appearing as a witness for Respondent was Dr. Darlene Calhoun, Physician Reviewer with eQHealth Solutions.

Appearing as a witness for Petitioner, who also in attendance at the hearing, was Roosevelt Johnson, Petitioner's father.

Respondent's composite Exhibit 1 was entered into evidence.

FINDINGS OF FACT

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

1. Petitioner is a 19 year-old Medicaid recipient. She is diagnosed with [REDACTED].
2. Petitioner lives with her mother and father. She attends school from 7:15 a.m. to 3:00 p.m. During the summer months, Petitioner attends school from 9:00 a.m. to 1:00 p.m. Petitioner's mother works Monday through Friday from 8:00 a.m. to 4:00 p.m. and the father works Monday through Friday from 7:00 a.m. to 3:00 p.m.
3. These work hours were reported on work schedule forms submitted with the prior authorization request. (See pages 50 and 51 of Respondent Exhibit 1.) The mother's work schedule form shows summer school hours are 7:00 a.m. to 5:00 p.m. Monday through Friday and Saturday and Sunday work hours vary. No further explanation is

reflected on the form. At the time of the hearing, summer school was over and regular school schedules were in effect.

4. In the past, Petitioner's sister assisted with her care but she is now away at college. There are no medical limitations for either parent in providing care to the Petitioner.

5. Petitioner receives physical therapy two hours per week, occupational therapy two hours per week, and speech therapy one hour per week. Petitioner has been approved for ten hours per week of respite care.

6. On May 31, 2016, Petitioner submitted a request for personal care services (PCS). She requested 8 hours per day, seven days a week, of PCS for the certification period June 1, 2016 through November 30, 2016.

7. After receiving additional information requested from Petitioner, including a copy of her Support Plan, Respondent completed its review on July 21, 2016. Respondent sent a Notice of Outcome to Petitioner providing the reason for 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."

8. On July 21, 2016, Respondent sent a Notice of Outcome to the requesting provider. This notice provided the principal reason for the service denial: "it duplicates services furnished by another provider." Additionally, it provided the following clinical rationale for the decision:

The patient requires assistance with ambulation and ADLs. The mother works M-F 8a-4p (M-Th 7a-5p during the summer); the father works M-F

7a-3p. The patient is already approved for respite care 10 hrs/wk. Deny all hours. The respite care could be used to provide assistance with ADLs in the AM and the parents are available to provide ADL care in the PM. The requested care would be for monitoring and supervision that could be provided by non-HHA personnel-supervision is not a covered service.

9. On August 1, 2016, Petitioner requested a reconsideration review.

10. Respondent completed the reconsideration review on August 3, 2016 and sent a Notice of Reconsideration to the Petitioner on August 4, 2016. The notice upheld the initial denial and added the reason: "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."

11. Petitioner filed a request for fairing hearing on July 29, 2016.

12. Petitioner's mother stated her work hours vary. She does not always get home by 4:00 p.m. because of traffic congestion and delays. Petitioner's father works as a waiver support coordinator and explained his work hours also vary and at times he is on call to respond to emergencies. Petitioner's mother disagreed with using respite hours for PCS because she and her husband need relief from caring for their daughter.

13. Both parents felt their daughter was eligible for PCS services and was being denied services because of them. The mother stated her daughter needs someone immediately upon returning home from school and pondered what would happen if neither parent was home due to travel delays and/or extended work hours.

14. On page 20 of Petitioner's Support Plan dated July 1, 2016 (See Respondent Exhibit 1, page 61) it states in relevant part:

...on school days her mother reports that [Petitioner] wakes up at 5:30 a.m. She is prepared for school by her parents and requires complete physical assistance for all tasks. Her father then transports her to school at 6:45 school starts at 7:15. Her father or brother or sister picks her up

from school at 2:15. On days which [Petitioner] has therapy she arrives home at 6:00 p.m. [Petitioner] eats dinner when she arrives home.... [Petitioner's] father transports her to and from school every day but on Wednesdays [Petitioner] participates in community based activities...

15. Respondent's physician consultant explained the only hours to be considered for PCS are the actual times needed to provide the services. Time to cover travel delays would be considered supervision/monitoring which is not a covered service. The work hour documentation submitted with Petitioner's request was used by Respondent in determining the parents' availability to provide care to Petitioner.

16. The physician consultant further explained that flex hours or on-call hours could not be used in determining the number of PCS hours needed. If PCS services were approved, a modification could be submitted for additional PCS hours needed but not originally covered by the regularly scheduled PCS hours.

17. The mother responded her daughter needs to be changed and provided a snack when she returns home from school, not simply supervised or monitored.

18. Respondent explained PCS services cannot be approved for unanticipated parent delays in returning home from work.

CONCLUSIONS OF LAW

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

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

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

23. 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).

24. 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.

25. The Florida Medicaid Home Health Services Coverage and Limitations Handbook (Handbook), October 2014, has been promulgated by rule into 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.

26. On page 2-26, the Handbook addresses how Medicaid treats flex hours or banking of hours:

Medicaid does not allow "banking of hours" or "flex hours". Only the number of hours that are determined medically necessary by the QIO can be approved. Home health service providers must request only the number of hours that are expected to be used and must indicate the times of day and days per week the hours are needed. If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service provider should submit a modification request to the QIO for the additional hours needed.

27. 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.

28. Regarding EPSDT requirements, The State Medicaid Manual, which is 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].

29. The parties agree Petitioner needs assistance with her activities of daily living and maintaining her health and well-being. The matter at issue involves whether Medicaid providing eight hour per day of PCS is medically necessary.

30. Petitioner's parents have been providing care to their daughter. Until she left for college, Petitioner's sister was providing assistance with Petitioner's care. Petitioner's parents are seeking PCS to cover hours before and after school and on weekends, two hours in the morning and six hours after school, Monday through Friday. However, Petitioner's Support Plan indicates she arrives home at 6:00 p.m. on days she has therapy. Six hours of PCS service in the evening would not be needed on these days.

31. Respondent reviewed the parents' work schedules and determined they could use the 10 hours of approved Respite care to provide PCS services in the morning. The father's work schedule is Monday through Friday; therefore, he is available to provide care to his daughter on weekends.

32. The undersigned has reviewed EPSDT and medical necessity requirements and have applied these requirements to the totality of the evidence. Petitioner has not

established, by the greater weight of the evidence, that Respondent's action in this matter is incorrect.

33. While the parents' work schedules may vary, personal care services are approved for specific times the services are needed. The parents' regular work schedules allow for them to provide care to their daughter before and after school. On weekends, the father is available to provide care to his daughter. Respondent has suggested the parents can use two hours of Respite care in the morning during the week to provide care for their daughter. Petitioner's request for eight hours of PCS services Monday through Friday appears excessive since, per the Petitioner's Support Plan, she gets home at 6:00 p.m. on days when she goes to therapy.

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-05838
PAGE - 10

DONE and ORDERED this 27 day of October, 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

Sep 19, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-05868
16F-05869

PETITIONER,

Vs.

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

And

AMERIGROUP,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 24, 2016, at 8:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent AHCA: No one appeared

For the Respondent Amerigroup: Carlene Brock, Quality Operations Nurse

STATEMENT OF ISSUE

At issue is the respondent's action denying the petitioner's request for additional home health services (homemaker services) and bathroom modification services under the Long Term Care (LTC) Program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

Appearing as witnesses for the respondent were Dr. Mary Colburn, Medical Director, and Paula Matos, Long Term Care Manager, from Amerigroup, which is the petitioner's managed health care plan. Also present as a witness for the respondent was Angie Cano, Program Manager from United Home Care, the petitioner's provider of home health services. Amerigroup was included as an additional respondent to this proceeding pursuant to its request to be added as a party.

The respondent submitted documents as evidence for the hearing consisting of the following which were marked as Respondent Composite Exhibit 1: Case Summary, Construction Estimate, Medical Assessment Form, Clinical Notes, and Denial Notices.

FINDINGS OF FACT

1. The petitioner is eighty-one (81) years of age and lives with her daughter.

The petitioner's medical conditions include [REDACTED]. She is non-ambulatory

and utilizes a wheelchair. She can use a walker with assistance. She needs assistance with activities of daily living such as cooking, dressing, and bathing.

2. The petitioner is a Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long Term Care (LTC) Plan. She receives services under the plan from Amerigroup.

3. The Agency For Health Care Administration (AHCA) is responsible for management of the managed long-term care plan contracts; statewide policy decisions and interpretation of all federal and state laws; and rules and regulations governing the contract. Managed Care Organizations such as Amerigroup provide services to Medicaid recipients pursuant to a contract with AHCA.

4. The petitioner currently receives the following home health services through Amerigroup: 5 hours weekly of homemaker services, 10.5 hours weekly of personal care assistance, 20 hours weekly of respite services, 24 hours monthly of attendant care/escort services (for trips or appointments outside the home), and home-delivered meals. The petitioner is currently utilizing the personal care services for 1.5 hours per day, 7 days per week; the homemaker services for approximately 1.5 to 2 hours per day on Tuesday, Wednesday, and Saturday; and the respite services for 5 hours per day on Tuesday, Wednesday, Thursday, and Friday.

5. The petitioner's daughter is her primary caregiver. The daughter is not currently employed but is attending classes at Broward College. Her class schedule is Monday from 3:30pm – 4:30pm, Tuesday from 2:00pm – 3:50pm, Wednesday from 3:30pm – 4:45pm, Thursday from 2:00pm - 3:50pm, and Saturday from 1:00pm –

2:50pm. She take a bus to the college and states it takes approximately 2 hours each way to travel to the college. She also stated she needs to arrive at the college early before her classes to utilize services such as the computer lab.

6. On or about July 29, 2016, the petitioner made a request to Amerigroup for an additional 8 hours weekly of homemaker services. On August 4, 2016, Amerigroup sent a letter to the petitioner denying her request for the additional homemaker services.

This denial letter stated the following:

We suggest you rearrange the hours of care you are getting now. We also suggest that you do not have two aides providing services at the same time.

7. The petitioner's daughter stated her mother should be approved for the additional hours because she needs assistance with all her daily living activities and the daughter's class schedule prevents her from providing all the care her mother needs. She does not want her mother to be left home alone when she is not there. Regarding the reference in the denial notice about 2 aides being in the home at the same, she stated this occurred because there was a change in home health providers.

8. The respondent's witness, Dr. Colburn, stated the additional hours were denied because the currently approved hours could be re-distributed to cover the daughter's school schedule. For example, the 5 respite hours currently being used on Friday could be used on another day when the daughter is attending classes.

9. The petitioner had also requested bathroom modification services, which were initially denied by Amerigroup. However, the Amerigroup representative announced at

the hearing that this service was subsequently approved. Accordingly, that issue became moot and was not addressed during the 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 Fla. Stat. § 409.285. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

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

13. Fla. Stat. § 409.979 sets forth eligibility requirements for the Long-Term Care Program and states:

(1) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3).

14. As stated in the Findings of Fact, the petitioner was determined to be eligible and enrolled in the Long Term Care Program.

15. The petitioner requested a fair hearing because she believes her services under the Program should be increased.

16. Fla. Stat. § 409.98 lists the services which must be covered by Long-Term Care plans. Respite services, personal care assistance, and homemaker services are among the services available from Long-Term Care plans and are addressed in the AHCA contract.

17. The petitioner currently receives Homemaker services, which are defined in the contract as:

General Household activities such as meal preparation and routine household care provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage these activities. Chore services, including heavy chore services and pest control are included in this service.

18. The petitioner also currently receives Personal Care services, which are defined in the contract as follows:

A service that provides assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living. This service includes assistance with preparation of meals, but does not include the cost of the meals. This service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or are essential to the health and welfare of the enrollee, rather than the enrollee's family.

19. The petitioner also currently receives Respite care services, which are defined in the contract as follows:

Services provided to enrollees unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite care does not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite care is provided in the home/place of residence, Medicaid licensed hospital, nursing facility or assisted living facility.

20. The AHCA contract also provides that a Plan “may place appropriate limits on a service on the basis of such criteria as medical necessity, as defined by the Agency, or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose.”

21. Fla. Stat. § 409.912 requires that Respondent “purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

22. The Florida Medicaid Provider General Handbook (“Medicaid Handbook”), effective July 2012, and Fla. Admin. Code R. 59G-1.010(166) define medical necessity as follows:

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

(a) Meet the following conditions:

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

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

23. After considering the evidence and testimony presented, the hearing officer concludes that the petitioner has not demonstrated that her home health services should be increased under the LTC Program. The petitioner needs assistance with all her activities of daily living (ADLs). However, she is currently approved for approximately 35.5 hours weekly of home health services to assist her with these activities. In addition, she is approved for 24 hours monthly of escort services to assist her with trips outside the home such as doctor's appointments.

24. The petitioner's daughter attends approximately 9 hours of classes weekly on 5 days per week. Even taking into account 4 hours per class day of travel time on the bus, the travel time would total 20 hours weekly. The travel time and class time total 29 hours weekly, leaving about 7 more hours weekly for study time or the computer lab. The petitioner may benefit from reallocating the approved hours to cover the time when her daughter is at classes, such as using the 5 respite hours from Friday on another day since her daughter does not attend class on Friday.

25. The issue regarding the bathroom modification service is now moot since that service was subsequently approved by Amerigroup.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19 day of September, 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]
AHCA, MEDICAID FAIR HEARINGS UNIT
AMERIGROUP HEARINGS UNIT

FILED

Oct 31, 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-05879

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Sumter
UNIT: 66292

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:35 a.m. on September 16, 2016.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Sylma Dekony, ACCESS
Economic Self-Sufficiently Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (or the Department) action to deny the petitioner Medicaid Disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

[REDACTED] the petitioner's sister, appeared as a witness for the petitioner. Petitioner did not submit exhibits. Respondent submitted five exhibits, entered as Respondent Exhibits "1" through "5". The record was closed on September 16, 2016.

FINDINGS OF FACT

1. On June 3, 2016, the petitioner (age 55) submitted a web application for Food Assistance and SSI-Related Medicaid for himself. Medicaid is the only issue.
2. For the petitioner to be eligible for SSI-Related Medicaid he 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 for the Department.
3. In 2013, the petitioner was in an automobile accident, causing him head injury and a crushed rib cage. Petitioner received Social Security Disability from September 2013 through April 2015. In 2015, the SSA reviewed the petitioner's case and determined he was no longer disabled. Petitioner appealed the SSA termination, a hearing date has not been scheduled.
4. On July 7, 2016, the Department electronically sent DDD the petitioner's information for a disability review. And on July 14, 2016, DDD denied the petitioner disability, due to adopting the SSA denial decision.
5. On July 18, 2016, the Department mailed the petitioner a Notice of Case Action, denying Medicaid Disability.
6. Petitioner's sister stated that the petitioner does not have new medical conditions the SSA is not aware of. And stated that the petitioner's medical conditions are the same as when he was approved by the SSA in 2013.
7. Petitioner's sister opined that the SSA only considered the petitioner's physical medical condition and not his mental medical condition when it terminated his disability in April 2015.

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...

(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. (emphasis added)

(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 the SSA determination is binding on the Department.

12. In accordance with the above authority, the Department denied the petitioner's June 3, 2016 Medicaid application, due to adopting the SSA termination decision.

13. Petitioner is appealing the April 2015 SSA disability termination, an appeal date has not been scheduled.

14. Petitioner's sister testified that the petitioner does not have new medical conditions and his medical conditions are the same as when he was approved by the SSA in 2013.

15. Petitioner's sister testified that the SSA only considered the petitioner's physical medical condition, not his mental medical condition, when it terminated his disability in April 2015.

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 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 31 day of October, 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]
[REDACTED]

APPEAL NO. 16F-05913

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
CIRCUIT: 04 Duval
UNIT: APD

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 1, 2016 at 1:15 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent: Melissa Dinwoodie, senior attorney with APD

STATEMENT OF ISSUE

Whether the respondent's decision denying the petitioner's request for an increase in his Developmental Disabilities Individual Budget Waiver (iBudget Waiver) funding was correct. The petitioner holds the burden of proof by a preponderance of evidence.

- Florida Administrative Code Rules 59G-1.010 and 59G-13.070.
- The Florida Medicaid Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook, September 2015

The hearing record was closed on November 1, 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 24) is enrolled the respondent's iBudget Waiver. The iBudget Waiver provides supports services to individuals with designated developmental disabilities in order for the individuals to live in the most independent setting possible.

2. The petitioner qualifies for waiver participation under the category of [REDACTED]. His other diagnoses include [REDACTED]. The petitioner is verbal and ambulatory. He feeds and takes medications by mouth. The petitioner can independently perform all the activities of daily living; however, he needs frequent verbal prompts and supervision to ensure proper hygiene. The petitioner independently uses public transportation, but does not monitor bus schedules and requires transportation assistance when out late.

3. Prior to the action under appeal, the petitioner lived in the family home with his father and stepmother. Due to problematic relations, the petitioner moved out of the family home in late 2015. He briefly lived in a supported living apartment that he shared with one roommate and a live-in caregiver. That living situation was terminated due to the petitioner's behaviors (taking food from the other resident). The petitioner then moved into a one-on-one living arrangement with a live-in caregiver, but the caregiver

moved out after a couple of weeks. The petitioner now lives alone in a two bedroom apartment.

4. The petitioner receives, through the iBudget Waiver, 4 hours daily personal support services and 15 hours monthly supported living coaching services. Personal support services provide assistance with the activities of daily living and meal preparation. Supported living coaching services provide assistance with personal finances, social and adaptive skills, and transportation. The petitioner's total annual iBudget Waiver amount is \$33,840.10.

5. In May 2016, the petitioner submitted a significant additional needs (SAN) request to the Agency requesting that his personal support hours be increased from 4 hours daily to 8 hours daily. The petitioner also requested funding for a behavioral assessment.

6. The amount of funding a waiver participant is eligible to receive is based on an algorithm which considers the individual's age, living arrangement, need for services and level of functioning. The algorithm amount is the minimum amount of waiver funding possible. Additional waiver funding is possible if a participant has "significant additional needs" as defined in the controlling legal authorities.

7. Waiver participants must demonstrate at least one of the four criteria set forth in waiver rule to qualify for a SAN increase: 1) potentially life threatening behaviors; 2) complex medical condition that requires continuous nursing care; 3) chronic co-existing medical conditions; and 4) the need for total physical assistance with all the activities of daily living (toileting, bathing, eating, etc.).

8. To make the SAN decision, APD reviews the participant's request form, QSI assessment tool, support plan, and other relevant documentation.

9. The SAN request form specifies the reason the applicant needs additional waiver funding. The form directs the participants to check the box which best describes the reason additional waiver funding is needed. The petitioner checked two boxes: "A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention" and "A significant need not listed above that would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, unless the increase is approved."

10. The QSI is an assessment tool designed to obtain functional, behavioral, and physical information about the waiver participant. The assessment is completed by APD. The petitioner's most recent QSI is dated June 7, 2016 and shows that the petitioner has low need for functional assistance services (assistance with the activities of daily living), low need for physical assistance services (assistance due to medical conditions), and high need for behavioral services (services due to mental health issues).

11. The support plan is a narrative developed with the assistance of the participant's support coordinator. The support plan outlines the participant's present situation in numerous life areas. The support plan also contains the participants' goals for the upcoming year and the supports and services needed to accomplish these goals.

12. The petitioner's most recent support plan was completed on December 17, 2015. The petitioner was still living in the family home and working as a bagger at Publix Supermarket at that time. The support plan notes that the petitioner's goals were to live in his own apartment with a roommate and to continue to work at Publix. He would need personal supports services and supported living coaching services to attain those goals.

13. The support plan was amended by the petitioner's waiver support coordinator on May 5, 2016 to reflect SAN update. The petitioner had moved out of the family home. He had been involuntary committed to the hospital for four days in April 2016 under the Baker Act due to drinking excessive alcohol and voicing suicidal thoughts after an argument with his girlfriend. The petitioner lost his job at Publix; his doctor determined he needed to reduce stress. The support plan SAN update noted a "decompensation" in the petitioner's behaviors. The update reads in relevant part:

On April 19, 2016, [petitioner's] personal support staff received a call from a social worker at [REDACTED], advising her that [petitioner] had been admitted, due to suicide attempt and suicidal ideations. [Petitioner] stated that he drank alcohol to kill himself because he was upset with his girlfriend. [Petitioner] also stated that when he was 10 years old, he attempted suicide because he was tired of living. [Petitioner] was admitted to [REDACTED] under suicide watch. Since his discharge from hospital on April 18, 2016 [sic], [petitioner] has continued to decompensate. He has suffered anxiety attacks and has expressed fear of being alone in his apartment. APD has only authorized 4 hours per day of Personal Support services, however, [petitioner] is in need of PS live-in staff to provide protective oversight.

14. APD concluded that the petitioner did not meet any of the SAN criteria set forth in the controlling legal authorities and denied his request for additional waiver funding. The petitioner is not appealing the denial of the behavioral assessment

because he is now receiving behavioral services from another program. The petitioner is appealing only the denial of the additional personal support services hours.

15. Leslie Richards, APD regional operations manager, appeared as a witness during the hearing. Ms. Richards made the decision under challenge. She explained the role of personal support services is to assist individuals with the activities of daily living, light housekeeping, and meal preparation. The petitioner is high functioning, he can independently perform these tasks with verbal prompts. The petitioner's personal support needs can be accomplished in the time allotted, 4 hours daily (2 hours in the morning and 2 hours in the evening). 8 hours of personal supports daily is the maximum allowed under waiver rules and is intended for individuals who need total physical assistance with the activities of daily living and meal preparation. This level of care is in excess of the petitioner's needs. Waiver rules prohibit the provision of services in excess of recipient need.

16. The petitioner and his witnesses argued that he needs additional personal support services to supervise his behaviors and unsafe living habits. The petitioner feels isolated without a job to go to everyday. He would like to have a meaningful day activity, such as an adult day program. The petitioner is afraid to live alone. He will force himself to stay awake at night (by drinking large quantities of energy drinks) and then sleep all day. This behavior has adversely affected his health (occasional heart palpitations). Lack of sleep causes him to miss appointments. In addition, he is cranky and uncooperative with family and support staff. The petitioner has impulse control issues and does things he likes to excess, such as smoking, drinking alcohol, and

eating bad foods. He has no danger awareness; he will leave his apartment door unlocked. As a result, his bicycle and electronic equipment are missing from his apartment. The petitioner often takes public transportation late at night into unsafe neighborhoods and requires transportation assistance to return home. The petitioner is vulnerable to persuasion and will give acquaintances money. The petitioner will not bathe or change clothes, or clean his apartment without verbal direction and regular reminders. The petitioner and his witnesses argued that he needs additional personal support services to ensure his health and safety.

17. On cross examination, the petitioner's witnesses admitted there have been no additional suicide attempts or serious threats since April of this year. The petitioner has not harmed himself or anyone else. No one has required medical attention due to the petitioner's behaviors. The petitioner's support staff acknowledged that his behaviors are, in-part, attention seeking in nature and he will later say he was not serious. However, they are concerned about his long term prospects if he does not receive additional support services.

18. In rebuttal, the respondent explained that all waiver services had an intended purpose and serve a particular need. Personal support services are not intended for supervision or companion care. The petitioner's team may wish to reassess his needs and determine which array of services would best address those needs (i.e., assisted living facility, adult day training, companion care, etc.). APD's current denial decision does not preclude the petitioner from submitting future requests.

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 393.125, Florida Statutes.

20. 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. At issue is a request for additional Medicaid services. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Fla. Admin. Code R. 65-2.060(1).

23. The respondent denied the petitioner's SAN request for additional personal support services.

24. iBudget Waiver SAN requests are addresses in Section 393.662, Florida Statutes, and Fla. Admin. Code R. 65G-4.0218.

25. Section 393.662, Florida Statutes, addresses the criteria for additional iBudget Waiver funding, above and beyond the amount determined by the algorithm:

(b) The agency may authorize funding based on a client having one or more of the following needs that cannot be accommodated within the funding determined by the algorithm and having no other resources, supports, or services available to meet the need:

1. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved. However, the presence of an

extraordinary need in and of itself does not warrant authorized funding by the agency. An extraordinary need may include, but is not limited to:

- a. A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;
- b. A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;
- c. A chronic comorbid condition. As used in this subparagraph, the term "comorbid condition" means a medical condition existing simultaneously but independently with another medical condition in a patient; or
- d. A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

26. The criteria for a SAN increase in iBudget waiver funded is further clarified in

Fla. Admin. Code R. 65G-4.0218, which states, in part:

(1) Supplemental funding for Significant Additional Needs (SANs) may be of a one-time, temporary, or long-term in nature including the loss of Medicaid State Plan or school system services due to a change in age. SANs funding requests must be based on at least one of the four categories, as follows:

(a) An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved. An extraordinary need may include, but is not limited to:

1. A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;
2. A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;
3. A chronic comorbid condition. As used in this subparagraph, the term "comorbid condition" means a medical condition existing simultaneously but independently with another medical condition in a patient; or
4. A need for total physical assistance with activities such as eating, bathing, toileting, grooming, personal hygiene, lifting, transferring or ambulation.

27. The respondent argued that the petitioner did not demonstrate that he meets SAN

criteria set forth in the controlling legal authorities. The petitioner argued that he needs

additional waiver funding for supervision of behaviors, ensure proper hygiene, and prevent social isolation.

28. The petitioner was Baker Acted for four days in April of this year due to drinking excessive alcohol and suicidal ideations. There have been no repeat episodes of this behavior. In addition, there is no evidence that the petitioner or anyone else has required medical attention due to his behaviors. The petitioner does not require nursing care due to a medical condition. The petitioner has multiple diagnoses, but there is no evidence of serious comorbid conditions. The petitioner does not require total assistance with the activities of daily living. After careful review, the undersigned concludes that the petitioner did not prove by a preponderance of the evidence that he meets the requirements set forth in statute and rule for a SAN increase in waiver funding.

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 for Persons with Disabilities, Agency Clerk, 4030 Esplanade Way, Suite 380, Tallahassee, FL 32399-0950. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped 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.



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]

Area 4 APD
Michele Lucas, APD Agency Clerk
Melissa Dinwoodie, Esq
Karen Harrison

FILED

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

Oct 04, 2016

Office of Appeal Hearings
Dept. of Children and Families



PETITIONER,

Vs.

APPEAL NO. 16F-05935
16F-05936

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66032

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on September 6, 2016 at 2:15 p.m.

APPEARANCES

For the petitioner: 

For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency
Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the following:

I. Respondent's action to terminate the petitioner's Medicaid benefits on August 31, 2016. Respondent carries the burden of proof by a preponderance of the evidence.

II. Respondent's action to decrease the petitioner's the Food Assistance Program (FAP) benefits beginning September 2016. Petitioner is seeking an increase. Respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner did not present any exhibits. Respondent submitted six exhibits, which were entered into evidence as Respondent Exhibits "1" through "6". The record was held open until close of business on September 16, 2016 for submission of additional evidence from the respondent. After the hearing on September 6, 2016, the respondent submitted additional information, which was entered into evidence as Respondent Exhibit "7". The record closed on September 16, 2016.

FINDINGS OF FACT

1. On May 17, 2016, the petitioner submitted an on-line application for Medicaid and FAP benefits for herself and her two children (ages 5 and 1). Petitioner listed her monthly expenses as rent of \$1,150.00, electricity and telephone. Petitioner listed her source of income as Supplemental Security Income (SSI) for her son of \$725.00 a month. Based on this application, the petitioner was approved for expedited FAO benefits. The respondent approved \$238.00 FAP benefits for May 2016 and \$511.00 for June 2016. The respondent pended the petitioner for an interview to determine her eligibility for ongoing FAP benefits.
2. On May 20, 2016, the petitioner completed a phone interview. During the interview, the petitioner reported that she also receives child support income of \$150.00 weekly. The respondent averaged the child support income by multiplying the weekly amount by a conversion factor of 4.3 to arrive at \$645.00 per month. The respondent obtained verification of the petitioner's son's SSI through the SSA State On-Line Query report which showed he receives \$729.00; however; the respondent budgeted \$721.00.

Based on this information, the respondent authorized the petitioner for \$412.00 FAP benefits for July 2016 through October 31, 2016.

3. On July 28, 2016, the respondent received a data exchange child support (DECS) request to impose a Child Support Enforcement (CSE) sanction on the petitioner for non-cooperation. As a condition of eligibility, recipients of public assistance must cooperate with CSE.

4. Petitioner's shelter expense was prorated as her needs were not included in the FAP budget due to the CSE sanction. The respondent calculated the petitioner's FAP benefits for her two children (the petitioner was excluded as an ineligible member) as follows:



BEGIN: 09/01/2016		END: 09/30/2016		STATUS: OPEN, PASS, HEAR	
		TOTAL GROSS INCOME:		1366.00	
		EARNED INCOME DEDUCTION:	-	.00	
		STANDARD DEDUCTION:	-	155.00	
TOTAL MEDICAL COSTS:		.00			
MEDICAL DEDUCTION:	-	.00			
EXCESS MEDICAL EXPENSES:	=	.00	EXCESS MEDICAL EXPENSES:	-	.00
			DEPENDENT CARE DEDUCTION:	-	.00
SHELTER COSTS:		766.66	CHILD SUP PAYMENT DEDUCT:	-	.00
UTILITY STD. (SUA/ BUA/ PH) :	+	345.00	HOMELESS INCM DEDUCTION:	-	.00
SHELTER/UTILITY COSTS:	=	1111.66	ADJUSTED INCOME:	=	1211.00
SHELTER STD(50% ADJ NET INC) :	-	605.50			
EXCESS SHELTER/DEDUCTION:	=	506.16	SHELTER DEDUCTION:	-	506.16
			FOOD STAMP ADJ INCOME:	=	704.84
ASSISTANCE GROUP SIZE:		2	MAX NET MONTHLY INCOME:		1328.00

5. The maximum monthly allotment of FAP benefits for a household size of two is \$357.00. The respondent took 30% of the food stamp adjusted income (\$704.84) to calculate the benefit reduction of \$212.00. The respondent subtracted the \$212.00

benefit reduction from the \$357.00 maximum FAP allotment to arrive at \$145.00 in FAP benefits beginning September 2016.

6. On August 3, 2016, the respondent mailed a Notice of Case Action notifying the petitioner that her FAP benefits would be reduced from \$414.00 to \$145.00 beginning September 2016. The notice also notified the petitioner that her Medicaid would end on August 31, 2016 due to failure to cooperate with CSE.

7. Petitioner did not want to pursue child support from the non-custodial parent. She explained she did not want to cooperate with CSE because the non-custodial parent sends child support income of \$150.00 weekly directly to her. Additionally, she does not want to cause any issues with the non-custodial parent which can potentially cause the child support income to end.

8. Respondent explained the Department's policy to prorate the expenses in the FAP budget due to the petitioner being sanctioned by CSE. Petitioner is determined to be an ineligible member for FAP benefits because she was sanctioned for non-cooperation with CSE; therefore, it is the Department's policy to exclude the portion of the ineligible member's shelter expenses from the FAP budget.

9. Respondent explained that once the petitioner cooperates with CSE, she could be included in the FAP and Medicaid benefits again.

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.

PETITIONER'S MEDICAID BENEFITS ISSUE

12. Cooperation as a condition of eligibility for Medicaid Program benefits is set forth in the Code of Federal Regulations at 42 C.F.R. § 435.610. It states:

(a) As a condition of eligibility, the agency must require legally able applicants and beneficiaries to:

(1) Assign rights to the Medicaid agency to medical support and to payment for medical care from any third party;

(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

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.

(c) The requirements of paragraph (a) of this section for the assignment of rights to medical support and other payments and cooperation in obtaining medical support and payments are effective for medical assistance furnished on or after October 1, 1984, The requirement for cooperation in identifying and providing information for pursuing liable third parties is effective for medical assistance furnished on or after July 1, 1988.

13. Cooperation with Child Support Enforcement is set forth in Section § 414.095, Florida Statutes, which states "as a condition of eligibility for public assistance, the

family must cooperate with the state agency responsible for administering the child support enforcement program.”

14. According to the rules above, the Department of Children and Families is responsible for imposing and removing sanctions. Petitioner was required to cooperate with CSE and failed to do so on July 28, 2016. The petitioner explained she did not want to cooperate with CSE as she already has a payment agreement with the non-custodial parent. Therefore, the petitioner was sanctioned and excluded from the FAP and Medicaid benefits.

15. The hearing officer could not find any exception to cooperating with CSE, except in cases where there is a determination of good cause. The petitioner has not established good cause for not cooperating with CSE.

16. After careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent’s action to terminate the petitioner’s Medicaid benefits effective August 31, 2016 was within the rules and regulations.

FOOD ASSISTANCE ISSUE

17. The Code Federal Regulations at 7 C.F.R. § 273.11 sets the requirements for custodial parent’s cooperation with the State Child Support Agency:

(o)(1) Option to disqualify custodial parent for failure to cooperate. At the option of a State agency, subject to paragraphs (o)(2) and (o)(4) of this section, no natural or adoptive parent or, at State agency option, other individual (collectively referred to in this paragraph (o) as “the individual”) who is living with and exercising parental control over a child under the age of 18 who has an absent parent shall be eligible to participate in the Food Stamp Program unless the individual cooperates with the agency administering a State Child Support Enforcement Program established under Part D of Title IV of the Social Security Act (42 U.S.C. 651, et seq.), hereafter referred to as the State Child Support Agency.

...

(iv) The individual must cooperate with the State Child Support Agency in establishing paternity of the child, and in establishing, modifying, or enforcing a support order with respect to the child and the individual in accordance with section 454(29) of the Social Security Act (42 U.S.C. 654(29)).

(v) Pursuant to Section 454(29)(E) of the Social Security Act (42 U.S.C. 654(29)(E) the State Child Support Agency will notify the individual and the State agency whether or not it has determined that the individual is cooperating in good faith.

...

(3) Individual disqualification. If the State agency has elected to implement this provision and determines that the individual has not cooperated without good cause, then that individual shall be ineligible to participate in SNAP. The disqualification shall not apply to the entire household. The income and resources of the disqualified individual shall be handled in accordance with paragraph(c)(2) of this section.

...

(5) Terminating the Disqualification. The period of disqualification ends once it has been determined that the individual is cooperating with the State Child Support Agency. The State agency must have procedures in place for re-qualifying such an individual.

18. 7 C.F.R. § 273.9 defines "Income" and "Deductions" 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:

(i) Assistance payments from Federal or federally aided public assistance programs, such as supplemental security income (SSI) or Temporary Assistance for Needy Families (TANF); general assistance (GA) programs (as defined in §271.2); or other assistance programs based on need....

(iii) Support or alimony payments made directly to the household from nonhousehold members. (emphasis added)

(d) Income deductions. Deductions shall be allowed only for the following household expenses:

(1) Standard deduction...

(6) Shelter costs...

(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...

(iii) Standard utility allowances...

19. 7 C.F.R. § 273.10 Calculating net income and benefit levels states in relevant part:

...

(c) Determining income—

...

(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.

Nonrecurring lump-sum payments shall be counted as a resource starting in the month received and shall not be counted as income.

...

(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)...

(C) Subtract the standard deduction...

(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.

20. 7 C.F.R. § 273.11, Action on households with special circumstances, states in relevant part:

...
(c) Treatment of income and resources of certain nonhousehold members. During the period that a household member cannot participate for the reasons addressed in this section, the eligibility and benefit level of any remaining household members shall be determined in accordance with the procedures outlined in this section.

...
(2) SSN disqualifications, comparable disqualifications, child support disqualifications, and ineligible ABAWDs. The eligibility and benefit level of any remaining household members of a household containing individuals determined to be ineligible for refusal to obtain or provide an SSN, for meeting the time limit for able-bodied adults without dependents or for being disqualified under paragraphs (k), (o), (p), or (q) of this section shall be determined as follows:

...
(ii) Income. A pro rata share of the income of such ineligible members shall be counted as income to the remaining members. This pro rata share is calculated by first subtracting the allowable exclusions from the ineligible member's income and dividing the income evenly among the household members, including the ineligible members. All but the ineligible members' share is counted as income for the remaining household members.

(iii) Deductible expenses. The 20 percent earned income deduction shall apply to the prorated income earned by such ineligible members which is attributed to their household. That portion of the households' allowable child support payment, shelter and dependent care expenses which are either paid by or billed to the ineligible members shall be divided evenly among the households' members including the ineligible members. All but the ineligible members' share is counted as a deductible child support payment, shelter or dependent care expense for the remaining household members.

(iv) Eligibility and benefit level. Such ineligible members shall not be included when determining their households' sizes for the purpose of:

(A) Assigning a benefit level to the household;

(B) Assigning a standard deduction to the household;

(C) Comparing the household's monthly income with the income eligibility standards;

...

(4) Reduction or termination of benefits within the certification period. Whenever an individual is determined ineligible within the household's certification period, the State agency shall determine the eligibility or ineligibility of the remaining household members based, as much as possible, on information in the case file.

21. The Department's Program Policy Manual, CFOP 165-22, passage 2610.0410,

Ineligible/Disqualified Members (FS) further address budgeting in the FAP:

Technically ineligible individuals may not participate in the Food Stamp Program. A technically ineligible individual is one who:

...

3. fails due to serving a child support sanction;

...

The technically ineligible individual may not be included in the household when food stamp benefits are determined. Treat the income, assets and expenses of technically ineligible individuals as follows:

1. Prorate the income of the ineligible individual and count all but the ineligible member's share toward the eligibility of the remaining household members for individuals who fail to meet SSN requirements, are ineligible noncitizens, are serving child support sanctions...

...

4. Expenses billed to the technically ineligible member but paid entirely with the eligible member's income because the ineligible member has no income, count in full in the budget. If the expense is billed to the technically ineligible member, but paid for with the eligible member's income and the ineligible member's income, prorate the expense in the budget. If the expense is billed to and paid entirely by the technically ineligible member, prorate the expense in the budget...

22. The above-cited authorities set forth the income, deductions and detailed budgeting procedures for the FAP. The Department followed rule in converting the petitioner's weekly child support income using a 4.3 conversion factor as she receives the child support income on a weekly basis. The respondent properly credited the

standard deduction, excess shelter deduction, and standard utility allowance in the petitioner's FAP budget.

23. According to the rules cited above and the Department's policy, the shelter expenses of an ineligible member are prorated in the FAP eligibility determination, except when the expenses are billed to the ineligible member but paid entirely with income from other eligible members because the ineligible member has no income. The respondent prorated the shelter expense used in the petitioner's FAP budget by dividing the shelter expense of \$1,150.00 by the petitioner's household size of three, which resulted in \$383.33. The respondent then removed the petitioner's \$383.33 portion as she is considered an ineligible member to arrive at the prorated shelter expense of \$766.66 ($\$1,150.00 - \383.33). However, the petitioner has no income of her own, the household's income consists of her son's SSI benefits and her children's child support income. The child support is considered as income of the children for whom the payment is intended. The undersigned concludes the respondent erred in prorating the shelter expense when determining the petitioner's FAP benefit amount.

24. Therefore, this matter is hereby remanded to the Department for corrective action. The respondent is to count the full \$1,150.00 shelter expense in the petitioner's FAP budget beginning September 2016. Once this corrective action has been completed, the respondent is to issue a new Notice of Case Action to the petitioner to notify her of the outcome, including her appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Medicaid appeal (16F-05936) is denied and the Department's action is affirmed. The FAP appeal (16F-05935) is granted and remanded to the Department to take corrective action as specified in the Conclusions of Law.

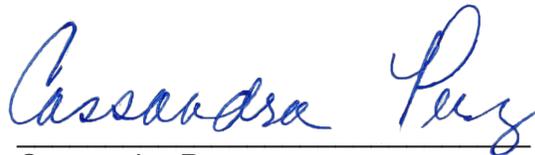
ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVER ISSUANCES.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 04 day of October, 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]
Office of Economic Self Sufficiency

FILED

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

Oct 27, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06003

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 Gadsden
UNIT: 88313

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 26, 2016 at 2:33 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Pat Hernandez, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's June 16, 2016 denial of his application for SSI-Related 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] on this date. The petitioner contacted the undersigned prior to the hearing and requested the

hearing be changed to a telephonic hearing, as he had no transportation to the location that day.

Ursula Robinson, hearing officer, was present as an observer with no objections.

The Department presented evidence prior to the hearing, which was entered as Respondent's Exhibit 1.

The record was held open through September 26, 2016 to allow the petitioner to submit documentation. The petitioner submitted documents on September 28, 2016 and October 3, 2016. These documents were entered as Petitioner's Composite Exhibit 1. The record closed on October 3, 2016.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on May 16, 2016. The petitioner was 44 years old at the time of his application. He reports no minor children in the home.

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 May 19, 2016 informing the petitioner of a need for a telephone interview on Wednesday, May 25, 2016 to complete an interview. The letter noted the interview would discuss the petitioner's SSA status, disabling condition, and medical treatment.

4. The petitioner maintains he did not receive a notice about an interview for disability.

5. The petitioner did not report any problems with receipt of his mail at home.

6. The Department recorded in case notes on May 25, 2016 that an intake interview was completed with the customer.

7. The Department also recorded in case notes on May 25, 2016 that the petitioner did not answer either phone number for the disability interview.

8. The Department issued a Notice of Case Action on May 26, 2016 requesting additional information due by June 6, 2016. The notice did not indicate the case continued to be pending an interview.

9. The Department recorded in case notes on May 27, 2016 that the petitioner completed an intake interview for Food Assistance. This interview did not contain the information needed for the disability interview. The note further states the client remained a no-show for the disability interview.

10. The Department recorded, in the case notes on May 31, 2016, a call from the petitioner regarding the status of his Medicaid application.

11. The Department issued a Notice of Case Action on June 16, 2016 denying the petitioner's application for Medicaid due to "failure to complete an interview necessary for us to determine your eligibility for this program."

12. The Department could not confirm if the worker reviewed the case notes to see the petitioner had called the Department on May 31, 2016 when a second note was entered on June 9, 2016 stating: "CL remains no-show for DDD interview."

13. The Department was not aware of any attempts by the worker to contact the customer after the May 31, 2016 call by the customer to the Department inquiring about his Medicaid application.

14. The Department recorded in case notes on June 14, 2016 a call from the petitioner inquiring about the status of his May 16, 2016 Medicaid application. He was advised it was still pending.

15. The Department could not confirm the Department staff reviewed the case notes prior to denying the application for Medicaid.

16. 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."

17. The petitioner stated his conditions include [REDACTED], [REDACTED]. The petitioner is also concerned he may have [REDACTED], but has not been diagnosed with it as of the hearing.

18. The petitioner appealed the July 2016 SSA decision.

19. The petitioner stated his condition has changed since his original September 2014 application.

20. The petitioner has no new diagnosis since the July 2016 denial by SSA.

21. The petitioner reports SSA is sending him to other doctors for evaluation.

22. The petitioner's evidence provides verification used for the Florida Retirement System showing his doctor considers him disabled.

23. The petitioner is concerned that he is unable to obtain the prescriptions his doctors are giving him. He further believes that a disability diagnosis and rehabilitation could help improve his condition.

CONCLUSIONS OF LAW

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

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

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

(1) (a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

27. The findings show the Department attempted to contact the petitioner for the necessary interview to submit for disability determination and the petitioner did not answer the call. The findings also show the petitioner called the Department following his hearing date inquiring about the status of his Medicaid application. The undersigned concludes the Department followed through on the first attempted disability interview. However, the undersigned also concludes the Department failed to follow up with the customer when he called after the initial interview date and inquired about his case.

28. 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.

29. 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.

30. 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).

31. 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.)

32. 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.

33. The undersigned explored potential eligibility for Medicaid for the petitioner under the SSI-Related Medicaid program. The petitioner was 44 years old at the time of application. 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.

34. 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 May 16, 2016. The findings also show SSA determined the petitioner was not disabled on July 13, 2016 and that decision has been appealed.

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.

35. The undersigned concludes the Department failed to complete the interview process with the petitioner and follow it with the determination of disability. However, due to the subsequent denial of disability by SSA, the above controlling authority now binds the Department to the SSA decision regarding disability. The findings also show the SSA decision is presently under appeal with no indication that SSA has refused to consider any new allegations. The undersigned concludes the SSA denial of disability results in the petitioner's ineligibility for SSI-Related Medicaid on the technical factor of disability.

36. Based on the evidence and testimony presented, the above-cited rules and regulations, the undersigned concludes the initial denial of SSI-Related Medicaid due to failure to complete the interview was done improperly, however, 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.

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 27 day of October, 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

Oct 31, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06023

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88674

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 8:35 a.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Joseph Austrie, operations management consultant

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of August 8, 2016 denying Medicaid eligibility as the petitioner was determined to "not meet the disability requirement." The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Margaret Poplin, Office of Appeal Hearings, observed the hearing with no objections.

The respondent submitted a packet of information that was entered into evidence and marked as Respondent's Exhibits "1" through "15".

FINDINGS OF FACT

1. In October 2015, petitioner, a 52 year-old single female, applied for disability benefits with the Social Security Administration (SSA). This application was denied in January 2016. The petitioner was found not to meet the disability requirements.
2. On July 25, 2016, by paper application, the petitioner applied with the respondent for Food Assistance Program (FAP) benefits and Medicaid. By notice of case action (NOCA) dated August 12, 2016, she was notified of the approval of the FAP benefits and the denial of Medicaid application. The denial reason was, "You or a member(s) of your household do not meet the disability requirements" (Respondent's Exhibit 1 and 2).
3. Petitioner applied for disability benefits with the SSA also on July 25, 2016 claiming new conditions not included in the October 2015 application. She submitted to the SSA the results from an MRI and CT scan indicating [REDACTED], [REDACTED]. The petitioner stated she is in constant pain, has severe swelling and is medically unable to work. This claim, as of the writing of this order is pending.
4. On August 1, 2016, a disability packet was sent by the respondent to the Division of Disability Determination (DDD) for review. On August 4, 2016, DDD concluded that the petitioner was not disabled. N32 was the reason given for the denial, which states

“non-pay-capacity for substantial gainful activity – other work, no visual impairment” (Respondent’s Exhibits 6 and 9). In the remarks on the Disability Determination Transmittal, CF-ES 2909, the examiner notes, “Hankerson January, 2016, same allegations.” The diagnoses listed at 11a and 11b on the 2909 are “07 coagulation defect” and “01 back disorder.”

CONCLUSIONS OF LAW

5. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.
6. 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. 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.

9. The findings show that petitioner applied for disability benefits with the SSA in October 2015 with primary diagnoses considered of [REDACTED]

[REDACTED] This application was denied as she was found not disabled. The denial date was January 2016.

10. The petitioner applied for Medicaid with the respondent on July 25, 2016. The SSA denial date is within 12 months of the Medicaid application date.

11. The petitioner refiled with the SSA for disability in July 2016. This application is still pending claiming conditions of [REDACTED] and the inability to work.

12. The July 25, 2016 Medicaid application was denied by the respondent after receiving a DDD determination of "not disabled" on August 4, 2016, with remarks "Hankerson 1/16, same allegations." The undersigned concludes that the conditions

claimed at the July 2016 disability application are not different enough from previous allegations made to the SSA to merit reconsideration by DDD.

13. In accordance with the above controlling authority, the undersigned concludes that the respondent correctly adopted the federal SSA disability decision rather than make an independent decision on petitioner's disability request.

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

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference ... (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (20007) (incorporated by reference).

15. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (by either the Department or SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs. Because petitioner is under age 65 and has not yet been determined disabled by SSA, she does not meet the technical criteria to be eligible for SSI-Related Medicaid; therefore, the Department 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 of the date stamped 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 31 day of October, 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

Oct 26, 2016

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-06063

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88369

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 29, 2016 at 11:37 a.m.

APPEARANCES

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

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

ISSUE

The petitioner is appealing the Department's action on August 16, 2016 to continue her enrollment in the Medically Needy (MN) program with an estimated monthly share of cost in the amount of \$598, which was later corrected to \$499.

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.

No evidence was received from the petitioner.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. On August 15, 2016, the petitioner completed an application to recertify for Food Assistance Program and Medicaid benefits. The household consists of the petitioner (age 51), her husband (age 48), and their mutual child (age 17). The petitioner's husband receives Social Security income in the amount of \$985 and her daughter receives Social Security income in the amount of \$405.

2. The Department provided the current Medicaid budget to explain how the corrected share of cost amount was calculated. The Department included in its evidence packet, the ACA MFAM Manual Budget Sheet (draft), which included the steps to determine if the household is eligible for Medicaid or the Medically Needy program.

3. Step one of the draft included determining the tax filing unit (TFU). The Department determined that the TFU included the petitioner, her husband, and child. The petitioner was considered the eligible adult (EA); her husband was considered the counted adult (CA); and their child was considered the counted child (CC), for a standard filing unit (SFU) size of three persons.

4. Step two includes comparing the Modified Adjusted Gross Income (MAGI) to the income standard for the TFU. If the MAGI is equal to or less than the income

standard, the assistance group is eligible for full-coverage Medicaid. The Department included in its calculations the gross unearned income in the amount of \$985, which exceeded the Income Standard of \$303 for a three person household. Since the income exceeded the income standard, the Department is instructed to proceed to step three.

5. Step three includes subtracting the appropriate standard disregard from the MAGI and comparing to the income standard. The AG is eligible for Medicaid if the income is less than the \$303 income standard. The Department's calculations included the gross income of \$985 subtracted by the \$183 standard disregard for a household size of three, which resulted in \$802. This amount was greater than the \$303 income standard. Therefore, the petitioner was ineligible for full-coverage Medicaid. The Department is instructed to proceed to step four.

6. Step four includes subtracting the MAGI disregard, which is 5 percent of 100% of the federal poverty level, from the income and comparing to the income standard. The Respondent's Exhibit 2, page 14, lists the MAGI disregard for a family size of three as \$84. If the result is less than the \$303 income standard, the AG is eligible for full-coverage Medicaid. The Department included in its calculations the result (\$802) from step three and subtracted the MAGI disregard in the amount of \$84, to result in the amount of \$718. This amount is greater than the \$303 income standard for three persons; therefore, the petitioner was ineligible for full-coverage Medicaid. The Department proceeded to calculate a budget for the Medically Needy share of cost.

7. The Department included its calculations the petitioner's husband's income in the amount of \$985. The Department subtracted the Medically Needy Income Limit (MNIL) of \$486 for a three person household from \$985 to result in a monthly share of cost in the amount of \$499.

8. The petitioner argues that she is normally healthy but needs Medicaid until she can get treatment to correct a botched surgery so that she can go back to work. The petitioner believes her husband's income should not be included in determining her eligibility for Medicaid.

9. The petitioner explained that she and her husband file their taxes together but do not claim their daughter. The petitioner contends that her son used to claim their daughter on his taxes, years ago, when he used to live with them.

10. The Department explained that an operator error was the cause of the prior budgets only including two persons in the SFU; this error caused the share of cost amount to be higher at \$598. The petitioner's daughter was included in the SFU as a counted child, which caused her needs, but not her income, to be included in the budget. The Department explained that the petitioner's husband's income cannot be excluded from the budget since he is her spouse.

CONCLUSIONS OF LAW

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

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

13. The Family-Related Medicaid income criteria are set forth in Federal Regulations at 42 C.F.R § 435.603 and 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.

(b) Definitions. For purposes of this section—

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

...

Parent means a natural or biological, adopted or step parent.

...

(c) Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid base 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.

14. The above authority explains that the income of every individual in the household is to be included as household income when determining eligibility for Medicaid. However, the income belonging to natural, adopted, or step children is excluded as long as the child is included in the household and is not expected to be required to file a tax return. In this case, the findings show that the petitioner's child is not claimed as a dependent and is not claimed on anyone else's tax return. The

petitioner and her husband file a joint tax return. Therefore, the undersigned concludes that the Department was correct to include as income the petitioner's husband's income and exclude the petitioner's daughter's income in its calculations.

15. The 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:

1. Mother;
2. Father, legal or biological

(d) If assistance is requested for the parent of a child in an intact family, the parent, the mutual child's other parent, the mutual child and all siblings of the mutual child who have no income must be included in the SFU. Any siblings who have income, or any other related fully deprived children, are optional members of the SFU. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI.

16. The Department's Program Policy Manual, CFOP 165-22, Appendix A-7, indicates the Family-Related Medicaid income limit for Parents is \$303 for a family size of three and the standard disregard is \$183. The Medically Needy Income Limit (MNIL) is \$486 for a family size of three and the MAGI disregard is \$84.

17. The Department's Program Policy Manual, CFOP 165-22, 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 KidCare and/or the Federally Facilitated Marketplace (FFM).

18. In this case, the Department considered only the petitioner's husband's Social Security income in the amount of \$985 to determine the petitioner's eligibility for Medicaid. The Department compared the household income to the Family-Related Income Limit in the amount of \$303 for a family size of three and determined that the petitioner was ineligible for full-coverage Medicaid as the household income exceeded the income limit. According to the above controlling regulations, the undersigned concludes that the Department's action to continue the petitioner's enrollment in the Medically Needy program was correct. The income exceeds the limit for the parent to receive full coverage Medicaid.

DECISION

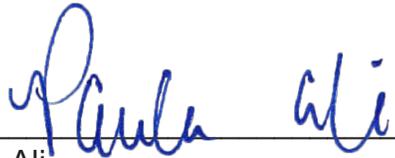
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

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 26 day of October, 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

FILED

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

Oct 31, 2016

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 16F-06099

PETITIONER,

Vs.

CASE NO. 1165497794

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88RRT

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 29, 2016, at 11:50 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Laverne Baker-Canel, supervisor.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny full Medicaid benefits for herself and her 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

On August 8, 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 \$1,794.

During the hearing, the petitioner submitted four (4) exhibits, which were accepted and marked as Petitioner's Exhibits 1 through 4. The respondent submitted four (4) exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 4. The record was left open through end of business day for the respondent to provide additional information for consideration. The information was timely received and marked as Respondent's Exhibits 5 & 6 and the record was closed.

FINDINGS OF FACT

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

1. Petitioner, [REDACTED], is 48 and is not pregnant. She is not currently employed and has no recent work history. She has applied for disability in 2012 and was denied.
2. Petitioner has the following medical conditions: [REDACTED]
[REDACTED] See Petitioner's Exhibits 1-4.
3. On March 18, 2016, the petitioner submitted an application requesting temporary Cash, Food Assistance Program (FAP) and Medicaid benefits for her family. Her household comprises of herself, her husband and their 13 year-old child. The husband is a tax filer with petitioner and the child. On that application, the petitioner did not report being disabled, See Respondent's Exhibit 1.

4. Petitioner's husband is gainfully employed. He gets paid weekly and provided the following paystubs; \$579.50 on 3/3/16; \$587.13 on 3/10/16; \$594.75 on 3/17/16 and \$594.75 on 3/24/16. Based on the information listed on the application, petitioner was approved for the Medically Needy benefits.

5. On April 7, 2016, the respondent sent the petitioner a Notice of Case Action informing her she was denied Cash Assistance and Food Assistance benefits due to excess income. Additionally, the notice informed her that her household was approved for the Medically Needy Medicaid and that all three members were enrolled separately with a \$1,870 SOC, See Respondent's Exhibit 2. The SOC has since been adjusted to \$1,794 based on a June 9, 2016 application.

6. Petitioner is seeking full Medicaid benefits for herself only and is challenging her enrollment in the Medically Needy Program. The respondent's most recent budget shows, in determining eligibility for Medicaid for the petitioner (NA R 2), the husband's weekly income was converted to a monthly amount to equal \$2,280. This amount is called modified adjusted gross income (MAGI). The 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.

7. As the petitioner was determined ineligible for full Medicaid, the 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 (\$2,280), resulting in an estimated SOC of \$1,794, See Respondent's Exhibit 5.

8. The 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. Additionally, she explained that petitioner's SOC amount is directly dependent on the household MAGI.

9. 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 she has a series of medical issues that required medical attention and that she wants to have Medicaid to get the care she needs. Petitioner has no recent disability 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. 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.

13. 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.

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, her husband and their child (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.

16. 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.

17. 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.

18. 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).

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 4 if income is received weekly for Medicaid eligibility determination. The undersigned could not find a better outcome in determining the household income.

21. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. The undersigned concludes the petitioner is not eligible for full Medicaid under the Family-Related Medicaid Program. The respondent proceeded to explore the Medically Needy Program. The undersigned recognizes the petitioner's concerns about 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 SFU as a household of three 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. It indicates that the MNIL for a household of three is \$486.

27. Originally, petitioner’s SOC was estimated to be \$1,870, after a subsequent application, it was reduced to \$1,794. The hearing officer reviewed the respondent’s

most recent SOC calculation and found no errors in the calculation. A more favorable outcome could not be found.

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 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.

FINAL ORDER (Cont.)
16F-06099
PAGE -11

DONE and ORDERED this 31 day of October, 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]
Office of Economic Self Sufficiency

FILED

Oct 17, 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-06130

PETITIONER,

vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 88584

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on September 15, 2016 at 1:00 p.m.

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Stan Jones, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner full SSI-Related Medicaid benefits and instead enroll him in the Medically Needy (MN) program effective July 2016 and ongoing is correct. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner was present and testified. Petitioner submitted no exhibits at the hearing. Respondent was represented by Stan Jones with the Department of Children

and Families (hereafter “DCF”, “Respondent” or “Agency”). Respondent submitted eight exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” through “8”.

FINDINGS OF FACT

1. On July 12, 2016, the petitioner completed an application for SSI-Related Medicaid benefits. The application listed the petitioner and his wife as the only household members; and the wife’s earned income as \$3,926.36 per month, the petitioner’s pension income, and the petitioner’s Social Security income as the only sources of income for the household.
2. On July 15, 2016, the respondent mailed the petitioner a Notice of Case Action that requested he submit documentation by July 25, 2016: The requested documentation was “Proof of all gross income from the last 4 weeks using the “Verification of Employment/Loss of Income” form or you may send in you last 4 pay stubs, Verify the other income that you reported on the Application 1256MTH. If you no longer receive this income then verify with a letter from the Agency when it ended.”
3. On July 18, 2016, the respondent verified the petitioner’s SSA and pension income; however, the respondent never verified the wife’s earned income.
4. Petitioner’s Social Security Disability Insurance (SSDI) amount is \$2,125 (gross) per month and the petitioner’s pension income is \$1,249.26 (gross) per month. Petitioner does not receive Medicare Part A and B.
5. Respondent calculated the wife’s earned income by utilizing the income reported on the application. Respondent determined the wife’s earned income as \$1,568.

6. Respondent determined the petitioner's Medically Needy (MN) estimated share of cost (SOC) amount as \$3,871 effective July 2016 and ongoing as follows:

\$2125.00	petitioner's SSDI income
<u>+\$1249.26</u>	<u>petitioner's pension income</u>
\$3381.00	petitioner's total unearned income
<u>-\$ 20.00</u>	<u>unearned income disregard</u>
\$3361.00	total countable unearned income
\$1568.00	wife's estimated earned income after allocations
<u>-\$ 65.00</u>	<u>earned income disregard</u>
<u>-\$ 751.50</u>	<u>½ remaining disregard</u>
\$ 751.50	estimated countable earned income
<u>+\$3361.00</u>	<u>total countable unearned income</u>
\$4112.50	total countable income
\$4112.50	total countable income
<u>-\$ 241.00</u>	<u>MNIL for a household of two</u>
\$3871.00	estimated share of cost

7. On July 19, 2016, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's July 12, 2016 MN Medicaid application was approved for July 2016 and ongoing. The notice also indicated the petitioner's estimated monthly SOC was \$3,871.

8. Petitioner does not agree with the respondent's determination that he is not eligible for full SSI-Related Medicaid benefits as he is not able to pay for all of his medical expenses as well as all of his household expenses. Petitioner also cannot afford to pay for private insurance and requires Medicaid to pay for his medical expenses.

9. Respondent explained the petitioner was not eligible for full SSI-Related Medicaid benefits as he is over the SSI-Related Medicaid income limit for one person and for a couple.

CONCLUSIONS OF LAW

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

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

12. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, defines the criteria to receive SSI-Related Medicaid benefits and states, in part:

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

(1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

...

(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

13. Pursuant to the above authority, the petitioner is eligible for the SSI-Related Medicaid programs as he is considered disabled.

14. Fla. Admin. Code R. 65A-1.713 (2), SSI-Related Medicaid Income Eligibility Criteria, defines the types of included and excluded income and states, in part:

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

(e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional programs.

15. Pursuant the above authority, the petitioner's SSDI income, his pension income, and his wife's earned income are considered included income in the determination of his SSI-Related Medicaid Benefits.

16. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2240.0610, Couple/One Requests Medicaid (MSSI) states:

The following policy is applicable only to MEDS-AD, QMB, SLMB, QI-2, EMA, Protected Medicaid, Medically Needy, and Working Disabled Programs.

If an individual is living with their spouse and only one is requesting or receiving Medicaid (or the spouse does not meet the technical criteria for the program), the income and assets must be deemed from the spouse who is not requesting assistance (or who does not meet the technical criteria). If there is not enough income to be deemed, the income standard for one is used. If there is enough income to deem, the individual must first pass the individual test for one. If they pass the individual income test, they must also pass the couple standard using deemed income from the spouse.

Note: Regardless of the income standard used, the asset standard for a couple must be used.

17. Pursuant to the above authority, if an individual is living with a spouse not eligible for SSI-Related Medicaid benefits, the spouse's income is potentially deemed when determining the individual's eligibility for an SSI-Related Medicaid program.

Respondent must determine if the spouse's income is to be deemed as the income

standard utilized in the determination of Medicaid benefits is based on whether or not the spouse's income is deemed.

18. The Policy Manual, CFOP 165-22, passage 2640.0214, Exceptions to Deeming Policy (MSSI) states:

When an individual applying for the Medically Needy, Protected Medicaid, Working Disabled, Emergency Medical Assistance to Noncitizens, QMB, SLMB, QI1, or MEDS-AD lives with an ineligible spouse, income must be deemed to the individual. There are three exceptions to this policy:

1. Income is deemed from spouse to spouse during the month of separation, but each is treated as an individual beginning with the month following the month of separation. When both members of a couple are institutionalized, they have the choice of having eligibility determined either as a couple or as individuals.

2. When one spouse receives HCBS and the other receives MEDS-AD, Medically Needy, QMB, SLMB, QI1, Working Disabled or Protected Medicaid, income will be deemed from the HCBS spouse to the MEDS-AD, QMB, SLMB, QI1, Working Disabled, Medically Needy or Protected Medicaid spouse. Income will not be deemed to the HCBS spouse.

3. Do not deem need-based income (such as TCA payments or VA pensions) from the ineligible spouse to the eligible individual. Determine eligibility as an individual when there is no deeming.

19. Pursuant to the above authority, there are three exceptions to the deeming policy when determining an individual's eligibility for SSI-Related Medicaid program. Petitioner does not meet any of the aforementioned exceptions; therefore, his wife's earned income must be deemed to the petitioner's SSI-Related Medicaid budget.

20. The Policy Manual, CFOP 165-22, passage 2640.0216, Determine If Ineligible Spouse Has Income To Deem (MSSI) states:

Step 1 - If the ineligible spouse's gross included income is less than one half the individual FBR, do not deem. Determine eligibility as an individual. If income is greater than one half the FBR, determine if there are any children who are not blind or disabled. If so, determine the unmet allocation for each child who is not blind or disabled. The ineligible child allocation is the difference between the couple FBR and the individual FBR.

Step 2 - Subtract each child's income who is not blind or disabled from the need allocation to determine the unmet need allocation. Add unmet allocation for all children to determine the total unmet allocation.

Step 3 - Subtract the total unmet allocation for all children who are not blind or disabled from the ineligible spouse's unearned income. (Formula: Unearned Income of Spouse - Total Unmet Allocation = Remaining Unearned Income/Unmet Allocation.)

Step 4 - If there is unearned income remaining, add the remaining unearned income to the ineligible spouse's earned income, if any. If there is an unmet allocation remaining, subtract the remaining unmet allocation from the spouse's earned income if any. The result is the total income after allocations.

Step 5 - Compare the total income after allocations to one half the FBR. If the total income after allocations is less than one half the FBR, do not deem. Determine eligibility as an individual. If the total income is more than one half the FBR, deeming is required.

21. The Policy Manual, CFOP 165-22, Chapter F, defines the Federal Benefit Rate (FBR) as the standard SSI benefit rate to be applied for any SSI individual in a given situation.

22. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI Income limit for an individual as \$733 and for a couple as \$1,100.

23. Pursuant to the above authorities, since the wife's earned income is more than one half of the FBR, then she has income that must be deemed to the petitioner's SSI-Related Medicaid budget.

24. The Policy Manual, CFOP 165-22, passage 2640.0217, Eligibility with Income Deemed from Spouse (MSSI) states:

The following policy is applicable only to MEDS-AD, QMB, SLMB, QI1, Medically Needy, Protected Medicaid, Working Disabled and Emergency Medical Assistance to Noncitizens.

When income is deemed from the ineligible spouse, the budget must be computed treating them as a couple. Follow these steps to determine the individual's eligibility and SOC:

Step 1 - Determine the couple's total included income. Subtract the total included income from the FBR for a couple. (Formula: Couple FBR - Total

Included Income = Surplus, Deficit). If there is a deficit, the individual may be eligible for SSI, but continue to determine eligibility for the categorical program.

Step 2 - If the individual has income equal to or less than the applicable income standard, process the case for the categorical program.

Step 3 - If there is not a deficit and the individual is otherwise eligible for Medically Needy, subtract the MNIL for two from the total included income. (Formula: Total included income - MNIL for Two = Potential Share of Cost.)

25. Pursuant to the above authority, since the wife's earned income is deemed to the petitioner's SSI-Related Medicaid budget, the petitioner's Medicaid budget must treat them as a couple. Furthermore, the respondent determines if the petitioner is eligible for full SSI-Related Medicaid by subtracting the household's total income from the couple FBR. In this instance, the household's total income is \$7,300.62 or the petitioner's SSDI and pension income of \$3,374.26 plus the wife's earned income of \$3,926.36. Respondent then subtracts \$1,100 (couple FBR) from \$7,300.62 for a total amount of \$6,200.62, which is then compared to the income standard for a couple.

26. Fla. Admin. Code R. 65A-1.713 (1)(a) SSI-Related Medicaid Income Eligibility Criteria defines the types of included and excluded income and states, in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan.

The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

27. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for a couple for MEDS-AD as \$1,175.

28. Pursuant to the above authorities, the petitioner's monthly SSDI income, pension income, and the deemed part of his wife's earned income exceed the Medicaid income

standard for him to receive full SSI-Related Medicaid benefits; therefore, he is correctly enrolled in the Medically Needy Program with a monthly share of cost.

29. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner has not met the burden of proof to indicate the respondent incorrectly denied him full SSI-Related Medicaid benefits and instead enrolled him in the Medically Needy Program with a monthly share of cost amount effective July 1, 2016.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's SSI-Related Medicaid appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 17 day of October, 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

Oct 26, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06453

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 04 Clay

And

MOLINA HEALTHCARE (MOLINA)

RESPONDENTS.
_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on October 17, 2016 at 3:13 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Carlos Galvez, government contract specialist with Molina

STATEMENT OF ISSUE

At issue is the respondent's decision denying a Medicaid provider, Nemours Children's Hospital (Nemours), reimbursement for medical services rendered to the petitioner July 26, 2016 – July 27, 2016.

PRELIMINARY STATEMENT

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

By notice dated August 2, 2016, Molina informed the petitioner that it denied Nemours' reimbursement request for medical services rendered to him July 26, 2016 – July 27, 2016.

The petitioner requested a hearing on August 22, 2016 to challenge the denial decision.

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

Present as a respondent witness from Molina: Elvis Leiva, manager of healthcare services. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1. Sheila Broderick, registered nurse specialist with AHCA, was present as an observer. The record was closed on October 17, 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 6) is a Florida Medicaid recipient. The petitioner is enrolled with Molina HMO.
2. The petitioner's treating physician determined that surgery was necessary to repair damage to his bladder. "Bladder reflux" was causing urine to "back-up" in the petitioner's kidneys; he was experiencing significant abdominal pain. The surgery was performed at Nemours on July 26, 2016. The petitioner was discharged from the hospital on July 27, 2016.
3. All Medicaid goods and services must be medically necessary. Some services require prior service authorization which is completed by the Agency, the HMO or another designee. Nemours submitted a service authorization request for the petitioner's surgery to Molina on July 27, 2016, the day after the surgery was performed.
4. Molina denied the provider's authorization request, citing improper procedure as the reason for the denial. Molina asserted that authorization request should have been submitted prior to Nemours performing the surgery.
5. The petitioner has not received a bill from Nemours. Molina asserted that the petitioner should never receive a bill from Nemours regarding this matter because providers who accept Medicaid must accept Medicaid's reimbursement decision, including denial decisions, and cannot seek reimbursement from the Medicaid recipient.

CONCLUSIONS OF LAW

6. Federal Medicaid Regulations at 42 C.F.R. § 431.220 states in relevant part, “(a) The State agency must grant an opportunity for a hearing to the following: (1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness (2) Any recipient who requests it because he or she believes the agency has taken an action erroneously...”

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

2900 FAIR HEARINGS AND APPEALS

Section 1902(a)(3) of the Social Security Act requires that States ‘provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.’ Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited . 2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).--Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

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

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

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

9. The respondents denied a provider's reimbursement request for medical services rendered to the petitioner. The petitioner was not denied a good or service and has no material interest in rather a provider is reimbursed for services. The Office of Appeal Hearings does not have jurisdiction over Medicaid provider reimbursement issues.

DECISION

The appeal is dismissed as non-jurisdictional.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 26 day of October, 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]
AHCA, Medicaid Fair Hearings Unit
Molina Hearings Unit

FILED

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

Oct 25, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06559

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 4, 2016 at 3:00 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

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 the nutritional supplement Glucerna was correct. The respondent bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a medical necessity form and prescription as evidence for the hearing, which was marked as Petitioner Exhibit 1.

Appearing as witnesses for the respondent were Melody Gordon, Utilization Manager, and Dr. Darwin Caraballo, Medical Director, for Coventry Healthcare, which is the petitioners' managed health care plan.

The respondent submitted the following documents into evidence, which were marked as Respondent composite Exhibit 1: Denial Notice, Authorization Request, Medical Assessment Form, and Plan of Care.

FINDINGS OF FACT

1. The petitioner is a one hundred and four (104) year old Medicaid recipient who is enrolled in the Statewide Medicaid Managed Care (SMMC) – Long-Term Care (LTC) plan. She receives services under the plan from Coventry Healthcare.
2. On or about April 18, 2016, the petitioner's treating physician submitted an authorization request to Coventry Healthcare for approval of the nutritional supplement drink called Glucerna. She had been previously supplied with Glucerna by Coventry.
3. On or about April 25, 2016, Coventry Healthcare denied the request for the Glucerna. The denial notice stated the following:

Your request for meal supplementation with Glucerna cans is denied. The medical records notes received do not indicate that your diabetes health condition is out of control and you need Glucerna to control it. Also, Aetna/Coventry guidelines consider nutritional supplements medically necessary when you need to be fed thru a tube or through a vein, or because of a medical problem with your bowels digesting or absorbing the nutrients in your diet. Based on the doctor notes we received, this is not your case.

4. The petitioner's granddaughter stated her grandmother cannot eat solid food, only pureed food, and she needs Glucerna twice per day for nutrition. She also stated her grandmother consumes another product called Ensure Plus pudding for nutrition. Her grandmother is not diabetic.

5. The respondent's witness, Ms. Gordon, stated Glucerna is more appropriate for use in diabetic patients and the petitioner is not diabetic. She also stated the petitioner may be able to obtain a similar product called Ensure Plus to provide nutrition. The health plan would need a prescription from her doctor to approve that product.

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 Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook ("DME Handbook"), effective July, 2010.

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 respondent since the petitioner had been previously approved for Glucerna. 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. The Medicaid Handbook and the DME Handbook are incorporated by reference in Chapter 59G-4, Florida Administrative Code.

12. Florida Statute § 409.912 requires that the respondent “...purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care.”

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. After considering all the documentary evidence and witness testimony presented, the undersigned concludes Coventry Healthcare correctly denied the petitioner's request for the Glucerna. The alternative product, Ensure Plus, would be more appropriate since the petitioner is not diabetic. The petitioner should follow up with her treating physician to obtain a prescription for Ensure Plus and then submit the request to Coventry for approval.

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 25 day of October, 2016,

in Tallahassee, Florida.

FINAL ORDER (Cont.)

16F-06559

PAGE - 6



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

████████████████████
AHCA, Medicaid Fair Hearings Unit
Idalia Falcon
Coventry Hearings Unit

FILED

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

Oct 25, 2016

Office of Appeal Hearings
Dept. of Children and Families

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

APPEAL NO. 16F-06562

PETITIONER,

Vs.

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

And

AMERIGROUP,

RESPONDENTS.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 24, 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 dental services (root canals and dental crowns) 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 Lisa Williams, Quality Operations Nurse, from Amerigroup, which is the petitioner's managed health care plan. Amerigroup 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 Amerigroup.

The respondent submitted the following documents as evidence for the hearing, which were marked as Respondent Composite Exhibit 1: Hearing Summary, Authorization Requests, Denial Notices, and Plan Provisions.

FINDINGS OF FACT

1. The petitioner is a thirty-four (34) 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 of requests for dental services.
2. On or about July 16, 2016, the petitioner's treating dentist (hereafter referred to as "the provider"), requested prior authorization from DentaQuest and/or Amerigroup for approval of 2 dental crowns. Amerigroup denied this request on July 16, 2016. The reason for the denial of the dental crowns was that it was a non-covered service or benefit. The petitioner's provider on August 1, 2016 also requested approval for 3 root

canals. This request was denied by Amerigroup on August 2, 2016 for the same reason – that it was a non-covered service or benefit.

3. The petitioner stated she needs to have these dental services performed but she cannot afford to pay for the services herself.

4. Ms. Salcedo from DentaQuest stated that the request services (root canals and dental crowns) are not covered services under Amerigroup'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 requests for the root canals and dental crowns were not denied due to any medical necessity considerations, but because those services are non-covered services or benefits according to the Amerigroup 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 Amerigroup, 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 Amerigroup. Root canals and dental crowns are non-covered services for adults under the Medicaid guidelines referenced above and under the Amerigroup dental plan provisions. Therefore, the hearing officer cannot make a determination that these services must be covered by the petitioner's plan.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25 day of October, 2016,

in Tallahassee, Florida.

FINAL ORDER (Cont.)

16F-06562

PAGE - 6



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

FILED

Sep 06, 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. 16N-00042

PETITIONER,

Vs.

CASE NO.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on July 18, 2016 at 10:36 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: [REDACTED], Administrator

ISSUE

At issue is the nursing home facility's intent to transfer and/or discharge the petitioner without providing him a Nursing Home Transfer and Discharge Notice. The facility has the burden of proof to establish by clear and convincing evidence that the transfer and/or discharge is appropriate under federal regulations found in 42 C.F.R. § 483.12.

PRELIMINARY STATEMENT

On June 15, 2016, a status conference was held to determine if the undersigned had jurisdiction over the matter. The undersigned reserved ruling on jurisdiction and set an administrative hearing for July 18, 2016 to determine if the nursing home facility properly transferred and/or discharged the petitioner.

Petitioner was present and testified. Petitioner presented one witness who testified: [REDACTED]. Petitioner presented no exhibits at the hearing. Respondent was represented by Wanda Cordero, Administrator of [REDACTED]. Ms. Cordero testified. Respondent presented one witness who testified: Kristy Sullivan, Business Officer Manager, with [REDACTED] and Nursing Home. Respondent submitted one exhibit, which was accepted into evidence and entered as Respondent's Exhibit "1". The undersigned submitted one exhibit, which was accepted into evidence and entered as Hearing Officer's Exhibit "1".

The record was left open until July 25, 2016 to allow both parties to submit additional evidence. On July 18, 2016, the respondent submitted additional evidence, which was accepted into evidence and entered as Respondent's Exhibit "2". On July 25, 2016, the petitioner submitted evidence, which was accepted into evidence and entered as Petitioner's Exhibit "1". The record closed on July 25, 2016.

FINDINGS OF FACT

1. Petitioner entered the facility in August 2014 and remained a resident until April 19, 2016.
2. On April 19, 2016, the petitioner became ill with an infection and was transported to the hospital. Petitioner discussed his illness with both the night and day nurses, who

recommended he be transported to the hospital if he did not wish to wait for the facility's physician to examine him. Petitioner decided not to be examined by the facility's physician and instead chose to be treated at the hospital. Petitioner argued the facility's day nurse called a non-emergency number to have him transported to the hospital.

3 Respondent argued the petitioner's mother called 911 to have her son transported to the hospital. The current administrator was not the administrator at the time the petitioner was discharged in April 2016. Respondent provided a letter from the nurse on duty that indicated the petitioner's mother called 911; however, the respondent did not submit into evidence any nurses' notes for the date of April 19, 2016.

4. The nursing home facility provided the petitioner with a written notice of its bed hold policy. The facility can discharge the petitioner if he remains in the hospital for more than eight days as the facility's policy allows it to hold petitioner's bed for only eight days after leaving facility. Respondent did not submit into evidence the written notice of its bed hold policy.

5. Petitioner has remained in the hospital since April 19, 2016 and he wishes to return to the nursing home facility.

CONCLUSIONS OF LAW

6. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Fla. Stat. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

7. The Code of Federal Regulations 42 C.F.R. § 483.12, limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was provided written notice of the facility's bed-hold policy:

(b) Notice of bed-hold policy and readmission—(1) Notice before transfer.

Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies—

(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident—

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

(4) Readmission to a composite distinct part. When the nursing facility to which a resident is readmitted is a composite distinct part (as defined in §483.5(c) of this subpart), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of readmission, the resident must be given the option to return to that location upon the first availability of a bed there...

8. Petitioner went to the hospital because of an illness. He did not wait for the facility's physician to examine him and instead chose to be treated at the hospital. The facility's nurse called the non-emergency number to have petitioner transported to the

hospital. The facility provided the petitioner with written notification of its bed hold policy that indicated the facility would hold his bed for eight days.

9. In order for the undersigned to have jurisdiction over the petitioner's transfer and/or discharge from the nursing home facility, the petitioner's transfer and/or discharge must meet certain criteria to have appeal rights.

10. Section 400.0255, Fla. Stat. addresses transfers and discharges that have appeal rights and states, in part:

(1) As used in this section, the term:

(a) "Discharge" means to move a resident to a noninstitutional setting when the releasing facility ceases to be responsible for the resident's care.

(b) "Transfer" means to move a resident from the facility to another legally responsible institutional setting.

(2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident.

(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant...

(10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer...

(17) The provisions of this section apply to transfers or discharges that are initiated by the nursing home facility, and not by the resident or by the resident's physician or legal guardian or representative.

11. Pursuant to the above authority, individuals only have appeal rights to challenge transfers and/or discharges that are initiated by the facility and not by the individual.

Petitioner did not wish to wait for the facility's physician to examine him and instead chose to be treated at the hospital. A nurse from the facility called a non-emergency number to have the petitioner transported to the hospital. Petitioner and not the facility initiated the transfer and/discharge from the nursing home facility.

12. The undersigned is not permitted to rule on the merits of the petitioner's appeal as the evidence indicates the respondent did not initiate the petitioner's transfer from the facility; therefore, the petitioner cannot challenge a transfer and/or discharge action he initiated.

13. The nursing home facility and the petitioner are encouraged to discuss how the petitioner may reenter the nursing home facility as he wishes to return to the facility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby DISMISSED as non-jurisdictional as the petitioner cannot challenge or appeal a transfer and/or discharge not initiated by the facility.

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 06 day of September, 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]

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-00051

PETITIONER,

Vs.

CASE NO.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 26, 2016 at 2:11 p.m. in [REDACTED]
[REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: [REDACTED]

ISSUE

At issue is the facility's intent to discharge the petitioner because the "safety of the other individuals in this facility is endangered." The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.12 (a) and Section 400.0255, Fla. Stat.

PRELIMINARY STATEMENT

Petitioner was present, testified, and was represented by Kevin Sparkman. Petitioner presented no exhibits at the hearing. Respondent was represented [REDACTED] [REDACTED] [REDACTED]. Respondent presented four witnesses from [REDACTED] who testified: [REDACTED] [REDACTED] [REDACTED] [REDACTED]. Respondent submitted two exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" and "2". The undersigned submitted one exhibit, which was accepted into evidence and entered as Hearing Officer's Exhibit "1".

FINDINGS OF FACT

1. Petitioner was admitted to the respondent's nursing facility on July 22, 2015. During the petitioner's admission to the facility, the staff reviewed and the petitioner signed an admission packet that explained the services the petitioner would receive at the facility.
2. On August 8, 2015, the respondent conducted a Diagnostic Interview with the petitioner during which it determined he was not a risk to others. Furthermore, the petitioner did not have any incidents of verbal or physical aggression when the interview was conducted.
3. On March 7, 2016, the petitioner hit a staff member on the arm and screamed at another while receiving personal care services. He also threatened to throw a rag at a staff member's face.

4. The facility contacted the police about the aforementioned incident. One of the staff members involved in the incident pressed charges against the petitioner. There is a pending criminal case against the petitioner for the March 2016 incident.
5. The staff member involved in the March 2016 incident did not receive any medical treatment from either a physician or nurse.
6. Between March 2016 and June 2016, the facility never counseled the petitioner about his behaviors and that he cannot hit and throw objects at others.
7. On April 25, 2016, the facility provided the petitioner a Notice of Transfer and Discharge. The reason for the discharge was "the safety of other individuals in this facility is endangered". Handwritten on the notice is "Engaging in behavior that is threatening and endangering to others in accordance with Florida Law".
8. The nursing home facility does not have any written policy concerning inappropriate behaviors, such as hitting a staff member. The first time the petitioner received any written notification about his behaviors was on April 25, 2016 when he received the discharge notice.
9. On June 6, 2016, the petitioner hit a staff member on the side of her head during his restorative therapy session. Petitioner quickly apologized to the staff member for his behavior. The facility contacted the police about the incident. The staff member involved did not press any charges, but instead completed a police report. The police report indicates the police officer "did not observe any injuries the" staff member involved in this incident.

10. The staff member did not receive any medical treatment from either a physician or nurse.
11. On June 15, 2016, the facility counseled the petitioner about his behaviors and that cannot hit and throw objects at others. At that meeting, the petitioner stated he would not display these behaviors as long as staff members did not hurt him.
12. Petitioner has never hit a resident while living in the facility. However, the nursing home facility explained that the petitioner is often very loud and aggressive and other residents are scared of him.
13. From December 29, 2015 through April 13, 2016, the petitioner engaged in several incidents of verbal aggression with staff members that included behaviors, such as screaming and cursing.
14. Petitioner explained he is friendly to the other residents and often gives them comfort and care. He feels he is not a "mean person".
15. The nursing home facility attributes the petitioner's inappropriate behaviors to his physical and mental health conditions.
16. Petitioner attributes his inappropriate behaviors to staff members who cause him pain while caring for him. Petitioner explained the facility has "good" and "bad" staff members. The "good" staff members understand how to care for him without causing him pain. The "bad" staff members gang up on him, do not listen to him, do not know how to care for him properly, and often cause him pain while caring for him.

17. Petitioner is paralyzed due to a spinal cord injury and requires a wheelchair for ambulation. He suffers from [REDACTED]

[REDACTED] Petitioner's left leg is bent and very sensitive to the touch.

18. Petitioner requires medications for his mental and physical ailments.

During the March 2016 incident, the petitioner's medications included Neurontin; Percocet; a muscle stimulator; and Soma. On June 8, 2016, the petitioner began taking Depakote. In July 2016, the petitioner began taking [REDACTED] and [REDACTED]. Petitioner also utilizes a morphine patch for pain.

CONCLUSION OF LAW

19. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

20. Federal Regulations appearing at 42 C.F.R. § 483.12, set forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights and states, in part:

(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;

21. In this case, the petitioner was given a notice on April 25, 2016, indicating that he would be discharged from the facility as "The safety of other individuals in this facility is endangered". Pursuant to the above authority, certain conditions must exist for a nursing home to involuntarily discharge a resident.

22. Section 400.0255, Fla. Stat., 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 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.

23. The respondent's reason for the discharge is "the safety of other individuals being endangered". This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.12) for which a nursing facility may involuntarily discharge a resident.

24. Pursuant to the above authorities, this discharge reason would require documentation from the resident's physician. A physician was required to sign the discharge notice or a physician's order must accompany the discharge notice. A physician did not sign the discharge notice, but a physician's order dated April 24, 2016 accompanied the discharge notice.

25. The respondent's sole reason for the discharge was the petitioner's physical aggression to staff members. Petitioner engaged in two incidents of physical aggression and in both incidents, the facility contacted law enforcement.

26. The staff members in both incidents did not receive any medical treatment from a physician or nurse.

27. In August 2015, the facility conducted a Diagnostic Interview and determined the petitioner was not a risk to others and did not display any verbal or physical aggression towards others. The first time the facility provided the petitioner written notification about his inappropriate behaviors was on April 25, 2016 and the first time the facility counseled the petitioner was after the June 2016 incident.

28. The petitioner has been a resident at the respondent's facility since July 2015. Other than the two incidents on March 7, 2016 and June 6, 2016, the petitioner has had no other documented incidents of physical aggression. The evidence submitted does not indicate the petitioner's two incidents of physical aggression jeopardized the safety of individuals in the facility. The staff members involved in both incidents did not require medical attention and these incidents did not demonstrate an escalating pattern of physical aggression.

29. The controlling authorities require a higher standard of proof in nursing home discharge hearings; there must be substantial and credible evidence at the leave of clear and convincing¹. The undersigned concludes the respondent's evidence does not rise to the level of clear and convincing.

¹ State v. Graham, 240 So.2d 486 (1974), states, "Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established. (Id. quoting Slomowitz v. Walker, 429 So.2d 797, 800 (Fla. 4th DCA 1983))."

30. After careful review of the evidence and cited controlling authorities, the undersigned concludes the respondent has not met its burden to prove, by clear and convincing evidence, that the petitioner presents a continued risk to the safety of other individuals in the facility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED. The facility has not established that this discharge is permissible under federal or state regulations; therefore, the facility may not proceed with the discharge 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 06 day of September, 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:



Sep 01, 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. 16N-00059

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on August 23, 2016, 9:28 a.m., at [REDACTED]

[REDACTED]

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: [REDACTED]

STATEMENT OF ISSUE

At issue is whether the facility's intent to discharge the petitioner due to non-payment of a bill for services, based on federal regulations found at 42 C.F.R. § 483.12 is correct. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

PRELIMINARY STATEMENT

Present as witnesses for the respondent were [REDACTED]

[REDACTED]

[REDACTED]

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 did not present any exhibits. The respondent presented one exhibit, which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The Agency for Health Care survey letter was entered as Hearing Officer's Exhibit 1.

FINDINGS OF FACT

1. The petitioner entered the nursing facility on May 22, 2015. He was admitted as a Medicaid pending resident through VITAS Hospice.
2. The petitioner's Medicaid application was approved in June 2015. He had a monthly patient responsibility of \$1,623.34 effective June 2015. The patient responsibility changed in December 2015 to \$1,624.34. In May 2016, it change to \$2,141.67, June 2016 it was \$1,659, July 2016 it was \$1,444.94, and his current patient responsibility for August 2016 is \$1,551.97.
3. His wife paid the patient's responsibility in full for June 2015 and July 2015. There was a returned check for June 2015 payment. She made the following payments towards the patient's responsibility:

FINAL ORDER (Cont.)

16N-00059

PAGE -3

June 2015	\$1,623.34 (returned check of \$1,624)
July 2015	\$1,623.34
August 2015	\$400
September 2015	\$400
October 2015	No payment
November 2015	\$500
December 2015	\$500
January 2016	No payment
February 2016	\$1,000
March 2016	\$1,624.34
April 2016	\$1,624 (returned check of \$1,624)
May 2016	No payment
June 2016	\$2,650
July 2016	\$1,000
August 2016	No payment

4. On May 31, 2016, the respondent issued a Discharge Notice to the petitioner's wife informing her that the petitioner would be discharged from the nursing facility effective May 31, 2016, due to non-payment of bill for services.

5. On June 8, 2016, the petitioner's wife requested a hearing on behalf of the petitioner to challenge the facility's action.

6. The nursing facility provided the petitioner's wife with monthly statements showing the balance owed each month. The outstanding balance owed through August 31, 2016 is \$13,338.30.

7. The petitioner's wife acknowledged she received monthly statements indicating the outstanding balance for services her husband received. She also acknowledged owing the nursing facility the above outstanding balance. She asserts she cannot pay

the patient responsibility as she has her own medical and living expenses. She believes the patient responsibility is too high.

8. The respondent offered the petitioner's wife a payment plan to bring the account current. She is to pay \$8,000 plus August's patient liability of \$1,551.97 due by August 29, 2016, a second payment of \$1,262.11 due by September 29, 2016, a third payment of \$1,262.11 due October 28, 2016 and the fourth payment of \$1,262.11 due November 29, 2016. In addition, she is to have the petitioner's monthly check issued directly to the nursing facility. The nursing facility will deduct the monthly patient responsibility and disburse the remaining balance to her. The petitioner's wife rejected this offer.

CONCLUSIONS OF LAW

9. 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.

10. 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 president'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.

11. The undersigned's jurisdiction is limited to the above six reasons and will only consider if the discharge is for a legal reason based on any of the six allowable reasons listed above.

12. The petitioner was approved for Medicaid and his initial patient responsibility was determined as \$1,623.43. He was responsible to pay this amount effective June 2015. The petitioner's wife made several full payments, several partial payments and some months no payment at all. As of the end of August 2016, the current outstanding balance is \$13,338.30. The nursing facility offered a payment plan but his wife rejected it. There is no dispute that the petitioner owes the facility \$13,338.30 in outstanding bills for services, as the full patient responsibility was not always paid or not paid in full every month.

13. According to the above authority, the facility may not discharge except for certain reasons, one of which is when the resident has failed, after reasonable and appropriate notice, to pay for the stay at the facility. The respondent has met its burden. The hearing officer concludes that the facility has given the petitioner reasonable and appropriate notice to pay for his stay at the facility.

14. Establishing the reason for a discharge being 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 any of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

15. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The facility may proceed with the discharge, in accordance with all applicable Federal Regulations, Florida Statutes, and Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 01 day of September, 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:



FILED

Sep 20, 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. 16N-00065

PETITIONER,

Vs.

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on August 23, 2016 at 1:40 p.m., at [REDACTED]

[REDACTED]

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: [REDACTED]

STATEMENT OF ISSUE

At issue is whether the facility's intent to discharge the petitioner due to non-payment of a bill for services based on federal regulations found at 42 C.F.R. § 483.12 is correct. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

PRELIMINARY STATEMENT

Present as witnesses for the respondent [REDACTED]

[REDACTED] Desey Cherry, representative for Medicaid Done Right.

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 entered the nursing facility on February 2, 2016. He came into the nursing facility as a Medicare Managed Care resident with United Health Care as his insurance company. United Health Care provided insurance coverage for him from February 5, 2016 through March 24, 2016.
2. He was responsible to pay \$160 per day for his co-payment beginning on February 23, 2016 through March 23, 2016 for a total of \$4,480. He had 'NO' co-payment for the first 20 days.
3. On March 24, 2016, United Health Care group stopped coverage as the petitioner was not making progress. The petitioner reached his maximum potential with skilled nursing care and as a result, was not eligible for the balance of the 100 days. As of March 24, 2016 he became a Medicaid-pending resident. The petitioner's representative argued that her husband was covered for the first 100 days regardless of

whether he was making progress or not; therefore, he is not responsible for any Medicaid patient responsibility for the first 100 days in the nursing care.

4. On June 1, 2016, he was converted to Medicaid and had a monthly patient responsibility of \$1,616.50.

5. On June 15, 2016, the respondent issued a Discharge Notice to the petitioner's POA, informing her that the petitioner was to be discharged from the nursing facility effective July 15, 2016, due to non-payment of bill for services.

6. On June 22, 2016, the petitioner requested a hearing to challenge the facility's action.

7. The nursing facility provided the monthly statements to the petitioner with the balance owed each month. The facility's representative explained the monthly balance to the petitioner's representative, but she did not agree with the amount owed.

8. The following table shows the charges and payments. The petitioner's POA admitted to receiving monthly statements but is disputing the outstanding balance. The nursing facility is requesting that the petitioner pay \$3,465.45 as his outstanding balance.

Owed for private pay 02/05/16 to 03/23/16	\$4,480.00
period 03/24/16 to 03/31/16	\$365.05
Billed for month 4/1/2016	\$1,981.51
Billed for month 5/1/2016	\$1,616.50
Payment to NH 05/16/16	-\$4,350.00
Billed for month 6/1/2016 patient responsibility	\$1,616.50
Payment to NH 06/20/16	-\$1,000.00
Billed 07/01/16 New monthly patient responsibility	\$1,604.50
Payment to NH 07/01/16	-\$1,958.10
Billed monthly patient responsibility 8/1/2016	\$1,604.50
Payment to NH 08/04/16	-\$2,000.00

9. The petitioner's representative asserts he should have been covered under United Health Care group for 100 days, not 47 days. The petitioner's representative asserts she may have overpaid the facility and is disputing the amount of the outstanding balance.

CONCLUSIONS OF LAW

10. The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by Federal Regulations appearing at 42 C.F.R. § 431.200. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes.

11. 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.

12. The undersigned's jurisdiction is limited to the above six reasons and will only consider if the discharge is for a legal reason based on any of the six allowable reasons listed above.

13. The petitioner was admitted to the nursing facility on February 2, 2016 and was covered under Medicare Managed Care/United Health Care group through March 23, 2016. He was responsible to pay an insurance co-payment of \$160 per day from February 23, 2016 to March 23, 2016. He was converted/approved for Medicaid on June 1, 2016. The facility billed him under Medicaid from March 24, 2016 (retroactive) as he was not covered under Medicare/United Health Care and had no other coverage. He was responsible for his patient responsibility effective March 24, 2016 to present. His representative has made several payments totaling \$9,308 but still has an outstanding balance of \$3,960.46. The nursing facility is requesting payment of \$3,465.45. The petitioner's POA acknowledged that she received monthly statements for her husband's stay at the nursing facility but disputes the amount owed. The undersigned reviewed the bill and finds that the petitioner has an outstanding bill of for her care at the nursing facility.

14. According to the above authority, the facility may not discharge except for certain reasons, one of which is when the resident has failed, after reasonable and appropriate notice, to pay for the stay at the facility. The petitioner has an unpaid bill for care at the respondent's facility.

15. The hearing officer concludes that the facility has given the petitioner reasonable and appropriate notice to pay for his stay at the facility. Based on the evidence

presented, the nursing facility has met its burden to prove that the petitioner failed, after reasonable and appropriate notice, to pay for his stay at the facility.

16. Establishing the reason for a discharge is lawful is just one-step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

17. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The facility may proceed with the discharge, in accordance with all applicable Federal Regulations, Florida Statutes, and Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 20 day of September, 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]
[REDACTED]
[REDACTED]
[REDACTED]

FILED

Sep 19, 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. 16N-00068

PETITIONER,

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on August 31, 2016, 1:39 p.m., [REDACTED]

[REDACTED]

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: [REDACTED]

STATEMENT OF ISSUE

At issue is whether the facility's intent to discharge the petitioner due to non-payment of a bill for services based on federal regulations found at 42 C.F.R. § 483.12 is correct. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

PRELIMINARY STATEMENT

Present as witnesses for the petitioner were [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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 did not present any exhibits. The respondent presented one exhibit, which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The AHCA site inspection report was entered as Hearing Officer's Exhibit 1.

The petitioner left the hearing and allowed his witnesses to complete the hearing on his behalf.

FINDINGS OF FACT

1. The petitioner entered the nursing facility on July 9, 2015, as a private pay resident. She became a Medicaid recipient and had a monthly patient responsibility (the amount she owes) due to the nursing facility each month.
2. On June 23, 2016, the respondent issued a Discharge Notice to the petitioner's Power of Attorney (POA), informing him that the petitioner was to be discharged from the nursing facility effective July 26, 2016, due to non-payment of bill for services.
3. On June 23, 2016, the petitioner requested a hearing to challenge the facility's action.

4. The nursing facility provided the petitioner with monthly statements with the balance owed each month. The outstanding balances are: \$1,216 for September 2015, 2,529 October 2015, \$2,529 for November 2015, \$4,091 for December 2015, \$5,653 for January 2016, \$7,215 for February 2016, \$8,777 for March 2016, \$10,213 for April 2016, \$11,649 for May 2016, \$13,085 for June 2016, \$14,571 for July 2016, and current balance \$16,057 for August 2016.

5. The nursing facility mailed monthly statements to the petitioner's POA informing of the outstanding balance. He was contacted several times by telephone to pay the outstanding balance, but it has not been paid.

6. The petitioner's POA did not dispute receiving the monthly statements or that he owed the facility. In July 2015, the POA made payments towards the petitioner's private pay portion, but he has not paid the patient responsibility beginning in September 2015. The POA used the petitioner's money for his own expenses.

6. The petitioner's representative is unable to pay the past due amount and the facility is not offering a payment plan.

CONCLUSIONS OF LAW

7. 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.

8. 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.

9. The undersigned's jurisdiction is limited to the above six reasons and will only consider if the discharge is for a legal reason based on any of the six allowable reasons listed above.

10. The petitioner was originally admitted to the nursing facility as private a pay resident but became a Medicaid recipient and had a monthly patient responsibility due to the nursing facility. She incurred an outstanding bill as her patient responsibility was not paid for several months. The current outstanding balance of past due patient responsibility is \$16,057. The petitioner's POA acknowledged that he received monthly statements for her stay at the facility, and does not dispute that he owes the nursing facility.

11. According to the above authority, the facility may not discharge except for certain reasons, one of which is when the resident has failed, after reasonable and appropriate notice, to pay for the stay at the facility. The petitioner has an unpaid bill for her care at the facility.

12. 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 evidence presented, the nursing facility established the petitioner/ POA failed to pay for her stay at the facility after reasonable and appropriate notice.

13. Establishing 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. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The facility may proceed with the discharge, in accordance with all

applicable Federal Regulations, Florida Statutes, and Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 19 day of September, 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]
[REDACTED]
[REDACTED]
[REDACTED]