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

APPEAL NO. 09F-05239

PETITIONER,

Vs.
AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
CIRCUIT: 18 Seminole

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was telephonically convened before the undersigned on January 11, 2010 at 3:00 p.m. The petitioner represented herself with testimony available from her doctor's nurse, , and her son's certified nursing assistant (CNA), . The respondent was represented by Lisa Sanchez, human service program specialist, with testimony available from Greg Schemel, chief compliance officer of American Eldercare. A hearing was originally scheduled for September 23, 2009 and was reset because the petitioner had not received evidence that was mailed to her. Other dates were cancelled due to the petitioner's health.

The hearing record was left open in order to receive more information from both American Eldercare and the physician. American Eldercare information was received and labeled Respondent's Exhibit 3. No further physician statement was received or was necessary.

ISSUE

At issue was whether hours of service provided by American Eldercare under AHCA – Medicaid funding in the Long Term Care Nursing Home Diversion Waiver Program were correct.

FINDINGS OF FACT

1. The petitioner has serious health impairments and the Medicaid waiver program is intended to help her avoid institutionalization. She receives assistance and services at her home from American Eldercare under the Medicaid waiver program.

2. Over the past year, the petitioner has suffered significant personal loss and health problems. Almost immediately after her husband died, she entered a nursing facility and stayed there between May 2009 and early August 2009. The petitioner does not want to live in a nursing facility or an assisted living facility.

3. The initial issue related to American Eldercare authorization of 8 hours per week of service as supplement to the Medicare home health services from Pinnacle Home Health. Upon discharge from the nursing facility, the respondent issued notice on August 13, 2009. It said that she would receive:

> 2 hours per day 4x week. Since you receive Medicare home health services thru Pinnacle Home Health, American Eldercare services will be provided as additional services to Medicare. You are entitled to receive bathing assistance thru Pinnacle services 3x week and we encourage you to accept these services. If you choose to accept these services you will have services in your home for a total of 7x week...

4. The petitioner requested a hearing because she wanted more hours of service from American Eldercare.

5. On August 26, 2009, her doctor requested to "extend the time allowed for an aide to be in her home to assist her. She could benefit from help at a minimum of 5 hours a day, 5 days a week..." The request is in Petitioner's Exhibit 1.

6. In late December 2009, the Medicare home health services ended. American Eldercare changed her plan of care, attempting to compensate. Notice of change was not issued. The petitioner was authorized for homemaking service on Mondays and Fridays at 2 hours each, and companion service on Wednesday and Saturday at 2 hours each. Bathing service was twice weekly (although facts of this service became unclear from additional information and this will be further addressed in the order). One-hour weekly shopping service was authorized. Approximately 11 hours were authorized and this was more than before.

7. The petitioner remained unsatisfied.

8. The petitioner's nurse noted she needed at least 4 baths weekly. The CNA also believed the petitioner needed more services.

9. Due to hygiene problems, additional health problems have occurred. The petitioner receives some hygiene assistance from her son and she has a personal hygiene appliance. However, her son is gravely ill. Due to her limited use of her arms and her mobility obstacles, hygiene is increasingly difficult.

10. Immediately following the hearing, on January 12, 2010 another American Eldercare assessment was completed. Results were shown in Respondent's Exhibit 3. The new authorization was as follows:

a) Tuesday, Thursday and Saturday "hands-on" bathing assistance.
b) Home health aide homemaker services Mondays and Fridays for 2 hours each. Laundry, changing sheets and light dusting to be provided.
c) Respite care from a home health aide on Wednesdays and Saturdays for 2 hours each.
d) Shopping assistance one hour every other week (less than before due to meal delivery provision).
e) Delivery of incontinence supplies such as chux and personal wipes.
f) Frozen home delivered meals for 5 days weekly.
g) An active Emergency Response Unit.
h) One vision exam and glasses to be provided.

CONCLUSIONS OF LAW

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 Hearing to conduct this hearing pursuant to Florida Statute, Chapter 120.80.

Florida Statute 409.912 addresses **Cost-effective purchasing of health care** and informs "The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. ..." Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) informing that "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity." Thus, decisions regarding Medicaid reimbursement to providers become part of an administrative review process.

Florida Statute 430.705 addresses the "**Implementation of the long-term care community diversion pilot projects**." Section (2)(a) says that the project is designed to "maximize the placement of participants in the least restrictive

appropriate care setting." Section (10) says the Department "...is authorized to adopt any rules necessary to implement and administer the long-term care community diversion pilot projects..."

Consistent with statute, the Florida Administrative Code addresses waivers and care standards as follows:

59G-13.080 Home and Community-Based Services Waivers.

(1) Purpose. Under authority of Section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. ...

58N-1.009 Care and Service Standards.
(1) Medicaid Waiver Services: The provider must provide all Medicaid waiver services in accordance with its contract with the department.
...
(3) Care Planning:
(a) Each participant must have a care plan. The care plan is the tool used by the case manager to document a participant's assessed needs, desired outcomes, and services to be provided. The care plan is a plan of action, developed with the participation of the case manager, the program participant, the participant's caregiver or representative, and to the extent possible, the participant's health care provider. It is designed to assist the case manager in the overall management of the participant's care.
1. At each face-to-face visit, the participant or representative and case manager must review the care plan and make changes, if necessary, to meet the participant's continuing needs. The participant or representative and case manager must acknowledge in writing that the care plan was reviewed and changes to the care plan were agreed upon, if applicable.
2. At any time a significant change is indicated, the participant or representative and case manager must acknowledge the change in

> writing. A significant change is defined as any deterioration or improvement in the participant's mental, physical or social condition that would require an adjustment in his or her care plan. A significant change could result in an increase or decrease in services, depending upon the outcome.
> 3. The participant or representative must receive a signed and dated copy of the care plan or care plan summary.
> (b) All changes in services in the care plan must be documented in the participant's file.

In view of these guidelines, the petitioner would be eligible for services that would minimize her potential need for institutional care. She is in an HCBS waiver program and the service provider is American Eldercare. She would be eligible to receive American Eldercare services within the contract and under the governing guidelines. However, any service must be medically necessary.

Florida Administrative Code 59G-1.010 (166) (a and c) says that in order for a service to be medically necessary, it must meet the following conditions:

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

After careful review of evidence, statutes, and regulatory guidelines, it cannot be concluded that a total of 25 hours weekly personal service has been justified. While the doctor may prefer the petitioner to receive more care, the evidence does not support that level. Moreover, doctor's order would not automatically ensure authorization of the petitioner's request. After careful review of the bathing testimony, it is concluded that weekly number of baths should be four. The level of health problems related to hygiene would justify one additional bath weekly and the testimony of the medical provider supports that level of service.

However, evidence simply does not establish medical necessity for the Medicaid waiver to provide 25 hours of an aide or personal service care. The services described in the January 12, 2010 plan of care are generally reasonable. The services reflect a variety of attention and care that is significantly greater than 8 hours weekly. The services include meal delivery, shopping, baths, homemaking, respite, supply delivery, emergency response system and vision care. With an additional fourth bath, the services should be sufficient to avoid institutionalization. As care needs continue, however, the administering agency is expected to follow the review process described in its guidelines.

DECISION

The appeal is granted as described, and denied as noted. Service authorization shall be as shown in the January 12, 2010 plan of care, with an

additional bath to raise total to four weekly. All other service shall continue as shown in the care plan.

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 19th day of February, 2010, in Tallahassee, Florida.

J W Alper
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: