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

[redacted]

APPEAL NO. 11F-00069

PETITIONER,

Vs.

CASE NO. 1278273794

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 13 Dade
UNIT: 88130

FILED
Dec. 20, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 8, 2011, at 1:07 p.m. and was reconvened on February 23, 2011, at 3:16 p.m. All parties appeared telephonically.

APPEARANCES

For the Petitioner: [redacted], with [redacted] nursing home.

For the Respondent: [redacted], Program Operations Administrator with Department of Elder Affairs (DOEA).

[redacted] ACCESS supervisor, ICP unit.

STATEMENT OF ISSUE

The petitioner is appealing the Department's action to deny his Home and Community Based Services Medicaid (Nursing Home) coverage based on the contention that he did not meet the Level of Care (LOC).

PRELIMINARY STATEMENT

By notice faxed on September 28, 2010, APS informed the facility that Mr. [redacted] Preadmission Screening and Resident Review (PASRR)/MI Level II determination was being denied because he did not meet the Level of Care (LOC).

Appearing as witnesses for the petitioner were [redacted], director of social services, [redacted], director of nursing (DON) and [redacted], social services coordinator. Appearing as witnesses for the Department were [redacted], [redacted] with CARES, [redacted], attorney with DOEA, [redacted] (DON), [redacted] (RN) Cares assessor and [redacted], ACCESS supervisor, ICP (in the first hearing).

FINDINGS OF FACT

1. The petitioner, age 40, has been residing at [redacted] Extended Care from March 16, 2010. Upon admission at the facility, the petitioner signed an affidavit designating [redacted] as his representative.

2. The Department of Elder Affairs, CARES Unit is required to conduct LOC evaluation to determine whether benefits should be approved for individuals who are placed in HCBS facilities. As part of their service eligibility and delivery process, they requested that the petitioner provide proof that he has met the Level of Care.

3. The Federal Omnibus Budget Reconciliation act of 1987 and 1989 contains requirements for pre-admission screening and annual resident reviews for persons suspected of having mental illness. Since 2007 [redacted], has been contracted by the Mental Health Program Office to perform PASRR Level II screening

services. In September 2010 they completed a screening on the petitioner to determine whether he would meet the level of care.

4. Florida, PASRR/MI Level II Determination Summary Report from [redacted] indicates that the petitioner was admitted into the facility on March 16, 2010 without a pre-admission screening (completed on March 30, 2010).

5. The report also indicates that while in the facility, the petitioner was sent to jail on May 18, 2010, after being charged with battery for allegedly hitting another facility resident.

6. The facility noted dated May 21, 2010 from [redacted] indicate that the patient was under treatment for a major mental illness or psychiatric diagnosis. The medical report also indicates that the patient had suicidal ideation (Petitioner Respondent Composite Exhibit 1).

7. The patient was discharged from [redacted] hospital and readmitted to [redacted] on June 2, 2010.

8. The [redacted] reviewer documented that the petitioner's first Level II PASRR evaluation was reviewed and denied on July 28, 2010 due to incomplete documentation.

9. Additionally, the reviewer documented that the second PASRR Level II was evaluated and closed on August 24, 2010 due to lack of information required to make a determination.

10. The facility submitted the last application for ICP Medicaid on September 7, 2010 and based on the MI condition mentioned, the Department requested a Level II PASRR/MI determination from [redacted] before making their final approval.

11. The reviewer documented that on September 21, 2010, a current request was received. It includes a Continuity of Care Form dated June 2, 2010 (after date of discharge).

12. The current Level II request was processed for evaluation by [redacted] the only agency authorized by the Mental health Program Office to perform PASRR Level II screenings (Substance Abuse and Mental Health Annual Plan Update, January 2008, page 60). Based on the information documented on the patient medical record, [redacted] concluded that the petitioner was not eligible for a PASRR/MI Level II LOC.

13. The summary report included specific chronological events to justify how [redacted] came to that conclusion with a final statement reading in part: “Given the information cited above, a nursing facility placement is deemed to be not appropriate given the patient’s unstable mental status and alleged history of violence”.

14. Based on her review of the patient medical record, [redacted], Licensed Clinical Psychologist with [redacted], has concluded that the patient did not meet the level of care (LOC) (Respondent Exhibit 1)

15. On September 28, 2010, she faxed her final report to both DCF/CARES unit and [redacted] Extended Care to inform them of her decision. In response, on January 4, 2011, the facility requested a hearing on behalf of the patient to challenge the respondent’s action.

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

17. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 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.

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

> 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.

19. Fla. Integrated Pub. Policy Manual, passage 1440.1300 addresses PROPRIATE PLACEMENT (MSSI) in part:

> To qualify for the Institutional Care Program (ICP) or Home and Community Based Services (HCBS), or the Program for All-Inclusive Care for the Elderly (PACE), the individual must meet special institutional eligibility criteria, including "appropriate placement."
> Appropriate placement means that an individual must be placed in a facility or program certified to provide the type and level of care the Department has determined the individual requires.
> Two basic requirements must be met for placement to be considered appropriate. These are:

1. the person must be determined by the Department to be medically in need of the type of care provided by the specific program, and
2. the person must be actually receiving the services (or for HCBS, must be enrolled in the waiver) which the Department has determined that the individual needs.

To be appropriately placed for ICP, a person must have been determined in need of an ICP level of care (by CARES) and actually be placed in a Medicaid facility which provides the specified level of care. No level of care is required for a QMB eligible individual (Medicaid eligible individual with income less than the federal poverty level) in a nursing home during the Medicare coverage period.

For Home and Community Based Services (HCBS), to be appropriately placed, a person must be in need of waiver services and be enrolled in the waiver as documented by form CF-ES 2515 with an appropriate case manager.

20. Fla. Integrated Pub. Policy Manual, passage1440.1302 addresses Who Determines Need for Placement (MSSI).

The agency or office responsible for determining the need for care depends on the applicant's age and what kind of facility or program is needed. After the eligibility specialist requests a determination, he must receive DOEA CARES Form 603 (Notification of Level of Care) from the responsible office to document the specific need in the case record.
Note: The eligibility specialist does not request level of care decisions for HCBS waivers but must receive documentation of decisions from case managers or CARES.
The determination will be obtained from one of the following offices:
CARES (Comprehensive Assessment and Review for Long Term Care Services), Department of Elder Affairs:
1. For ICP: determines Level of Care for applicant/recipients over age 21 in nursing facilities, swing beds or hospital based nursing facility beds.
2. For HCBS: determines if applicant/recipient meets waiver requirements for a specific HCBS waiver, including Channeling, Aged and Disabled Adult, Project AIDS Care, Assisted Living, Traumatic Brain and Spinal Cord Injury, Long-Term Care Community Diversion, Cystic Fibrosis, Alzheimer’s or Comprehensive Adult Day Health Care…

21. Fla. Admin. Code 59G-4.180 addresses Level II services in part:

(c) Intermediate care services level II is limited health related care and services required by an individual who is mildly incapacitated or ill to a

degree to require medical supervision. Individuals requiring this level of care shall:

1. Be ambulatory, with or without assistive devices,

2. Demonstrate independence in activities of daily living, and

3. Not require the administration of psychotropic drugs on a daily or intermittent basis or exhibit periods of disruptive or disorganized behavior requiring 24-hour nursing supervision.

(d) Examples of services, in addition to medical supervision, that qualify as intermediate care level II:

1. Administration of routine oral medication;

2. Assistance with mobilization, helping a resident maintain balance when transferring from bed to chair and providing necessary help when climbing steps or manipulating wheelchair in difficult places;

3. Assistance with bathing, that is, assembling towels, soap, and other necessary supplies, helping the recipient in and out of the bathtub or shower, turning the water on and off, adjusting water temperature, washing and drying portions of the body which are difficult for the recipient to reach and being available while the recipient is bathing himself;

4. Assistance with dressing, that is, helping the recipient to choose and to put on appropriate clean clothing, and fastening hooks, buttons, zippers and ties;

5. Assistance with meals, that is, helping with cutting up food and pouring beverages;

6. Assistance with grooming, that is, helping the recipient to shave, wash, comb and curl hair, and to clean and file fingernails and toenails. Fingernails or toenails should not be cut by the recipient unless approved by the physician;

7. Provision of social and leisure services which are arranged for and individually designed to reduce isolation and withdrawal and to enhance communication and social skills;

8. Self-administration of medical gases, oral medications, subcutaneous medication after a regimen of therapy has been established and self-administration approved by the physician;

9. Ongoing medical and social evaluations to determine the point when a recipient's progress has reached the stage at which medical and related needs can be met appropriately outside of the nursing facility or through alternative placement or services;

22. Based on the relevant information documented in the patient's medical record, [redacted] has determined that he did not meet the LOC.

23. The petitioner representative argued that the petitioner was already approved back in 2008 and his condition has not changed. She argued that the petitioner has

experienced serious drawback every time he is out of the facility because he requires constant care and supervision that can only be found in a nursing facility. She acknowledged the petitioner mental condition, but insisted that it's nothing new.

24. The Department explained that they could not make an independent determination for the petitioner because [redacted] has reviewed the petitioner's medical records and has concluded that he has met the state definition of mental illness. The reviewer has noted that the facility failed to properly screen the petitioner and has failed to complete a PASRR Level II evaluation despite a long documented history of mental illness. The report also indicates that the patient stayed in the facility for an initial period of 32 days (exceeding the 30 day exemption limit).

25. Respondent Exhibit [redacted] PASRR/MI Level II Determination Summary Report) shows that the petitioner does not meet the Level of Care based on current medical/mental needs.

26. As shown in the Findings of Fact show that the petitioner was denied PASRR/MI Level II Determination because [redacted] concluded, after reviewing his medical record that he has met the state definition of mental illness. After reviewing the above-cited regulations and the testimonies of both parties, the undersigned concludes that the Department's action to deny the petitioner's eligibility is correct. The petitioner's representative has failed to meet her burden in demonstrating that [redacted] PASRR/MI Level II eligibility determination summary report was incorrect.

27. The hearing officer concludes that the Department's only action to abide by [redacted] denial of the petitioner's LOC is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is denied and the Department's action 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 department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this _____ day of _____, 2011,

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@dcf.state.fl.us

Copies Furnished To: [redacted], Petitioner
District 11, ESS: [redacted]