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

APPEAL NO. 09N-00142

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 17, 2009, at 3:21 p.m., at the respondent facility. The petitioner was not present. The petitioner was represented by her husband, Dr . Present as witnesses for the petitioner were family friends, and The respondent was represented by , resident services director and admissions coordinator. administrator was present as an observer.

ISSUE

At issue is whether or not the respondent's August 31, 2009 proposed action discharging the petitioner from the facility is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The respondent facility is seeking to discharge the petitioner because her "bill for services at the facility has not been paid after

reasonable and appropriate notice to pay". The facility held the burden of proof at the level of clear and convincing.

FINDINGS OF FACT

1. The petitioner was admitted into the respondent facility on February 14, 2009 from a local hospital. At the time of admission, the petitioner's principal payer source was Medicare Part A; total monthly charges are approximately $6,700. Medicare paid 100% of the facility's charges for the first 20 days; for another 80 days, Medicare paid 20% of the charges. Medicare payments ended in June 2009; the petitioner's status was converted to private pay at that time.

2. The facility issued a Nursing Home Transfer and Discharge Notice to the petitioner on August 31, 2009 (effective October 1, 2009). The Notice explains that the non-payment of facility charges is the reason for the discharge.

3. As of the date of the hearing, the total balance due to the facility was over $34,000. The facility entered into evidence copies of monthly billing statements which were sent to the petitioner's husband. The facility also entered into evidence multiple collection notices which were also sent to the petitioner's husband notifying him that the petitioner's account balance was past due. The petitioner's husband admitted that monies are owed to the facility. He, however, disputed receiving monthly billing statements. He asserted that he only received three billing statements and two collection notices (he could not recall the dates the statements and notices were received). He admitted that the address shown on the statements and notices provided during the hearing was correct; the facility asserted that none of the mail ever returned as undeliverable. The undersigned, therefore, finds that the monthly billing statements

and collection notices were received by the petitioner's husband. The facility provided evidence which shows that in addition to billing statements and collection notices, multiple phone calls were made to the petitioner's husband regarding the unpaid bill.

4. The petitioner's husband explained that it was a local hospital (in which the petitioner had been receiving medical treatment) that chose the respondent facility, not he. The petitioner's husband explained that he can not afford to pay the facility's monthly charges out of pocket; this was explained to facility staff at the time of admission. The petitioner's husband asserted that the facility assured him that an application would be submitted to the Department of Children and families (DCF) for Medicaid benefits; he believed that Medicaid would pay for the petitioner's nursing home charges. The facility explained that at the time of admission the petitioner was gravely ill; staff with the local Hospice Program initiated the Medicaid application sometime shortly after the petitioner's admission (neither party could recall the date of application). As the petitioner's condition improved rapidly over the next few weeks, she no longer met the requirements for Hospice representation; the local Hospice organization withdrew from the case. Facility staff took over as the petitioner's representative for the Medicaid application; the type of Medicaid requested was changed from Hospice to Institutional Care Program (ICP) Medicaid. As of the date of the hearing, a determination had not been made regarding the petitioner's Medicaid eligibility. The facility believes the family's failure to provide requested verification to DCF is the reason for the delay; the petitioner's representatives believe miscommunication between the three parties (DCF, the facility and the petitioner's

husband) has caused the delay. The petitioner's husband argued that he does not know what information is needed to complete the Medicaid application.

5. The petitioner's husband argued further that it is his belief that his wife should not be charged for her stay at the facility because the petitioner fell and injured her hip shortly after admission. The petitioner's husband believes the facility's lack of attention to the petitioner's needs caused her hip injury and therefore, her care should be free. The facility disputed responsibility for the petitioner's hip injury as well as the husband's conclusion that the petitioner should receive free services.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Federal Regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In the instant case, the discharge notice shows the petitioner is to be discharged from the respondent facility because bill for services has not been paid.

Federal regulations at 42 C.F.R. §483.12 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--
> (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.

(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;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section...

The legal authority cited above sets forth the reasons for which a Medicaid or Medicare certified nursing facility may discharge a resident; nonpayment of facility charges is listed as a reason residents can be discharged from a nursing facility.

Florida Statutes 400.0255, Resident transfer or discharge; requirements and procedures; hearings, states in part:

(15)(b) ...The burden of proof must be clear and convincing evidence...

(15)(d) The decision of the hearing officer shall be final. Any aggrieved party may appeal the decision to the district court of appeal in the

appellate district where the facility is located. Review procedures shall be conducted in accordance with the Florida Rules of Appellate Procedure.

The legal authority cited above makes it clear that in the instant case the facility holds the burden of proof at the level of clear and convincing.

The facility proposes discharging the petitioner because she owes over $34,000 to the facility for services rendered. The Findings of Fact prove that the facility did give reasonable and appropriate notice to pay in the form of monthly billing statements, collection notices and phone calls. The undersigned found no legal authority to support the petitioner's husband's assertions that the hip injury which the petitioner suffered during her stay at the facility negates the petitioner's responsibility to pay for her care at the facility. Therefore, the undersigned concludes that the facility's proposed discharge action is within the federal guidelines and the action is affirmed.

DECISION

The appeal is denied. The respondent met its burden of proof to show the discharge reason meets the reasons stated in the controlling Federal regulation. The facility may proceed with the discharge in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and

any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 2nd day of December, 2009,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
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Copies Furnished To: .