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

APPEAL NO. 09F-08079

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 15 Palm Beach
UNIT: BSCP

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 20, 2010, at 1:50 p.m., in Lake Worth, Florida. The petitioner was present and represented himself. Appearing as witnesses were and , both of

Representing the respondent was David King, management analyst, Agency for Health Care Administration (AHCA). Appearing as witnesses were John Wanecski, Medicaid Waiver specialist and Kristen Russell, program administrator for the BSCIP Program. Both witnesses are with the Department of Health. . . appeared telephonically at her request.

ISSUE

At issue is whether the Agency was correct is reducing Companion hours from six per day to five per day in the Brain and Spinal Cord Injury Medicaid Waiver Program (BSCIP). The Agency has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a forty-seven year old (DOB 11-16-62) recipient of benefits in the BSCIP. He has been receiving benefits since January 2001.
2. For each 12 month certification of benefits, the petitioner's service provider submits a care plan for approval. The care plan indicates which services are required.
3. A care plan was submitted for the certification period July 2009 through June 2010. The plan was approved.
4. The Department of Health, which runs the BSCIP under AHCA jurisdiction, considers available funding before approving care plans. Funding for the BSCIP is not obtained from general revenue but from its major source, the BSCI Trust Fund. The Trust Fund gets its income from traffic fines both vehicle and boat.
5. When care plans are reviewed, the Department will consider if any of the services are medically necessary for the petitioner's well being or quality of life. After the October/November review the decision was

made that a reduction of one hour in the petitioner's Companion service would not change his quality of life.

6. The petitioner is a six foot, 245 pound quadriplegic. He receives, among all his services, Companion care, Personal care, and Nursing care. He lives alone and is dependent on the care received.
7. The respondent explains that the types of care available are defined in their Traumatic Brain and Spinal Cord Injury Waiver Services Handbook (hereafter the Handbook). And, due to budgetary restraints, services are available on a limited basis and are reviewed for efficacy and medical necessity every six months.
8. Because Companion care is a non-medical service, the respondent explains that a physician's approval to reduce the service was not required.
9. The petitioner submitted documents from three physicians: (urologist); (internist); and (pain management). All three would prefer the services remain as is to keep the petitioner's status from a medical perspective.
10. The VIP America representatives would like to see additional Personal care because this care concerns the petitioner's activities of daily living (ADL) such as bathing and toileting. Companion care is for laundering, cleaning, and other household chores.

11. Ms. Russell concludes by explaining that no one client is to be put in jeopardy. That reducing the Companion care by one hour would not harm the petitioner.

12. The Companion hours may be split to meet the petitioner's needs the best.

CONCLUSIONS OF LAW

The Traumatic Brain and Spinal Cord Injury Waiver Services Handbook April 2006 was promulgated to establish the format for providing services to eligible members. The legal authorities can be found in the Handbook:

Legal Authority

Medicaid home and community-based services (HCBS) waiver programs are authorized under Sections 1902 (A)(10)(B) and 1915(C) of the Social Security Act and governed by Title 42, Code of Federal Regulations (C.F.R.), Part 441, Subpart G.

The Florida Medicaid TBI/SCI Waiver Program is authorized by Chapters 381.75 and 409, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

Specific statutory authority for the promulgation of the TBI/SCI Waiver Services Handbook into rule is found in the following provisions of law: Chapters 408.301, 408.302, and 409.919, F.S.

The Agency for Health Care Administration (AHCA) has final authority on all policies, procedures, rules, regulations, manuals and handbooks pertaining to the waiver. The Department of Health (DOH) is authorized by AHCA to operate and oversee the waiver in accordance with the Interagency Agreement for Medicaid between AHCA and DOH regarding the TBI/SCI Waiver Program.

Further, BSCIP is the acronym for the Brain and Spinal Cord Injury Program operated by the Florida Department of Health. The TBI/SCI Waiver Program is operated as a function of BSCIP.

BSCIP has headquarters in Tallahassee and has regional offices located throughout the state.

Concerning the description of the Program, the Handbook notes:

> Recipients in the TBI/SCI Waiver Program have access to support and services, which enable them to live at home and in the community. Eligibility is limited to the number of unduplicated recipients stated in the waiver application or amendments that is approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, and by the amount of state matching revenue appropriated by the legislature.
>
> State matching funds for the waiver are generated from the TBI/SCI Trust Fund. Revenue from moving traffic violation fines, Driving Under the Influence, Boating Under the Influence convictions and $1.00 from all temporary tags goes into this fund. The Florida DOH, BSCIP operates the waiver under the authorization of AHCA's Division of Medicaid. The waiver has a five-year span and may be renewed at the discretion of the Centers for Medicare and Medicaid Services.

The petitioner is informed of his rights with the following information from the Handbook:

> All recipients served through the waiver may select from enrolled, qualified service providers and may change providers at any time. Once a recipient has an approved plan of care, the funds allocated to that plan follow the recipient. Within the funds allocated in the plan of care, the recipient is free to change enrolled, qualified providers as desired to meet the goals and objectives set out in the plan.
>
> When an applicant is denied his choice of service or enrolled provider, he must be notified in writing of the reason and provided with a Notice of Decision form (Appendix G).

Medical necessity is explained as follows:

> Waiver services may be provided only when the service or item is medically necessary. Medically necessary is defined in 59G-1.010(166)(a)(c), F.A.C. as follows:

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

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

• 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;

• Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;

• 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,

• 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.

The Handbook then discusses the concept of redetermination and notes:

The plan of care must be reviewed at least every six months. At the time of review, all authorized services are examined to determine their effectiveness and benefit to the recipient. The community support coordinator must ensure that this process is completed in a timely, orderly manner to prevent disruption of services.

It is at this juncture that the respondent seeks to reduce the Companion service by one hour.

The description of Companion services is:

> Companion services are non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the recipient with such tasks as meal preparation, laundry and shopping as specified in the plan of care. The provision of companion services does not entail any invasive hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the recipient.
>
> Regarding limitations, Companion services are limited to the amount, scope and duration of the services described in the recipient's plan of care and approved budget for cost of services. Companion services cannot be provided by a legally responsible family member.
>
> The maximum reimbursement for companion services is $3.00 per unit, not to exceed 24 units (six hours) per day. A unit is defined as a 15-minute time period or portion thereof. **Companion services cannot be concurrent with attendant care services or personal care services.** [my emphasis]

Upon review, the petitioner has been receiving benefits according to his yearly care plans since 2001. As required, the respondent must review these plans every six months.

At the latest review it was determined that the Companion care could be reduced by one hour daily without disrupting the petitioner's quality of life. A reduction of Companion hours would not, in this hearing officer's opinion, interrupt the petitioner's medical circumstance. Medical care remains the same.

Companion services are described above. They are non-medical in nature and do not require nursing assistance. What is noted is that the Companion service should not be provided concurrently with attendant or personal care services.

DECISION

The appeal is denied. The respondent's action is affirmed. The care plan that is in effect should not have the Companion service performed concurrently with the personal and nursing care. This would offer the petitioner separate times when the companion is available.

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 22nd day of January 2010,

in Tallahassee, Florida.

Melvyn Littman
Hearing Officer
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Copies Furnished To