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

[redacted]

APPEAL NO. 11N-00053

PETITIONER,

Vs.

CASE NO.

Administrator
[redacted]

RESPONDENT.
_____/

FILED
June 11, 2011
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN AND FAMILIES

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at the nursing facility on April 19, 2011 at 1:15 p.m.

APPEARANCES

For the Petitioner: [redacted], daughter

For the Respondent: [redacted], business office manager of the facility

STATEMENT OF ISSUE

At issue is whether or not the petitioner's discharge from the nursing facility in accordance with the requirements of the Code of Federal Regulation at 42 C.F.R. §483.12(a).

PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice dated March 14, 2011, the facility advised the petitioner of its intent to discharge her from the facility based on the contention that "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The petitioner timely requested an appeal.

Observing the proceeding was [redacted], Ombudsman, [redacted] LTCOC, [redacted] Ombudsman and [redacted] son-in law.

Present for the facility was [redacted] assistant Director of Nursing, [redacted] administrator, and [redacted], social services director.

FINDINGS OF FACT

1. The petitioner (age 87) was admitted to the facility on September 4, 2010 under Medicare Part A. On October 20, 2010, the petitioner was advised that the anticipated end of the Medicare benefit period would be December 12, 2010 and that at the end of the benefit period she would be billed privately for her care. The correspondence dated October 20, 2010 further advised that the petitioner could apply for Nursing Home Medicaid. The petitioner's representative believed the petitioner would be covered under Medicare until December 12, 2010.

2. On November 2, 2010, the physical therapy department issued a seven day discharge notice to the resident for not participating in therapy. The last treatment day for occupational and physical therapy was October 4, 2010. Speech therapy ended on November 8, 2010 as maximum potential had been achieved. On November 9, 2010, the petitioner was discharged from all therapy and her Medicare

benefit period ended on that day. The resident's payor source was changed from Medicare to private pay effective November 9, 2010.

3. The petitioner was advised to apply for possible Medicaid coverage and on November 30, 2010, a statement for services was sent to the petitioner. The Statement of Account advised the amount due from the petitioner was $10,600 which included advance charges for December 2010 of $6,200.

4. The petitioner's representative believed the nursing home would apply for the Institutional Care Program (ICP) under Medicaid and that her attorney would be handling a Qualified Medicaid Income Trust. She asserts she did not know the application was not filed until she began receiving collection letters for past due balances. Further, the petitioner has medical insurance with TriCare and claims for the balance of co insurance were still pending as of the date of hearing.

3. On December 13, 2010, a collection letter was sent to the petitioner. The facility social work department was advised by the petitioner's representative that she believed the attorney was handling the application for Medicaid. There was a need for the petitioner to establish a Qualified Income Trust to establish eligibility for Medicaid coverage. The representative did not adequately fund the QIT until February 2011. Medicaid eligibility was approved effective February 2011.

4. On December 31, 2010 a statement of account was sent to the petitioner and her representative showing a balance due from the petitioner of $16,600. On January 12, 2011 and February 22, 2011 certified mail collection notices were sent to the petitioner's representative. The months of November 9, 2010 through January 31, 2011 were billed under private pay.

4. A Notice of Transfer/Discharge was sent to the petitioner by certified mail on February 22, 2011. A Notice of Transfer/discharge was reissued to the petitioner and her representative on March 14, 2011 as the facility did not fax a copy of the original to the Ombusdsman.

5. The representative has made three payments of $4,598.82 (the patient responsibility) to the facility and on April 18, 2011 a payment of $3,750 was received. As of the date of the hearing, the petitioner's outstanding bill was $18,847.46.

6. The petitioner's representative does not believe she owes for the past months of November and December 2010 as she was originally advised that Medicare would pay for her stay at the facility until December 12, 2010. Further, she believes there was a lack of communication regarding her mother's treatment. Her mother was ill and did not participate in the therapy sessions because she did not feel well enough. She does not dispute that she owes for January 2011 ongoing and intends to pay for those months. It is her argument that the payments she made should be applied to those months rather than for the months of November 9, 2010 through December 31, 2010.

7. The petitioner's representative is concerned that the facility intends to discharge the petitioner to the representative's home in the community. The respondent indicated that it will continue to make efforts to find another suitable placement for the petitioner.

CONCLUSIONS OF LAW

7. Jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. §431.200.

8. Florida Statute 400.0255, Resident transfer or discharge; requirement and procedures; hearing --, informs at (15)(b) that the burden of proof is clear and convincing evidence.

9. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In the instant case, the respondent proposes discharging the petitioner from the facility due to the contention that petitioner's bill for services has not been paid after reasonable and appropriate notice to pay. Federal regulations do permit a discharge for this reason, as set forth at 42 C.F.R. §483.12(a)(2)(v) which states in relevant part:

> (a) Transfer and discharge—
> (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—
> … (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.
> …

10. The Findings of Fact show that the petitioner has an outstanding balance, owed to the facility, for the cost of her care and that the facility has notified the petitioner and her representative of the balance due for the cost of care. The petitioner's representative argued that she does not owe for the past months of November and December 2010 because she was originally advised that Medicare would be the payor for those months. The Findings show that the petitioner became private pay when her

therapy ended resulting in termination of Medicare benefit coverage effective November 9, 2010 and before Medicaid eligibility coverage began in February 2011.

11. The controlling federal regulations do not address any excusable situations which lead to a balance owed to the facility and therefore are not considered in the ruling.

12. According to the above authorities, the facility may not discharge except for certain reasons, one of which is when the resident has failed, after reasonable and appropriate notice to pay for the stay at the facility. Therefore, the hearing officer concludes that the nursing facility has met its burden to prove that the petitioner has not appropriately paid for her stay at the facility and that reasonable and appropriate notice to pay for such stay has been made. Therefore, the hearing officer concludes that the discharge action is in accordance with the controlling federal and state authorities.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the appeal is denied. The respondent may proceed with the proposed discharge in accordance with the Agency for Health Care Administration's applicable rules.

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 _____ day of _____, 2011,

in Tallahassee, Florida.

_____
Linda Garton
Hearing Officer
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Copies Furnished To: [redacted], Petitioner
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Respondent
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