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

[redacted]

APPEAL NO. 11F-07415

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT:

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned first convened an administrative hearing in the above-referenced matter on December 2, 2011 at 1:40 p.m. The hearing was reconvened on December 9, 2011 at 2:56 p.m.

APPEARANCES

For the Petitioner: His father, [redacted]

For the Respondent: [redacted] medical health care program analyst with the Agency for Health Care Administration (AHCA).

STATEMENT OF ISSUE

At issue is the respondent's decision of August 26, 2011 to deny Medicaid authorization for custodial care coverage from July 12, 2011 to July 31, 2011 at a non-contracted skilled nursing facility (SNF). The petitioner seeks the respondent's contracted provider, [redacted] to reimburse him for SNF custodial care costs of $4,578 that were privately paid for this period.

PRELIMINARY STATEMENT

By notice dated July 8, 2011, [redacted] notified the petitioner that he was not eligible for custodial care placement in a nursing home effective July 12, 2011 because his care needs could be met in a less restrictive environment. At the end of the [redacted] appeals process, the respondent informed the petitioner's father and representative by notice dated August 26, 2011 that payment for this custodial care coverage from July 12, 2011 through July 31, 2011 was denied. The petitioner seeks reimbursement of the $4,578 privately paid for this care during this period.

On September 16, 2011, the petitioner timely requested a hearing to appeal the above decision. The hearing was scheduled and first convened on December 2, 2011, and was reconvened on December 9, 2011.

The petitioner's father, [redacted] represented the petitioner and testified. [redacted] hearing coordinator with the Department of Children and Families ACCESS Program, appeared as a witness for the respondent only at the first convened hearing. [redacted] chief compliance officer with [redacted] appeared as a witness for the respondent on both hearing dates. [redacted], medical director with [redacted]

appeared as a witness for the respondent only on the second convened hearing date. Two contract managers with the Department of Elder Affairs: [redacted], and [redacted] observed at both hearing dates. All parties appeared by telephone on both convened hearing dates.

The record was held open for a 14 day period to allow for the submission of authorities the respondent relied upon in making its decision. On December 13, 2011, the undersigned received the Florida Administrative Code Rules 58A-5.0181 Admission Procedures, Appropriateness of Placement and Continued Residency Criteria, and 59G-1.010 Definitions for reference. These were labeled the Respondent Exhibit 7 for reference.

FINDINGS OF FACT

1. The petitioner is [redacted] with a birth date [redacted] The petitioner has diagnoses to include: senile dementia Alzheimer type, incontinence, anemia, and seborrheic dermatitis. He has a history of: heart problems, high blood pressure, urinary tract infection, angina, unsteady gait, falls, general weakness, inguinal hernia, eczema, and vision problems. As of January 20, 2011, the petitioner was rarely oriented to place and never oriented to time. The petitioner requires some assistance with activities of daily living.

2. Up until May 22, 2011, the petitioner resided in the [redacted] On May 22, 2011, the petitioner was admitted to [redacted] because of a fractured right knee. The petitioner remained hospitalized until June 7, 2011 when he was transferred to [redacted] for rehabilitative therapy.

3. On June 29, 2011, [redacted] received a call from the petitioner's father, [redacted]. [redacted] requested to dis-enroll his father from [redacted] in order for him to be transferred to a skilled nursing facility (SNF), and be enrolled for Medicaid under the Institutional Care Program (ICP). [redacted] then advised [redacted] that dis-enrollment would be effective July 31, 2011. The [redacted] case manager then advised [redacted] that his father could be subject to private billing for care received at a SNF if he was discharged from rehabilitative therapy prior to July 31, 2011. [redacted] then believed it unlikely that the petitioner would be transferred out of rehabilitative care prior to July 31, 2011.

4. On July 8, 2011, the [redacted] case manager received a phone message from the [redacted] rehabilitation facility that the petitioner was to be discharged from skilled services on July 11, 2011. [redacted] determined that the petitioner did not benefit from aggressive physical and occupational therapy as much as desired due to advanced dementia. On July 8, 2011, the [redacted] case manager spoke with [redacted] to advise of this discharge date. [redacted] advised that a discharge to a SNF required pre-authorization from [redacted] before approval for payment. Due to cognitive decline and increased fall risk, [redacted] believed the petitioner to be SNF appropriate, based on his opinion as a physician as well as the opinion of another treating physician. The [redacted] advised [redacted] that there are ALF's that are able to safely provide the petitioner's level of care. [redacted] advised [redacted] that his prior ALF would be contacted to assess his return to this ALF.

5. As of July 8, 2011, [redacted] advised [redacted] that he sought the petitioner's placement at [redacted] Both of these SNF's are contracted

facilities with [redacted] However, A[redacted] advised [redacted] that prior authorization was necessary by [redacted] to determine the medical necessity of placing the petitioner at a SNF, and the petitioner could be liable for private payment in the absence of this authorization.

6. On July 8, 2011, [redacted] sent notice to [redacted] that the petitioner did not meet criteria for nursing home placement, labeled Respondent Exhibit 2. [redacted] determined that the petitioner's needs could be met in a less restrictive environment such as an ALF. This letter sent to [redacted] advises him to seek ALF placement as follows: "We encourage you to choose one to move by 8/12/2011."

7. On July 11, 2011, [redacted] was notified by the petitioner's prior ALF, [redacted] that the petitioner is completely appropriate to be transferred back to this ALF facility. [redacted] called [redacted] on this date to advise him of such.

8. On July 13, 2011, [redacted] received a returned call from [redacted] who confirmed that he had received a letter by facsimile informing that his request for SNF custodial placement had been denied. [redacted] then advised [redacted] that the dates of disenrollment "do not make sense." The [redacted] case manager advised [redacted] that the dates are as determined by the State of Florida and not by [redacted] [redacted] advised of his intention to appeal this decision.

9. On August 1, 2011, [redacted] received a signed and completed disenrollment form from [redacted] due to the desire to be placed in an SNF. [redacted] determined the petitioner dis-enrolled effective July 31, 2011. The petitioner was approved for Institutional Care Program and Medicaid benefits (ICP) effective August 1, 2011 and

after. The petitioner remained at the [redacted] SNF, which is a non-contracted SNF facility with [redacted] After several days of prior search, [redacted] was unable to find an available bed at a SNF facility contracted by [redacted], per testimony.

10. On August 24, 2011, [redacted] called to request appeal through the [redacted] appeal process on the denial of coverage from July 12, 2011 to July 13, 2011. On August 26, 2011, the [redacted] appeals committee denied the appeal. Per notice dated August 26, 2011, the [redacted] appeals committee determined the petitioner's needs could be met in a less restrictive setting, such as an ALF. The [redacted] committee further determined that the SNF where the petitioner is presently placed, [redacted] is not a network provider with [redacted] On September 16, 2011, the petitioner requested this instant appeal to the Office of Appeal Hearings.

11. The petitioner was enrolled in the Medicaid Waiver Long Term Care Diversion Program (LTCDP) from April 1, 2006 until benefits under this program were closed effective July 31, 2011. The petitioner had experienced prior falls at the [redacted] ALF where he previously lived, per testimony. [redacted] believes that the petitioner should be placed in an SNF rather than an ALF due to increased risk of fall and advanced dementia. [redacted] further relied on the concurring opinion of a treating physician and therapist at [redacted] rehabilitation to conclude that the petitioner should be placed in a SNF rather than an ALF. [redacted] seeks reimbursement of the $4,578 he personally paid the [redacted] SNF for the custodial care the petitioner received from July 12, 2011 through July 31, 2011.

12. Since the time of the last fall, the petitioner now ambulates with a wheelchair. The [redacted] physician disputed that the petitioner's needs could not continue to be safely met at the [redacted] ALF.

CONCLUSIONS OF LAW

13. 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 §120.80 Fla. Stat.

14. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

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

16. Fla. Stat. ch. 430.705 establishes:

> Implementation of the long-term care community diversion pilot projects.—
> (1) In designing and implementing the diversion pilot projects, the department shall work in consultation with the agency. (2)(a) The department shall select projects whose design and providers demonstrate capacity to maximize the placement of participants in the least restrictive appropriate care setting…(6) The department shall provide to prospective participants a choice of participating in a community diversion pilot project or any other appropriate placement available…(9) Community diversion pilot projects must: (a) provide services for participants that are of sufficient quality, quantity, type, and duration to prevent or delay nursing facility placement…

17. Fla. Admin. Code § 59G-13.080 Home and Community-Based Services Waivers informs in part:

> (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…

18. The above cited authorities set forth the purpose of the LTCDP and explains that Medicaid recipients who would otherwise receive services in an institution elect to receive services in the community in the least restrictive possible environment. Finding number 11 shows that the petitioner was an enrolled participant in the LTCDP from April 2006 until dis-enrollment from the Medicaid Waiver Program was made effective July 31, 2011.

19. The respondent's contracted [redacted] provider determined that the petitioner could be safely returned to his prior residence in a contracted ALF after his release from rehabilitative therapy on July 13, 2011. The petitioner disputes this [redacted] position and asserts that the petitioner's increased risk for fall in view of advancing dementia shows that placement should be in a skilled nursing facility (SNF). The language of the above statute shows that the intent of the Long-Term Care Community Diversion Pilot Project is to provide appropriate services to prevent or delay nursing facility placement. Further, participants are to be placed in the least restrictive, but still appropriate care setting. The least restrictive care setting in this instant appeal would be for the petitioner to remain in his prior placement in an ALF rather than the skilled nursing facility placement. It would then be necessary to determine whether an ALF or SNF

placement is the appropriate care setting based on the definition of "medical necessity" found in the Florida Administrative Code Rule 59G-1.010 (166).

20. To determine the defined "medical necessity" of prescribed treatment or services, the opinion of the treating physician is to be given great weight, even though such physician opinion is not necessarily compelling. However, prior to a further review of whether or not it is medically necessary to place the petitioner in a SNF rather than an ALF, it is necessary to determine if the respondent is responsible to pay for care the petitioner received at a non-contracted SNF.

21. The petitioner's son made efforts to have his father placed in a SNF that was contracted with [redacted] Since a bed in an [redacted] contracted SNF facility could not be found, the petitioner's son (and representative) elected to transfer the petitioner into skilled care at the non-contracted [redacted] facility on July 12, 2011. The petitioner's son determined that SNF placement was the appropriate care setting to meet the petitioner's needs based on the medical opinion of treating medical providers and his own medical opinion. Fla. Admin. Code Rule 59G-8.100(15)(b) describes such out of plan use for non-emergency services, as follows:

22. **59G-8.100 Medicaid Contracts for Prepaid Health Plans.**

(15) Out of Plan Use.

(b) When an enrollee utilizes covered services, other than emergency services and family planning services, available under a Medicaid-funded prepaid plan from a non-contract provider, the contractor shall not be liable for the cost of such utilization unless the contractor referred the enrollee to the non-contract provider or authorized the out of plan utilization. **The enrollee shall be liable for the cost of unauthorized use of contract covered services from non-contract providers.** If the contractor issues a plan identification card, it shall

include a telephone number that the non-contract provider may call for authorization and billing information. (emphasis added)

22. The petitioner was provided advance notice that he may be personally liable for the cost of SNF care if such care was not concluded as medically necessary, and was not provided by an [redacted] contracted facility. In the absence of emergency, application of the above rule shows that the respondent's [redacted] provider is not responsible for the cost of SNF care in the "unauthorized use of contract covered services from non-contract providers." The available evidence does not show that there was an emergency to require the petitioner's placement in a SNF.

23. In sum, according to the above authorities, the respondent, through its [redacted] provider, is not responsible for the cost of the non-emergency SNF care provided by a facility from July 12, 2011 to July 31, 2011 that is not contracted with [redacted] Since the respondent is not responsible for this cost of care in a non-contracted SNF, it is moot to further develop whether or not it was medically necessary for the petitioner to be placed in a skilled nursing facility based on his medical condition. Thus, the respondent is correct to deny the petitioner's request for reimbursement of $4,578 privately paid for SNF care during the period of July 12, 2011 to July 31, 2011.

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 _____ day of _____, 2012,

in Tallahassee, Florida.

_____
Jim Travis
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
[redacted], Area 6 Medicaid Field Manager