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

APPEAL NO. 07F-03891

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 10 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 15, 2007, at 2:00 p.m., in Fort Lauderdale, Florida. The hearing was rescheduled from July 17, 2007, at the respondent's request. The petitioner was not present. She was represented by her mother . The Agency was represented by Sheila Samuels, registered nurse specialist. Present on the telephone from Kepro was Dr. Robert Buzzio, physician, and George Smith, review operations supervisor.

ISSUE

At issue is the Agency's May 25, 2007 action of reducing the petitioner's skilled home nursing services from 12 hours daily 7 days per week to 8 daily hours 7 days per week. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a child, date of birth [illegible] She has been receiving skilled home nursing services of 12 hours daily 7 days per week. Included in the evidence is a copy of a Recipient Denial Letter, dated May 25, 2007, stating that 240 hours of skilled home nursing services were denied, and 480 hours were approved for her from June 1, 2007 to July 30, 2007. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld notice dated June 15, 2007. This notice informed the petitioner that the denial of the 240 hours of skilled home nursing services was upheld, and that 480 hours was approved, which is 8 hours daily 7 days per week, effective June 1, 2007.

The notices sent to the petitioner explained that it was determined by Kepro that the medical care of the skilled home nursing services of 480 hours was determined to be medically necessary. Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner, dated May 21, 2007, stating that she was diagnosed with a short gestation, which was a 24 week gestation, disorders of phosphorus metabolism, newborn hemolytic disease, isoimmunization nec, primary apnea of newborn, and respiratory distress syndrome in newborn.

Included in the evidence is a copy of a Kepro Synopsis of Case report, concerning the reconsideration, dated June 5, 2007, recommending that the petitioner be provided with 480 hours of skilled home nursing services, and her mother can provide more independent care because she is not working. This was after a second board certified pediatrician reviewed the petitioner's medical records.

There was an additional reconsideration done on June 14, 2007, by the second board certified pediatrician, upholding the initial denial, and approving 8 hours daily 7 days per week of skilled home nursing services. At the hearing, the petitioner's mother asserted that she was planning to start school, but has not started yet. According to her, she plans to attend school Monday, Wednesday, and Friday, and is also looking for work. According to Robert Buzzio at the hearing, he agrees with the reduction of the skilled home nursing services for the petitioner.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. 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;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
> (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.

Fla. Admin. Code 59G4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
1. Ordered by and remain under the supervision of a physician;
2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury;
6. Consistent with the nature and severity of the individual's condition or the disease state or stage.

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that skilled home nursing services must be ordered by the attending physician, and documented as medically necessary. The petitioner was receiving skilled home nursing services of 12 hours daily 7 days per week, and it was determined that these services would be reduced to 8 hours daily 7 days per week, which is 480 hours from June 1, 2007 to July 30, 2007.

The Agency's determination takes into account what is medically necessary for the petitioner, and her mother's availability to help care for her. The physician that testified at the hearing agrees that the petitioner needs skilled home nursing care, and he agrees with the pediatric physician's determination of reducing the skilled home nursing services from 12 hours daily to 8 hours daily. After careful consideration, it is determined that the Agency's action to reduce the skilled home nursing services, is upheld.

DECISION

This appeal is denied and the Agency's action is affirmed.

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 31st day of August, 2007,

in Tallahassee, Florida.

Stuart Imberman

Stuart Imberman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [illegible], Petitioner
Gail Wilk, Area 10 Medicaid Adm.

Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-03143

PETITIONER,

Vs.

CASE NO. 1243237481

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 09 Palm Beach
UNIT: 88322

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 26, 2007, at 10:45 a.m., in Riviera Beach, Florida. The petitioner was not present. Representing the petitioner was Stephen Hall, attorney. Appearing as witnesses were: , social services director; , social services assistant; and , nurse supervisor, all from Nursing and Rehabilitation Center. Representing the respondent was Terry Verduin, District 9 legal. Appearing as a witness was Idali Hilgenfeldt, specialist II.

An original hearing was convened September 9, 2006 on this matter. The Final Order of October 23, 2006 found the petitioner was not disabled for Institutional Care Program (ICP) Medicaid eligibility.

When this Final Order was appealed to the 4th District Court of Appeals, the respondent determined that the recording of the hearing was not clear enough so it requested that jurisdiction be relinquished pending the outcome of this hearing.

ISSUE

The petitioner is appealing the respondent's action to deny her Medicaid benefits in the Institutional Care Program (ICP) Medicaid on the basis that she did not meet the disability criteria. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a fifty-seven year old (D[illegible]) resident of a nursing facility in [illegible] County, Florida. An application for Institutional Care Program (ICP) Medicaid benefits was submitted, on her behalf, May 23, 2006.
2. The petitioner had been admitted to the facility June 2005 following a two week stay at the psychiatric pavilion of [illegible]. The petitioner had been Baker Acted after a breakdown. She was and continues to be delusional and confused.
3. Because the petitioner was not 65 years old, she did not meet the aged criteria for eligibility. The respondent, therefore, completed a disability package and sent it to the District Medical Review Team (DMRT).
4. The DMRT completed their findings, based upon the medical information submitted, June 22, 2006. The DMRT notified the respondent that the petitioner did not meet the disability requirement for the Program because it felt the

"impairment is no longer severe at time of adjudication but not expected to last twelve months". This is noted by the code N34.

5. Based upon the DMRT's denial, the respondent denied the petitioner's application for ICP benefits.
6. As of the hearing date, applications were submitted to Social Security for both a disability determination and for Supplemental Security Income (SSI). Social Security denied both, not on the question of disability, but for assets exceeding their eligibility limits.
7. The petitioner established a special needs (qualified disabled) trust. However, because no disability determination was ever made, Social Security counts the funds in the trust as an asset.
8. The petitioner is disputing the findings of the DMRT. The petitioner has been diagnosed with Schizophrenia, Major Depression, Dementia, and hypertension. She receives medication for all diagnoses to include Risperdal, Lexapro, and Exelon.
9. Concerning her activities of daily living (ADLs), the petitioner ambulates but with no direction. She needs guidance for almost all her responsibilities. She cannot do sequential tasks. She requires help with her bathing, feeding, and dressing. She has poor memory. She has a flat affect.
10. It is noted that she does not initiate conversation. There has been no improvement in her conditions and there are signs of worsening, particularly the dementia. She needs nursing assistance to take her medications.

11. The petitioner was last employed as a tax attorney. And according to her treating psychiatrist [redacted] "Ms. West is permanently disabled and unable to work".

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.710 (1) sets forth the rules of eligibility for elderly and disabled individuals. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 42 U.S.C. § 1396a(m), and 20 C.F.R. § 404.1505 **Basic definition of disability**. The regulation states in part:

> (a)The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see Sec. 404.1560(b)) or any other substantial gainful work that exists in the national economy.

42 C.F.R. § 435.541 **Determinations of disability** states in part:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
>
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in Sec. 435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under Sec. 435.909.
>
> (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section--

> (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
>
> (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
>
> (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA....

Authority is given to the respondent to have the DMRT make a determination of disability.

The hearing officer evaluated the petitioner's claim of disability using the sequential evaluation as set forth in 20 C.F.R. § 404.1520. The first step is to determine whether or not the individual is working. The petitioner is not working and, therefore, meets the first step.

The second step is to determine whether or not the individual has a severe impairment that will last more than twelve months. Documentation provided shows that the petitioner's condition(s) meet the second step requirement.

The third step is to determine whether or not the individual's impairment(s) meets or equals a listed impairment in appendix 1 of the subpart of the Social Security Act. Among the petitioner's conditions is that of schizophrenia. Reviewing 12.00 Mental Disorders:

> A. Introduction. The evaluation of disability on the basis of mental disorders requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on your ability to work, and consideration of whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in nine

diagnostic categories: ...schizophrenic, paranoid and other psychotic disorders (12.03)....

12.03 Schizophrenic, Paranoid and Other Psychotic Disorders:

Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

a. Blunt affect; or

b. Flat affect; or

c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or

2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

Upon reviewing the medical information provided, the petitioner's schizophrenic condition alone would qualify her as having a disabling condition. She meets the conditions set forth in A, B, and C. Combining the additional medical problems only accentuates the underlying disabling existence.

DECISION

The appeal is granted and the petitioner is found to be disabled. However, she must meet all the respondent's other criteria to be ICP eligible.

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-

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

APPEAL NO. 07F-03538

PETITIONER,

Vs.

CASE NO. 1253196699

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 07 Orange
UNIT: 88999

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned-hearing officer convened an administrative hearing in the above matter on July 12, 2007, at 11:10 a.m., in Orlando, Florida. The petitioner did not appear. [redacted] petitioner's representative, appeared on the petitioner's behalf. [redacted], benefits coordinator of [redacted] and Nick Barton, executive director of Aged Pooled Special Needs Trust, appeared as witnesses for the petitioner. Reginald Schofield, economic self-sufficiency specialist supervisor, appeared and represented the respondent-Department.

ISSUE

At issue is the respondent's action of January 2, 2007, denying the petitioner's application for Institutional Care Program Medicaid (ICP) for failure to follow through in

establishing eligibility. Also at issue is the respondent's delay in processing the petitioner's application dated March 30, 2007, for ICP Medicaid.

FINDINGS OF FACT

1. The parties stipulated to the following facts:
2. The petitioner submitted an application for Institutional Care Program (ICP) Medicaid on November 30, 2006.
3. The respondent issued a notice dated December 4, 2006, to the petitioner requesting the return of several items. The deadline date for submission of these items was December 14, 2006. The notice also informed that the petitioner had a total of 30 days by which to submit all of the information before it issued a denial for failure to provide the verification.
4. The petitioner submitted all requested information on December 15, 2006.
5. The petitioner submitted additional asset information to the respondent that was not officially requested but was informative in nature on December 22, 2006.
6. On January 2, 2007, the respondent's eligibility specialist denied the petitioner's application for failure to follow through in establishing eligibility.
7. The petitioner's representative made several contacts following the denial to check on the status of the case and find out on what basis the respondent denied the case. The representative received no response.
8. On February 15, 2007, the petitioner's representative met with the respondent's representative who informed her that the application was denied and that a new application needed to be filed regardless of the fact that the previously requested information was submitted in December 2006.

9. On February 22, 2007, the petitioner's representative filed a written hearing request with the respondent to appeal the January 2, 2007, denial. This hearing request was never forwarded to the Office of Appeal Hearings.
10. Due to the volume of difficulties experienced in trying to get the petitioner's application approved, the petitioner's representative filed another application on March 30, 2007. The same documentation requested with the prior application was again requested and in addition, verification of the petitioner's monthly Veteran's Benefit payment was needed. The representative provided this verification.
11. In May 2007, the respondent acknowledged that all information was received but that the case was awaiting disability approval by the District Medical Review Team (DMRT).
12. The petitioner's representative filed another hearing request directly with the Office of Appeal Hearings which was received on June 11, 2007.
13. At the hearing, the petitioner argued that the respondent mishandled the application and is well over the time standard allowed for application processing. The respondent has a duty to act on the application immediately.
14. The respondent conceded that it made errors in the handling and processing of the petitioner's application dated November 30, 2006, including improper denial and causing delay. The respondent forwarded the petitioner's file to the District Medical Review Team (DMRT) on July 3, 2007, for determination of disability for ICP Medicaid. The petitioner met all others factors of eligibility for the program and the application was currently pending for the DMRT's approval or denial of

the factor of disability. Once the DMRT issues a decision, the respondent will issue an approval or denial of the Medicaid application.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.205 states in relevant part:

> **Eligibility Determination Process** [emphasis original]...(1)(c) Time standards for processing applications vary by public assistance program. The time standard begins with the date on which the department or an outpost site receives a signed and dated application and ends with the date on which benefits are made available or a determination of ineligibility is made. For the Medicaid program, the time standard ends on the date an eligibility notice is mailed. Applications must be processed and determinations of eligibility made within the following time frames:...Medical Assistance and State Funded Programs for individuals who apply on the basis of disability...90 days...All days counted after the date of application are calendar days. Applicant delay days do not count in determining non-compliance with the time standard. See paragraph (e) of this rule...(e) There are situations of non-agency processing delays due to unusual circumstances for Medicaid disability-related applications. Unusual circumstances that might affect the timely processing of Medicaid are determined and documented in accordance with 42 CFR subpart 435.911 and include applicant delay, physician delay and emergency delay as defined below. Unusual circumstances are considered non-agency processing delays and the calendar time passing during such delay(s) is not counted as part of the 90-day time standard for determining the timeliness of Medicaid eligibility decisions based on disability...1. Applicant delay is defined as the time attributed to the applicant who fails to keep any scheduled appointment or to provide requested and required eligibility information...2. Physician delay is defined as the time attributed to a physician when medical evidence or when a medical examination is requested and is not provided timely...3. Emergency delay is defined as time attributed to other situations beyond the agency's control. These delays are situations such as disasters, unexpected office closure(s) and systems inaccessibility or unavailability...

The respondent is under a duty to approve or deny a disability-related application by the 90th day from the date of the application. The above provision indicates there are certain types of acceptable delay that can occur during the processing of an application which cause it to be approved or denied untimely. None of the types of delay described

above apply to this case. The findings show that the respondent's own actions caused delay in the processing of the petitioner's application for ICP Medicaid dated November 30, 2006. The respondent must act upon the petitioner's application, dated November 30, 2006, promptly.

DECISION

The appeal is granted. The respondent's denial of the application dated November 30, 2006, is reversed. The DMRT has had sufficient time to issue a decision on the factor of disability and in the event that its decision is still pending upon receipt of this order, the DMRT is ordered to issue a decision within 10 days.

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 30th day of August, 2007, in Tallahassee, Florida.

Jeannette Estes

Jeannette Estes
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To

Petitioner

7 DPOES: Janet DeChristopher

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

APPEAL NO. 07F-03454

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 20, 2007, at 2:35 p. m., at the West Dade Service Center, in Miami, Florida. The petitioner was not present, but was represented by his mother, The respondent was represented by Erica Woodard, registered nurse specialist, Agency For Health Care Administration (AHCA). Present as witnesses for the respondent, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO and George Smith, review operations supervisor with KePRO. Ron Ruel, RN, was present observing the hearing.

ISSUE

At issue is the respondent's action of May 29, 2007, to deny the petitioner 240 hours of Home Health Aide (HHA) services, for the period of May 5, 2007 through July 3, 2007, due to medical necessity. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who was eight years of age at time of review, has a condition called Hunter Syndrome, a genetic disorder with progressive mental and physical deterioration.

2. On behalf of the petitioner, ... Health Service, a home health care provider, requested authorization for 240 HHA hours for the certification period May 5, 2007 through July 3, 2007. The provider indicates that the petitioner requires constant supervision. He attends school Monday through Friday 7:00 a.m. to 5:00 p.m. The primary caregiver (mother) works ten hours daily. The provider provides HHA for personal care daily from 5:00 p.m. to 9:00 p.m.

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the respondent. The Prior Authorization Process was completed for the petitioner by KePRO.

3. On May 29, 2007 a physician consultant reviewed the petitioner's request and made the following determination: "Mom is at home by the time pt returns from school. Mom seems to be able to care for the pt as she does so in the absence of CNA services..." The physician consultant denied the request for service as medical necessity had not been demonstrated.

4. The provider requested a reconsideration and submitted additional medical information.

5. On June 5, 2007, a different physician consultant reviewed the information and denied the request stating: "I agree partially with physician consultant and suggest to modify the denial for assistant service. The care and needs of this recipient could be

provided by regular Home Health HHA visits in less than two hours, therefore I suggest to uphold this denial for paraprofessional HHA services and request provider to submit a request for HHA visits to address the ADL needs and care for this recipient."

6. On June 6, 2007, the petitioner was notified of the above decision.

7. The petitioner's representative expressed that she works for ten hours, does all the household chores and cares for her son, but she needs rest.

8. Dr. Buzzeo responded that the program that AHCA provides does not support respite care, and rest is considered respite care. Dr. Buzzeo explained that the reason for the denial was because the petitioner is at school from 7:00 a.m. to 5:00 p.m. and the mother is available at home after 5:00 p.m. to provide care to the petitioner. Dr. Buzzeo notes that if the caregiver needs help, this can be done on a HHA visit of less than two hours per day.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.901(14) **Definitions** states in part:

> "Medicaid agency" or "agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

Fla. Stat. ch. 409.901(4) **Home Health Care Services** states in part:

> The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.

Fla. Admin. Code 59G-1.010, which applies to the Florida Medicaid Program states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. 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;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Fla. Admin. Code 59G-4 **Home Health Services** states in part:

(1) This rule applies to all home health agencies licensed under Chapter 400, Part IV, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.
(2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.
(3) When terminating, reducing, or denying private duty nursing or personal care services, Medicaid will provide written notification to the recipient or the recipient's legal guardian. The notice will provide information and instructions regarding the recipient's right to request a hearing.

The Home Health Services Coverage and Limitations Handbook (October 2003) explains service requirements for Home Health Aide Visit Service on page 2-14, stating in part:

Home health aide services may be reimbursed only when they are:
- Ordered by the attending physician;
- Documented as medically necessary; ...

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag;
- Assisting with transfer or ambulation;
- Reinforcing a dressing;
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN;
- Assisting with an ice cap or collar;
- Conducting urine test for sugar, acetone or albumin;
- Measuring and preparing special diets;
- Providing oral hygiene;
- Bathing and skin care; and
- Assisting with self-administered medication.

The respondent, through KePRO, took action on May 29, 2007, to deny the petitioner 240 hours of HHA for the period of May 5, 2007 through July 3, 2007, as medical necessity had not been demonstrated. This decision was based on the information as provided by the petitioner's service provider and the petitioner's medical necessity need of the request for the service.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the respondent's action.

DECISION

This appeal is denied as stated in the Conclusions of Law.

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 3rd day of August, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
Building 5, Room 203
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Copies Furnished To: [redacted] Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Sharon Lang
Mary Wheeler
Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-02817

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 18, 2007, at 10:58 a.m., at the Caleb Service Center, in Miami, Florida. The petitioner appeared by telephone at her request and represented herself. The Agency was represented by Donna Pollins, senior human services program specialist, Agency for Health Care Administration (AHCA). On the telephone was Deborah Parthemore, operations manager with KePRO; Dr. Frank Castrina, medical director from KePRO; Elizabeth Mesa, case manager from Maxmed and Rosty Batista, Medicaid coordinator for Maxmed. Mary Wheeler and Theresa Ashey were also present via the telephone observing the hearing. Blanca Alvarez Buylla served as an interpreter. The record was left open for a total of fourteen additional days in order for the petitioner to submit additional information. Additional information was submitted within the time frame allotted.

ISSUE

At issue is the Agency's action of March 12, 2007, to deny the petitioner's request for Home Health Aide (HHA) visit one time a day for the period of January 16, 2007 through March 16, 2007, because the documentation submitted by the agency (provider) does not support the medical necessity for the visit frequency of the services requested. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who was 59 years of age at time of review, has severe and numerous medical problems that require medical services as provided through the Agency for Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA will be further addressed as the respondent.

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the respondent. The Prior Authorization Process was completed for the petitioner by KePRO.

3. On January 16, 2007, the provider, Maxmed Inc. requested 59 hours of HHA visits, one time a day, Monday through Sunday.

4. The plan of care submitted by the provider indicates in part that the petitioner suffers from urinary incontinence, has transmetatarsal amputation to left foot and right great toe and requires assistance with ADL's and personal care.

5. The respondent's witness indicated that after review of the information provided to KePRO regarding the medical needs of the petitioner, a KePRO physician consultant

determined that the HHA visits could not be authorized because there was not sufficient documentation regarding why the petitioner was unable to participate in her own care.

6. A reconsideration of the above decision was requested. All information pertinent to the case was reviewed by a KePRO reconsideration physician consultant who upheld the original denial of the requested service.

7. On March 27, 2007, the provider notified KePRO that the information previously submitted concerning the caregiver who works long hours was a misunderstanding with another patient. The provider explained that the petitioner's caregiver is her mother, who takes responsibility of making decision as to care/treatment, but not the person performing bathing, dressing and other kind of assistance for patient.

8. At the hearing, the petitioner explained that she brought to the provider her plan of care by her doctor showing her medical condition and the amputation that she had on both of her feet. The petitioner purported that she had two thromboses and has the same skin/circulatory condition in her hands that does not allow her to do her own personal care.

9. The respondent's witness responded that there was no information sent to KePRO saying that she had circulatory problems with her arms or her hands, or a skin condition of her hands.

10. On August 1, 2007, the hearing officer received a letter from the petitioner's treating physician. This letter by Dr. Elizabeth Mesa, dated July 30, 2007, states in part: "Mrs. [redacted] eficiency is also affecting her upper extremities leading to decrease sensation, coldness, claudication of hands, which incapacitates her to provide own

personal care. Mrs. lives with elderly mother and has no other relative to provide assistance with her care."

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.901(14) **Definitions** states in part:

> "Medicaid agency" or "agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

Fla. Stat. ch. 409.901(4) **Home Health Care Services** states in part:

> The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.

Fla. Admin. Code 59G-1.010, which applies to the Florida Medicaid Program states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. 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;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Fla. Admin. Code 59G-4 **Home Health Services** states in part:

> (1) This rule applies to all home health agencies licensed under Chapter 400, Part IV, F.S., and certified by the Agency for Health Care

Administration for participation in the Medicaid program for home health care.
(2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.
(3) When terminating, reducing, or denying private duty nursing or personal care services, Medicaid will provide written notification to the recipient or the recipient's legal guardian. The notice will provide information and instructions regarding the recipient's right to request a hearing.

The respondent, through KePRO, took action on March 12, 2007, to deny the petitioner's request for Home Health Aide (HHA) visit one time a day for the period of January 16, 2007 through March 16, 2007. This decision was based on information as provided by the petitioner's service provider and the petitioner's medical necessity need of the request for the service.

After considering all the evidence, including new medical evidence from her treating physician, the Fla. Admin. Code and all of the appropriate authorities set forth in the findings above, the hearing officer finds the Agency's action to deny the petitioner's request for Home Health Aide (HHA) visit one time a day was not correct.

DECISION

This appeal is granted as stated in the Conclusions of Law.

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 13th day of August, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Health Systems Development Administrator

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

APPEAL NO. 07F-03339

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 26, 2007, at 1:22 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's grandmother, I ı. Also present on behalf of the petitioner was the petitioner's maternal great aunt, Present as a witness for the petitioner was Karen Gurian, director of clinical services from Maxim, the petitioner's provider agency. The Agency was represented by Erica Woodard, Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the Agency was George Smith, review operation supervisor from KePRO. KePRO is located in Tampa, Florida. Present as observers

were Karen Kinser and Julie Clifton, both from AHCA. A continuance was granted on behalf of the respondent for a hearing previously scheduled on July 25, 2007.

ISSUE

At issue is the Agency's action of May 28, 2007, to deny/cancel the petitioner's request for continued private duty nursing services from 720 hours of the service to 0 for the period of May 24, 2007 through July 22, 2007. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about one year of age, has severe and numerous medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "Agency". The petitioner has a twin, who additionally receives services through AHCA.

KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on May 28, 2007, that the petitioner's request for continued 720 hours of private duty nursing was going to be denied/reduced to 0 hours for the period of May 24, 2007 through July 22, 2007. The Agency's witness indicated that after review of the information provided to KePRO, from the petitioner's representatives, did not indicate a need for the level or amount of skilled nursing services for the petitioner. The petitioner requested a timely hearing and the previously approved benefits of private duty nursing were reinstated.

The Agency witness indicated that the Agency's reason for the denial/cancellation of service is based on the petitioner not having a condition that would require skilled nursing care. The Agency suggested that a Home Health Aide would be more appropriate and suitable for the petitioner.

A reconsideration was requested, but the Agency upheld the original decision.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. 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;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(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...

Fla. Admin. Code 59G-4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.

(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
1. Ordered by and remain under the supervision of a physician;
2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury;
6. Consistent with the nature and severity of the individual's condition or the disease state or stage...

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary.

The Agency, through KePRO, took action on May 28, 2007 to deny/cancel the petitioner's request for continued private duty nursing services from 720 hours of the service to 0 for the period of May 24, 2007 through June 22, 2007. This decision was based on the information as provided by the petitioner's nursing service and the petitioner's medical necessity need of the request for the service.

The petitioner's representative argued that the petitioner could get infections based on her medical condition and she herself is not medically trained to care for the petitioner. She also argued that the petitioner needs the use of a nebulizer, and thus must be monitored by a nurse or someone well trained. She argued that she herself needs a nurse at night to monitor the petitioner and her sister so she can get some rest. The

Agency argued that the Agency's decision was correct and that a CNA or home health aide would be appropriate for the petitioner.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action of May 28, 2007, to deny/cancel the petitioner's request for continued private duty nursing services from 720 hours of the service to 0 for the period of May 24, 2007 through June 22, 2007.

DECISION

This appeal is denied and the Agency's action affirmed.

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 21st day of August, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Sharon Lang
Mary Wheeler
Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-03338

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 26, 2007, at 1:00 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's grandmother, [redacted]. Also present on behalf of the petitioner was the petitioner's maternal great aunt, [redacted]. Present as a witness for the petitioner was Karen Gurian, director of clinical services from Maxim, the petitioner's provider agency. The Agency was represented by Erica Woodard, Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the Agency was George Smith, review operation supervisor from KePRO. KePRO is located in Tampa, Florida. Present as observers

were Karen Kinser and Julie Clifton, both from AHCA. A continuance was granted on behalf of the petitioner for a hearing previously scheduled on July 19, 2007.

ISSUE

At issue is the Agency's action of May 28, 2007, to deny/cancel the petitioner's request for continued private duty nursing services from 720 hours of the service to 0 for the period of May 24, 2007 through July 22, 2007. The Agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about one year of age, has severe and numerous medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "Agency". The petitioner has a twin, who additionally receives services through AHCA.

KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on May 28, 2007, that the petitioner's request for continued 720 hours of private duty nursing was going to be denied/reduced to 0 hours for the period of May 24, 2007 through July 22, 2007. The Agency's witness indicated that after review of the information provided to KePRO, from the petitioner's representatives, did not indicate a need for the level or amount of skilled nursing services for the petitioner. The petitioner requested a timely hearing and the previously approved benefits of twelve hours a day of private duty nursing were reinstated.

The Agency witness indicated that the Agency's reason for the denial/cancellation of service is based on the petitioner not having a condition that would require skilled nursing care. The Agency suggested that a Home Health Aide would be more appropriate and suitable for the petitioner.

A reconsideration was requested, but the Agency upheld the original decision.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. 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;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(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...

Fla. Admin. Code 59G-4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.

(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
1. Ordered by and remain under the supervision of a physician;
2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury;
6. Consistent with the nature and severity of the individual's condition or the disease state or stage...

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary.

The Agency, through KePRO, took action on May 28, 2007 to deny/cancel the petitioner's request for continued private duty nursing services from 720 hours of the service to 0 for the period of May 24, 2007 through July 22, 2007. This decision was based on the information as provided by the petitioner's nursing service and the petitioner's medical necessity need of the request for the service.

The petitioner's representative argued that the petitioner could get infections based on her medical condition and she herself is not medically trained to care for the petitioner. She also argued that prescribed monitors for the petitioner were no longer provided to the petitioner, so it will be additionally more difficult to care for the petitioner. The Agency argued that the Agency's decision was not based any decision to remove monitors. The

Agency also argued that the Agency's decision was in regard to the private duty nursing service only.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action of May 28, 2007, to deny/cancel the petitioner's request for continued private duty nursing services from 720 hours of the service to 0 for the period of May 24, 2007 through July 22, 2007.

DECISION

This appeal is denied and the Agency's action affirmed.

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 21st day of August, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: (, Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Sharon Lang
Mary Wheeler
Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-01150

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 23 Hillsborough
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on June 8, 2007, at 9:46 a.m., in Tampa, Florida. The minor petitioner was present but is not able to testify. The petitioner was represented by Linda Breen, attorney with Bay Area Legal Services. His grand-mother and caregiver, [redacted], was present as a witness for the petitioner.

The respondent was represented by Traci Wilks, attorney with the Agency For Health Care Administration (AHCA). Anne Williams, registered nurse specialist, appeared as a witness for the respondent. Nancy Gettling, the petitioner's support coordinator with Support Associates of Tampa Bay, Inc., appeared as a witness for the petitioner. Barbara Ecenia, operations specialist also with Support Associates of Tampa Bay, appeared as a witness for the petitioner.

Three individuals from Kepro South were present by telephone. Dr. Robert Buzzeo appeared as a witness for the respondent. Teresa Ashy, review operations supervisor, and George Smith, review operations specialist, both appeared by phone as observers.

Two witnesses for the petitioner also appeared by phone: Dr. Steven Kennedy, primary care physician at the University of South Florida, and Thomas A. Lynch, licensed practical nurse.

ISSUE

At issue is the respondent's decision of February 1, 2007 to reduce private duty nursing (PDN) services paid by Medicaid from 22 hours daily, 7 days weekly, to 12 hours daily, 7 days weekly. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is fifteen years old with a birth date of The petitioner lives with and receives care from his grandmother, is 65 years old as of July 1, 2007. has provided care for the petitioner since January 1996.
2. The petitioner is a medically complex young man who was a near drowning victim in early childhood. Due to this event, the petitioner suffered neurological injury, respiratory insufficiency with subsequent tracheostomy/G-tube dependency. Due to this injury, the petitioner has an ineffective cough and requires regular help to

clear respiratory sucretions. The petitioner is dependent for all activities of daily living and requires constant 24-hour attention.

3. Dr. Steven Kennedy is a board-certified pediatrician and has been the petitioner's primary treating physician for the past three years. Dr. Kennedy provides general check-ups, sick visits, and coordinates the petitioner's plan of care. Dr. Kennedy gives additional diagnoses to include static encephalopathy, quadriplegia, seizures, feeding problems with tracheostomy.
4. Dr. Kennedy opines the petitioner to need continuous assessment of respiratory status with frequent suctioning. Further, Dr. Kennedy's plan of care includes skilled nursing to assess/observe neurological, GI, GU, nutrition/hydration, skin integrity and mental status shift. Dr. Kennedy opines that it is not reasonable for the petitioner's 65 year-old caretaker to be expected to provide 12 hours of care daily for the petitioner.
5. Dr. Robert Buzzeo is a board-certified pediatrician who provides a physician review for requested medical services for the contracted Kepro organization. Dr. Buzzeo relies on clinical information normally supplied by the home health agency to determine the need for requested medical services.
6. Dr. Buzzeo was the physician reviewer who reconsidered the petitioner's need for residential nursing hours on February 7, 2007. The only records Dr. Buzzeo had to review were electronic medical

records to determine the need for the services at issue. Dr. Buzzeo opined that more clinical information was needed to support the request for 22 hours daily nursing care, with information on the caregiver's ability to provide care. Dr. Buzzeo opined the petitioner to require 12 hours daily nursing care, based on the information available for his review.

7. The petitioner's grand-mother and caregiver, , is not a medical professional. Ms. t is competent to generally provide the petitioner's care needs, but has difficulty with certain functions due to the petitioner's weight. Ms. lives with her 43 year-old son, but he does not assist with the petitioner's care. There are no other natural supports to provide care to the petitioner, besides Ms.

8. Due to Ms. s interventions in the petitioner's care needs with nursing staff, and the overall lack of nursing staff, Ms. has not been able to obtain paid nursing assistance since February 2007. However, a prior paid home health LPN volunteered about five hours in May 2007. Since February 2007, Ms. receives about two and one-half hours of uninterrupted rest per day due to the petitioner's care needs. Ms. omplains of extreme fatigue and escalating blood pressure.

CONCLUSIONS OF LAW

The Florida Administrative Code Rule 59G-1.010 addresses relevant definitions within the Medicaid Program, which also apply to this Medicaid decision on the private duty nursing services at issue. Subsection (166) of the Florida Administrative Code Rule defines "medically necessary" care, goods or services, as follows:

> ...means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. 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;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the contracted Kepro South reviewing pediatrician recommends the reduction of nursing services from 22 to 12 hours daily. However, the petitioner's treating pediatrician opines the petitioner to continue to require 22-hour daily skilled nursing services.

The petitioner's caregiver is competent to provide care to the petitioner. The language of the "Home Health Services Coverage and Limitations Handbook," on page 2-15, shows that parents and caregivers must participate in care "to the fullest extent possible," as in the following excerpt:

> Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render.

The petitioner's caretaker is a 65-year-old grandmother who has recently provided almost constant care to the petitioner with extremely limited periods of rest. Nursing services have been authorized at the reduced level of 12 hours daily, but the petitioner has been unable to secure nursing services since February 2007. In light of the caregiver's advanced age and fatigue in providing care, and the treating physician's opinion that 22 hours daily nursing care is required, it is concluded that the petitioner continues to need 22 hours daily nursing hours, as medically necessary. This conclusion is further supported by the fact that the reviewing KePro South pediatrician had limited clinical information from the nursing agency to render opinion on the overall need for nursing hours.

DECISION

This appeal is granted. The Agency has not met its burden to prove that nursing services can be reduced to 12 hours daily.

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, 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 First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. 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 7th day of August, 2007,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
Patrick Glynn, Area 6 Medicaid Adm.
Tracie Wilks, Esq.
Linda Breen
Barbara Ecenia
Mary Wheeler

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

APPEAL NO. 07F-03680

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 10 Broward
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 17, 2007, at 9:15 a.m., in Fort Lauderdale, Florida. The petitioner was present and represented himself. The Agency was represented by James Machonis, senior human services program specialist. Present on the telephone from Kepro was Dr. Maureen Levy, medical director; Teresa Ash, supervisor; and Diane Weller, contract manager.

ISSUE

At issue is the Agency's May 11, 2007 action of denying a request for the Medicaid Program to pay for a hospital stay from February 19, 2004 to March 11, 2004, for the petitioner. The petitioner has the burden of proof.

FINDINGS OF FACT

Kepro is an organization under contract with the Agency for Health Care Administration, (AHCA) that conducts medical reviews for Medicaid prior authorizations,

for inpatient hospital medical services for Medicaid recipients in Florida. This determination is for medical necessity under the terms of the Florida Medicaid Program. The reason for this denial was due to lack of medical necessity. The petitioner, date of birth September 21, 1973, was a Medicaid recipient in February 2004 and March 2004. He was in I Hospital in lorida, and there is a request for the Medicaid Program to pay for the dates of February 19, 2004 to March 11, 2004.

Included in the evidence is a copy of a Recipient Denial Letter, dated May 11, 2007, informing the petitioner that Medicaid benefits were denied for the dates of February 19, 2004 to March 11, 2004. The reason for the denial was that due to medical necessity, it does not appear that he required inpatient services. Included in the evidence is a Recipient Denial Letter, dated May 18, 2007, informing the petitioner that Medicaid benefits were denied for the dates of February 19, 2004 to March 11, 2004. The reason for the denial was that due to medical necessity, it does not appear that he required inpatient services. Also included in the evidence are copies of two Recipient Reconsideration Denial notices dated June 18, 2007. One of the notices states that the denial was upheld, and the other notice states that the denial was overturned.

Included in the evidence are copies of Internal Focus Review Findings from Kepro, showing that some of the days that the petitioner was in the hospital was approved for Medicaid benefits, and some of the days were denied. On page one of the findings, it states that the denied days are February 28, 2004 to March 6, 2004, and one day from March 10, 2004 to March 11, 2004. Then, on page 9 of these findings, it states that Medicaid benefits were denied from March 6, 2004 to March 9, 2004, and the other days were approved.

On the Internal Focus Review Findings form, the dates of February 20, 2006 to March 11, 2006 are listed. The dates should be February 20, 2004 to March 11, 2004, not 2006. On page 1 of theses findings, it states that on May 7, 2007, Kepro was presented with information about the petitioner's hospital stay from February 19, 2004, and the subsequent 20 days. Previous to February 19, 2004, the petitioner was in the University Hospital, in Broward County, Florida. At that time, he was found to have severe cardiomyopathy with aortic and tricuspid mitral insuffiency.

When the petitioner was admitted to emorial Hospital on February 19, 2004, he was diagnosed with dysphagia with liquids and solids, dyspnea, and congestive heart failure. The position of the respondent is that based on information provided, it was determined that the petitioner's stay at the hospital from March 6, 2004 to March 9, 2004, was not medically necessary for inpatient services. At the hearing, Dr. Levy agreed with this determination. At the hearing, it was discussed, and it was not sure if the petitioner would be billed for his stay at the hospital for the denied services, if the hearing would be denied by the hearing officer.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Fla. Stat. 120.80.

Fla. Admin. Code at 59G-1.010 defines medically necessary, and states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. 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;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(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.

Kepro, contracted by the Agency has the authority to conduct prior authorization reviews in order to establish if services are medical necessary. Kepro denied a request for the Medicaid Program to pay for a hospital stay from February 19, 2004 to March 11, 2004, for the petitioner, based on the lack of medical necessity for this service. After a reviewing process, it was determined that the denial was changed to the dates of March 6, 2004 to March 9, 2004, due to the lack of medical necessity. The doctor that testified at the hearing agreed with this determination. After careful consideration, it is determined that the Agency's action to deny the request for the Medicaid Program to pay for the petitioner's hospital stay for March 6, 2004 to March 9, 2004, is upheld.

DECISION

The appeal for the Agency to pay for the petitioner's hospital stay for February 19, 2004 to March 11, 2004 is partially granted, as explained in the Conclusions Of Law.

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 10th day of August, 2007, in Tallahassee, Florida.

Stuart Imberman

Stuart Imberman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: , etitioner
Gail Wilk, Area 10 Medicaid Adm.

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

APPEAL NO. 07F-03794

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 25, 2007, at 10:40 a.m., in Opa Locka, Florida. The petitioner was present and represented herself. The Agency was represented by Oscar Quintero, senior human services program specialist, Agency for Health Care Administration (AHCA). Present as witnesses for the Agency via the telephone were: Dr. Marcelino Oliva, medical director, KePRO; Diane Weller, registered nursing consultant for the KePRO contract, AHCA and George Smith, review operations supervisor, KePRO. KePRO is located in Tampa, Florida.

ISSUE

At issue is whether the Agency was correct in denying the petitioner's request for a Medial Thigh Lift procedure on July 24, 2007, with subsequent hospitalization through July 25, 2007, for a total of one day inpatient hospitalization, because the medical procedure is not medically necessary. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, [redacted], is a 48 years old recipient of Medicaid benefits who has been diagnosed with Lipodystrophy.

2. On June 15, 2007, a Prior Authorization for a Medial Thigh Lift procedure to be performed at [redacted] Hospital on July 24, 2007, with subsequent hospitalization through July 25, 2007, was requested by Dr. Milton Armstrong based on above cited diagnosis.

3. KePRO has been authorized by AHCA to perform medical review for the Medicaid Prior (service) Authorization for inpatient hospital medical services program for Medicaid recipients in the State of Florida. The Prior Authorization Process was completed by KePRO.

4. On June 15, 2007, a physician consultant Board-certified in surgery reviewed the case and recommended the medical director for KePRO make a decision regarding Medicaid coverage of this procedure.

5. On June 19, 2007, the medical director recommended the PC Board-certified in general surgery reviews the case and indicated that there is not enough clinical information as to the need of this procedure. The medical director noted that Medicaid does not pay for cosmetic surgery and he does not know if this procedure is needed.

6. On the same date, the physician consultant Board-certified in surgery determined that inadequate clinical data was given to support the procedure as

medically necessary. This consultant recommended denial, pending adequate clinical data supporting medically, not cosmetically, needed surgery.

7. On June 20, 2007, this Prior Authorization was denied because the respondent determined that the procedure, as described to them, does not appear to require inpatient services.

8. On June 29, 2007, a physician consultant Board-certified in general surgery, which had not issued the first level denial, completed the second opinion review and upheld the denial with the following determination: "Recommend uphold denial. Thigh lifts after weight loss not a medical necessity."

9. The provider did not request a reconsideration of the denial.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.901(14) **Definitions** states in part:

> "Medicaid agency" or "agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

Fla. Stat. ch. 409.905 states in relevant part:

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided **only when medically necessary** and in accordance with state and federal law

Fla. Admin. Code 59G-1.010, which applies to the Florida Medicaid Program states in part:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. 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;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The petitioner argued that she needs a Total Thigh Lift because her thighs flap and causes her to fall. The petitioner explained that due to the flapping of her thighs, she suffers from skin infections, has lower pain and ambulation problems. The petitioner further explained that she had to undergo reconstructive surgery of the mouth due to a fall she had. The petitioner contends that the procedure is not cosmetic surgery but medically necessary.

The petitioner presented medical records from (; Hospital and letters from three different physicians assessing the petitioner's medical condition and recommending the need for surgery. (Petitioner Exhibits 1 and 2)

The petitioner explained that Dr. Armstrong is willing to operate on her at . Memorial Hospital with students from the University of Miami. The petitioner purported that the person from Dr. Armstrong office who submitted the request for the procedure is new and does not know how to proceed to get an authorization.

The respondent argued that the Agency's decision was correct based on the information as provided by the petitioner's service provider.

The respondent recommended the petitioner to take all of the above noted information to the physician that is going to do the surgery and get them to submit a reconsideration request. The respondent asserted that they are willing to take another look at the additional information, but explained that they cannot approve the procedure through her; it has to go through the physician who is going to perform the surgery.

As the Findings of Fact shows, a prior service authorization review was performed, and it was determined that given the information provided, medical necessity was not demonstrated for a Medial Thigh Lift procedure and one day inpatient hospitalization.

After considering the evidence, the Florida Administrative Code Rules and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action to deny the request for surgery and one day inpatient hospitalization.

DECISION

This appeal is denied as stated in the Conclusions of law.

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 August, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Health Systems Development Administrator

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

APPEAL NO. 07F-03879

PETITIONER,

Vs.

CASE NO. 1160211922

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 10 Broward
UNIT: 88139

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 17, 2007, at 1:00 p.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by [redacted], life management specialist. The respondent was represented by Liliane Clerie, economic self-sufficiency specialist.

ISSUE

At issue is the Department's May 31, 2007 action of denying the petitioner's application for Institutional Care Program Medicaid benefits for November 2006 through January 2007, because the value of her assets exceeded the program's eligibility limit. The petitioner has the burden of proof.

FINDINGS OF FACT

Included in the evidence is a copy of a Notice Of Case Action form, dated May 31, 2007, stating that the petitioner's March 29, 2007 application was approved for Institutional Care Program Medicaid benefits effective February 2007. The Institutional Care Program Medicaid application was denied for November 2006 through January 2007, because the value of the petitioner's assets exceeded the program's eligibility limit. As of the time of the hearing, the petitioner resided at the [redacted] Nursing Home, in [redacted], Florida.

Included in the evidence are copies of the petitioner's SunTrust Bank statements. This includes information showing the petitioner's Free Checking account, number [redacted], Select 50 Checking account, number [redacted], and a Certificate of Deposit account, investment number [redacted], at SunTrust Bank. The Certificate of Deposit account was opened on June 12, 2006 with a starting balance of $8,208.00. It was then cashed in, and according to the April 24, 2007 statement, included in the evidence, the balance was zero as of that time. On February 23, 2007, there was a $15,000.00 payment from the petitioner to facility where she resides.

The balance of the petitioner's SunTrust Bank accounts exceeded the Institutional Care Program Medicaid benefits $2,000.00 asset limit until February 2007, therefore the application was denied for November 2006 through January 2007. The petitioner's representative is not disputing that the value of the petitioner's assets exceeded the asset limit during that time. She is seeking the Institutional Care Program Medicaid benefits for the petitioner for November 2006 through January 2007, claiming that the funds in the

bank accounts were not available because of the circumstances involving the petitioner's relatives, who acted as her power of attorney.

Included in the evidence is a copy of a letter from the petitioner's niece dated June 2, 2007. In the letter, she explains that her cousin who lives in Virginia, was the petitioner's power of attorney. In November 2006, she decided that she did not want to be the petitioner's power of attorney, and it was not until February 2007 that became the power of attorney for the petitioner. In February 2007, she cashed in the petitioner's Certificate of Deposit account, she then funded her checking account, and paid $15,000.00 to the Nursing Home.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.303 states in part:

> (1) Specific policies concerning assets vary by program and are found in the program specific rule sections and codes of federal regulations. In general assets, liquid or non-liquid, are resources or items of value that are owned (singly or jointly) or considered owned by an individual who has access to the cash value upon disposition. Assets of each member of the SFU must be determined. A decision of whether each asset affects eligibility must be made.
> (2) Any individual who has the legal ability to dispose of an asset owns the asset. For food stamps the asset is considered unavailable if the ability to dispose of the asset is dependent upon a joint owner who refuses to comply.
> (3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility on the factor of assets. Assets are considered available to an individual when the individual has unrestricted access to the funds. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for the individual's support and maintenance, even though the individual chooses not to do so.

Fla. Admin. Code 65A-1.716 sets forth the asset limit in the Medicaid Program at $2,000.00 for an individual. The petitioner's Institutional Care Program Medicaid benefits

application was denied for November 2006 through January 2007, because the value of her assets in her bank accounts exceeded the $2,000.00 asset limit. The petitioner's representative did not dispute that the value of the petitioner's assets exceeded the asset limit during that time. She is seeking the ICP Medicaid Program benefits for the petitioner for November 2006 through January 2007, claiming that the funds in the bank accounts were not available because of the circumstances involving the petitioner's relatives, who acted as her power of attorney.

The petitioner's relative, who lives in Virginia, was her power of attorney, and in November 2006, she decided that she did not want to be her power of attorney. It was not until February 2007 that the petitioner's niece became her power of attorney, and in February 2007, she cashed in the petitioner's Certificate of Deposit account, she then funded her checking account, and brought the value of the petitioner's assets below the $2,000.00 asset limit.

Actually, due to the inaction of the first power of attorney to get the petitioner's assets below the asset limit, the application for the Institutional Case Program Medicaid benefits was denied for November 2006 through January 2007. It is determined that the assets were available during that time, and the power of attorney at that time, failed to act. After careful consideration, it is determined that the Department's action to deny application for Institutional Care Program Medicaid benefits for November 2006 through January 2007, due to the petitioner's assets exceeding the program eligibility limit, is upheld.

DECISION

This appeal is denied and the Department's action is affirmed.

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 6th day of August, 2007,

in Tallahassee, Florida.

Stuart Imberman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: , Petitioner
10 DPOES: Lisa Henson

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

APPEAL NO. 07F-03420

PETITIONER,

Vs.

CASE NO. 1223480038

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 11 Dade
UNIT: 88601

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 28, 2007, at 1:55 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was not present, but was represented at the hearing by her daughter, ... nd her son, ... The Department was represented by Cathy Mugarra, economic self sufficiency specialist II.

ISSUE

At issue is the Department's action of May 9, 2007 to deny the petitioner's April 19, 2007 application for ICP (Institution Care Program) Medicaid benefits based on the petitioner or her representatives not following through in establishing eligibility.

FINDINGS OF FACT

The petitioner is currently residing in a nursing home and the facility had filed an application for ICP benefits with the Department for the petitioner on April 19, 2007. The

petitioner was previously receiving ICP benefits, but the benefits had been cancelled by the Department previous to April 2007.

The Department mailed the petitioner or her representatives a request for information form on April 19, 2007. This form indicated that certain eligibility information needed to be sent or presented to the Department by April 30, 2007. No information was received by the Department from the petitioner or the petitioner's representative by the given deadline of April 30, 2007. Based on not receiving this information from the petitioner or the petitioner's representative; the Department denied the petitioner's April 19, 2007 application for ICP benefits on May 9, 2007 for: "you did not follow through in establishing eligibility."

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.205 sets forth the eligibility determination process of the Florida Medicaid Program which includes the ICP Program and states in part:

> (a) Eligibility must be determined initially at application and if the applicant is determined eligible, at periodic intervals thereafter. The applicant is responsible to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility as determined by the eligibility specialist within time periods specified by the eligibility specialist.

As shown in the Findings of Fact, the Department denied the petitioner's April 19, 2007 application for ICP and Medicaid benefits based on: "You did not follow through in establishing eligibility."

The petitioner's representative argued that they had submitted all the information to the nursing home for the Medicaid benefits for the petitioner. They argued that they, as

relatives of the petitioner, were unaware that the nursing home had submitted an application to the Department for the ICP benefits for the petitioner.

The respondent advised the petitioner's representatives at the hearing to file an application for the ICP benefits themselves as soon as possible. The petitioner's representatives agreed to do so.

After considering the evidence, the Florida Administrative Code Rule and all of the appropriate authorities set forth in the Findings above, the hearing officer finds the Department's action to deny the petitioner's April 19, 2007 application for ICP and Medicaid benefits on May 9, 2007, based on the petitioner not following through in establishing eligibility, as correct.

DECISION

This appeal is denied and the Department's action affirmed.

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 3rd day of August, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: . . . . . etitioner
District 11, ESS: Teresa Zepeda
FREDINA BARR

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

[redacted]

APPEAL NO. 07F-03577

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 02 Jackson
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 25, 2007, at 2:30 p.m., in Marianna, Florida. The petitioner was not present but was represented by his father, [redacted]. Testifying on behalf of the petitioner was his mother, [redacted], waiver support coordinator, Total Life Choices and his nurse, [redacted], LPN. The agency was represented by Gina Nolan, RNS, Agency for Health Care Administration (AHCA).

ISSUE

The petitioner is appealing AHCA's action of May 23, 2007 to reduce Private Duty Nursing and Personal Care Services from a request of 813 hours to 793 for the months of May 15, 2007 through July 13, 2007 based on the contention that the

intensity or level of medical care requested was not medically necessary. The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner (date of birth [redacted] is a Medicaid recipient residing with his parents. The petitioner is also receiving waiver support coordination. The petitioner's care is medically complex. He has respiratory problems which requires constant supervision of his breathing, suctioning due to chronic inflammation of his airway creating mucous plugs and constant repositioning due to contractures . In addition the petitioner has seizures and brittle bone syndrome. He is tube fed and medications are administered through a g-tube.

2. The petitioner has been receiving private duty nursing services under Medicaid. A request for 813 hours of private duty nursing was submitted by the provider, Medical Services of NW Florida, for the period of May 15, 2007 through July 13, 2007.

3. Requests for private duty nursing are reviewed with a Medicaid contract provider who completes prior authorization for the requested service. That contract provider is KePRO. The request for services is submitted by the home health care provider, in this case, Medical Services of Northwest Florida. The requests are for 60 day time periods. All communication is sent between KePRO and the provider until a decision is reached. KePRO reviews the written request for services to determine if the number of hours requested are medically necessary. If additional information is

needed, KePRO contacts the provider. Once services, as in this case, were denied or modified, a notice is sent to the recipient's family.

4. KePRO received the request for 813 hours of private duty nursing (PDN) submitted by the provider, Medical Services of Northwest Florida, on May 17, 2007 which was two days after the requested date of service beginning May 15, 2007. KePRO reviewed the request for PDN and on May 23, 2007 originally approved 793 hours due to a miscalculation of the hours provided by the Home Health provider.

5. A request for a Reconsideration review was submitted to KePRO by the home health agency provider along with a corrected calendar. On June 7, 2007, after reconsideration, KePRO overturned the original denial and approved 813 hours of PDN requested by the home health agency provider.

6. A hearing request was received by KePRO on June 13, 2007. The petitioner's parents do not agree with the decision by KePRO. At the hearing, the petitioner's father argued that the home health provider only asked for the number of hours of PDN that was available in the community. It is the parents' contention that the petitioner requires 24 hours/7 days per week of PDN and this amount is medically necessary. Further, the parents believe that the petitioner is being denied due process because the authorization for services are authorized after the new certification period begins. He believes that he should be given a notice of adverse action whenever the certification period is to expire and that the requirement to recertify every 60 days creates a hardship.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

Florida Statutes § 409.919 Rules (2006) states:

> The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906, as they relate to these responsibilities, and any other provisions related to responsibility for the determination of Medicaid eligibility.

Florida Statute 409.905 addresses Mandatory Medicaid services with section (4) informing that Home Health Care Services can be covered. Under subsection (b) the following information is relevant:

> The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services...The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep and care for other family dependents...

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program,** with (1)(d) describing "medical necessity or medically necessary" standards and says in relevant part: "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity..." Consistent with Fla. Admin. Code 59.G-1.010, **Definitions**, states for medical necessity:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. 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;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
> (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 Home Health Services Coverage and Limitations Handbook defines private duty nursing (at page 2-15):

> Private duty nursing services are medically necessary skilled nursing services that may be provided in a child's home or other authorized

settings to support the care required by the child's complex medical condition.

The Home Health Services Coverage and Limitations Handbook provides that for private duty nursing, prior authorization must be received (at page 2-17):

> **Service Authorization:** All private duty nursing services must be prior authorized by a Medicaid service authorization nurse prior to the delivery of services.

In accordance with the provider manual (CMS 1500) prior authorization requests must be submitted by the provider (at 2-2):

> **Who Submits the Request** The request for prior authorization must be submitted by the provider who plans to furnish a service, except for out-of-state prior authorization.

As a result of the reduction in private duty nursing services paid for by Medicaid, the petitioner, through his representatives, appeal this action, asserting that the home health provider submitted a request for PDN based on available care rather than 24 hours/7 days a week that they believe to be medically necessary.

According to the above authorities, the request for prior authorization must be submitted by the provider who plans to furnish a service. The Findings of Fact show that the request for prior authorization was submitted by the provider who furnishes PDN service in the amount of 813 hours. The Findings show that upon reconsideration, the petitioner was authorized to receive the requested pre-authorization of 813 hours PDN services and that there is no loss of benefits to the petitioner. As the request for PDN was for 813 hours and subsequently approved and until the provider requests a

higher number of hours, it would be premature for the undersigned authority to address the need for 24hours/7 days per week. Therefore, the issue in reference to the reduction of PDN hours is considered to be moot as the agency approved the requested amount. The appeal pertaining to the reduction of PDN hours is hereby dismissed as moot.

AHCA's Home Health Services Coverage and Limitations Handbook (October 2003) Plan of Care certification period, states in part:

> The attending physician must review the POC at least every 60 days. The attending physician is required to indicate his approval by signing each POC.
> The attending physician must countersign an ARNP or physician assistant signature on a POC.
> Each POC must incorporate or include as a separate document the physician order for home health services.
> If home health services require pre-certification or service authorization, the POC must be reviewed and signed by the attending physician before submitting the pre-certification or service authorization request.

Home Health Services Coverage and Limitations Handbook (October 2003), Appendix B states:

> Service authorization is the approval process required prior to providing certain services to recipients under 21 years of age. Medicaid will not reimburse for these services without service authorization when it is required.
> **Services Requiring Service Authorization**
> The following home health services require service authorization for reimbursement:
> · Private duty nursing; and
> · Personal care.

The petitioner argued that due process is denied because benefits are authorized after the begin date of the certification period. The above authority shows that private

duty nursing is a home health service requiring a service authorization for reimbursement. Recertification is completed for 60 day periods. The Findings show that the provider did not request PDN until May 17, 2007 and that a decision was reached originally on May 23, 2007. The Findings further show that a reconsideration was completed and benefits were provided at the requested level and intensity on June 7, 2007 The petitioner is provided with a notice of authorization providing the petitioner the right to a hearing and reinstatement due to a timely appeal. The petitioner has been provided with timely notice advising him of his appeal rights and reinstatement rights. The undersigned authority concludes that the petitioner has been properly provided due process.

DECISION

The appeal is dismissed as moot as there is no corrective action to order. The petitioner was authorized to receive the PDN hours requested.

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 31st day of August, 2007,

in Tallahassee, Florida.

Linda Garton
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted], Petitioner
Willis A. Hardy Jr., Field Office Manager
Mary Wheeler
Karen Kinser, Nursing Consultant

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

[redacted]

APPEAL NO. 07F-03074

PETITIONER,

Vs.

CASE NO. 1214332510

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 09 Palm Beach
UNIT: 88322

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 2, 2007, at 9:20 a.m., in [redacted] Florida. The petitioner is deceased. Representing the petitioner was [redacted], case worker, [redacted] County. Representing the respondent was [redacted] specialist supervisor.

ISSUE

At issue is whether the respondent was correct in denying retroactive Institutional Care Program (ICP) Medicaid benefits for the month of December 2006 due to a submitted application not qualifying for these benefits.

FINDINGS OF FACT

1. The petitioner was receiving ICP benefits while residing at the Hospice facility. Her benefits were to be recertified for ongoing eligibility by the end of November 2006.
2. The respondent mailed the Hospice a Notice of Case Action (Respondent's Exhibit 1) October 31, 2006, indicating that benefits would stop November 30, 2006. This was sent because there was no application submitted for recertification.
3. The petitioner passed away January 2007. It was not until April 2007 that the Hospice submitted a new application seeking benefits for December 2006.
4. In consideration of retroactive benefits, the respondent may only look back three months from any given application. Because December 2006 was a fourth month, the respondent denied eligibility.
5. The representative explains that the Hospice did not receive Notice of the termination of the benefits. There was no return mail for the sent Notice.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.702 **Special Provisions** states in part:

(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.

(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her

representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility.

Upon review, the hearing officer must presume that, without returned mail, Hospice was notified of the need to recertify. There was no recertification application.

Concerning the submitted April 2007 application, the respondent may only look back three months. In this case, that would be January 2007. There was no December 2006 eligibility based upon the April 2007 application.

DECISION

The appeal is denied. The respondent's action is affirmed.

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 16th day of August, 2007,

in Tallahassee, Florida.

Melvyn Littman

Melvyn Littman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted], Petitioner
9 DPOES Martha Prock
[redacted]

FILED

AUG 3 1 2007

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

[redacted]

APPEAL NO. 07F-04260

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 09 Palm Beach
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 28, 2007, at 9:23 a.m., in [redacted] Florida. The petitioner was not present. Representing the petitioner was his mother [redacted] Representing the respondent was [redacted] management analyst, Agency for Health Care Administration (AHCA). Appearing as witnesses were [redacted] registered nurse specialist, AHCA; [redacted] M.D.; and [redacted] review operation supervisor. Dr. [redacted] and Ms. [redacted] are both with the Keystone Peer Review Organization (KePRO) and both appeared telephonically at their request.

ISSUE

At issue is whether the respondent was correct in reducing private duty nursing (PDN) hours from 98 to 84 hours per week due to the extra hours not meeting a medical necessity requirement. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 14 year old (DOB [redacted]) recipient of Medicaid services. He is diagnosed with a tracheostomy; gastrostomy; infantile cerebral palsy (unspecified); grand mal status (epileptic; and dyspnea and respiratory abnormalities.
2. He has been receiving PDN 14 hours per day, seven days per week. For the period June 23 through August 21, 2007, the petitioner's provider submitted a request to maintain the PDN hours. As part of the eligibility determination process, medical progress reports are forwarded to KePRO for review. KePRO is the organization contracted by AHCA to perform these reviews.
3. Initially, KePRO approved the requested hours for Monday through Saturday and denied Sunday hours. Ms. [redacted] requested a reconsideration and this too was denied.
4. Ms. [redacted] is employed as a pediatric nurse with regular working hours 8:00 a.m. to 8:00 p.m., Monday through Friday. She will work an occasional Saturday but is on call both Saturday and Sunday. Although her normal work place is "local", she does have to travel up to 60 miles on occasion.
5. Ms. [redacted] is a single mother. Her family support system will be moving away from her home area.
6. When Ms. [redacted] is home she sleeps in the same room as her son and will perform the necessary repositioning and suctioning as needed. She is seeking to have the PDN hours be maintained and not reduced.

7. The respondent notes that in their Handbook (Home Health Services Coverage and Limitations Handbook), it is the parental responsibility to care for the child. Especially in this instance where the mother is a pediatric nurse and the requisite training is already there.

8. The respondent indicates that with the mother at home on Sundays there was no reason to offer Sunday hours. KePro has no authority to be flexible with the hours that are requested by the provider.

CONCLUSIONS OF LAW

Fla. Stat. s. 409.905 **Mandatory Medicaid Services** states in part:

(4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides services pursuant to this subsection shall be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefore, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(a) In providing home health care services, the agency may require prior authorization of care based on diagnosis.

(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents. When implemented, the private duty nursing utilization management program shall replace the current authorization program used by the Agency for Health Care Administration and the Children's Medical

Services program of the Department of Health. The agency may competitively bid on a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency is authorized to seek federal waivers to implement this initiative.

Fla. Admin. Code 59G-1.010 **Definitions** states in part:

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

(a) Meet the following conditions:

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

2. 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;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(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.

Home Health Services Coverage and Limitations Handbook October 2003 Covered Services, Limitations, and Exclusions states in part:

Private Duty Nursing Definition

Private duty nursing services are medically necessary skilled nursing services that may be provided in a child's home or other authorized settings to support the care required by the child's complex medical condition.

Private Duty Nursing Requirements

Private duty nursing services must be:

- Ordered by the attending physician;
- Documented as medically necessary;
- Provided by a registered nurse or a licensed practical nurse;
- Consistent with the physician approved plan of care; and
- Authorized by the Medicaid service authorization nurse.

Parental Responsibility

Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render.

Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.

Medicaid does not reimburse private duty nursing for respite care. Examples are parent or caregiver recreation, socialization, and volunteer activities.

In this instant case, the respondent has the burden of proof when reducing or terminating benefits or services. Evidence and testimony presented indicate that the mother is well qualified to care for her son. She is normally at home on the weekends with some Saturdays on her work schedule. KePRO has considered this aspect and allowed the PDN for Saturdays.

When the mother is at home on Sundays she has the responsibility to care for her child. The Handbook, under parental responsibility, indicates that "Medicaid does not reimburse private duty nursing for respite care". Although Ms. [redacted] is on call for work duty on the weekends, Sunday PDN would offer the opportunity for her to "rest". In this regard she may not utilize PDN services.

DECISION

The appeal is denied. The Agency's action is affirmed.

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 31st day of August, 2007,

in Tallahassee, Florida.

Melvyn Littman

Melvyn Littman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted], Petitioner
Mark Pickering, Area 9 Medicaid Adm.
[redacted]

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

[redacted]

APPEAL NO. 07F-03409

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 20, 2007, at 2:35 p. m., at the [redacted] Service Center, in Miami, Florida. The petitioner was not present, but was represented by his mother, [redacted] The respondent was represented by [redacted] registered nurse specialist, Agency For Health Care Administration (AHCA). Present as witnesses for the respondent, via the telephone, was Dr. [redacted] physician reviewer, from KePRO and [redacted] review operations supervisor with KePRO.

ISSUE

At issue is the respondent's action of May 29, 2007, to deny the petitioner 1,080 hours of Home Health Aide (HHA) services, for the period of January 12, 2007 through March 12, 2007, due to medical necessity. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who was twenty years of age at the time of review, has severe and numerous medical problems that require medical services a provided through the Agency For Health Care Administration's (AHCA) Medicaid State plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1.

2. On behalf of the petitioner, [redacted] Health Care Inc., a home health care provider, requested authorization for 1,080 HHA hours for the certification period of January 12, 2007 through March 12, 2007, to cover HHA hours from 8:00 a.m. to 12:00 midnight, seven days a week.

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the respondent. The Prior Authorization Process was completed for the petitioner by KePRO.

3. On May 29, 2007, a physician consultant reviewed the petitioner's request and made the following determination: "Notes do not mention current status of the pt; very limited info given. I would deny this request and would request the nursing agency to provide details of the case." The physician consultant denied the request for service as medical necessity had not been demonstrated.

4. On June 5, 2007, a different physician consultant reviewed the reconsideration request stating: "Reconsideration review for this 20yr. old autistic, po (by mouth) fed diabetic needs assist with activities of daily living, mother not working had surgery during this time, Provider requests a HHA 8AM-12PM MONDAY TO SUNDAY. Kepro has determined this to be a total of 960 hours, which should be APROVED. Rescind the total

denial sent by physician consultant and approve 960 deny 120 agency miscalculated. I assume provider meant to write the hours as 8am to 12am."

5. On June 13, 2007, the petitioner was notified of the above decision.

5. At the hearing, the petitioner expressed that she agrees with this decision.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.901(14) **Definitions** states in part:

"Medicaid agency" or "agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

Fla. Stat. ch. 409.901(4) **Home Health Care Services** states in part:

The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.

Fla. Admin. Code 59G-1.010, which applies to the Florida Medicaid Program states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. 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;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Fla. Admin. Code 59G-4 **Home Health Services** states in part:

(1) This rule applies to all home health agencies licensed under Chapter 400, Part IV, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.
(2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.
(3) When terminating, reducing, or denying private duty nursing or personal care services, Medicaid will provide written notification to the recipient or the recipient's legal guardian. The notice will provide information and instructions regarding the recipient's right to request a hearing.

The Home Health Services Coverage and Limitations Handbook (October 2003) explains service requirements for Home Health Aide Visit Service on page 2-14, stating in part:

Home health aide services may be reimbursed only when they are:
- Ordered by the attending physician;
- Documented as medically necessary; ...

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:
- Assisting with the change of a colostomy bag;
- Assisting with transfer or ambulation;
- Reinforcing a dressing;
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN;
- Assisting with an ice cap or collar;
- Conducting urine test for sugar, acetone or albumin;
- Measuring and preparing special diets;
- Providing oral hygiene;
- Bathing and skin care; and
- Assisting with self-administered medication.

The respondent, through KePRO, took action on May 29, 2007, to deny the petitioner 1,080 hours of Home Health Aide (HHA) services, for the period of January 12, 2007 through March 12, 2007, due to medical necessity. This decision was based on the information provided by the petitioner's service provider.

During the reconsideration process, KePRO rescinded the original denial and approved 960 and denied 120 hours, as the provider miscalculated the total hours.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the respondent's action.

DECISION

This appeal is denied as stated in the Conclusions of Law.

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 7th day of August, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
[redacted] Nursing Consultant

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

[redacted]

PETITIONER,

APPEAL NO. 07N-0093

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 19, 2007, at 1:35 p.m., in Miami, Florida. The petitioner was not present but was represented by his grand niece, [redacted] and her husband, [redacted] Appearing on behalf of the petitioner was [redacted] and [redacted], both with the Ombudsman Council of South Dade. Appearing telephonically at his request was [redacted] attorney for [redacted] Testifying on behalf of the facility was [redacted] social services director at the facility.

ISSUE

At issue is the May 28, 2007 transfer of the petitioner from St. Anne's Nursing Center. The facility has the burden of proof to establish the transfer was in compliance with the requirements.

FINDINGS OF FACT

The petitioner (age 92) had been living with his grand niece (proxy) and her family. The petitioner was hospitalized for a few days and on April 23, 2007 was admitted to the nursing facility for skilled Medicare services.

The facility's initial social service plan of care (April 24, 2007) for discharge goal planning, shows that the petitioner's stay is expected to be short-term and that he will be returning to the community (Respondent's Composite Exhibit 3).

On May 25, 2007 the petitioner's proxy was telephonically contacted by the facility advising her that the 30 day skilled services coverage through Medicare, would end May 28, 2007. The proxy was faxed (Respondent's Exhibit 2) a copy of Notice of Medicare Non-Coverage on May 25, 2007. The Notice informs the proxy, that Medicare Advantage plan will end skilled services coverage effective May 28, 2007 and states that Medicaid Advantage "determined that Medicare probably will not pay for your current skilled services after the effective date indicated... You may have to pay for any skilled services you receive after the above date." The Notice provides information for an immediate appeal of the decision to end Medicare coverage of services. An appeal was not requested of the decision by Medicare Advantage, to end Medicare skilled services effective May 28th.

The proxy states that she did not receive the May 25, 2007 fax of the Notice, from the facility. A transmission verification report shows that a successful transmission of three pages was made on May 25 from the facility to the proxy's correct fax number (same fax number contained in Petitioner's Exhibit 1). The hearing officer concludes that

the Notice was sent to the petitioner's proxy at the correct fax number. Given the amount of telephonic contact between the facility and the proxy on that specific day, if this fax had not been received, the proxy would have followed up with the facility in order to obtain the Notice and she did not.

Additionally, in a letter (Petitioner's Exhibit 1) reflecting a fax date of May 31, 2007 from the proxy to the Ombudsman, the proxy states that she was called by the facility and informed that her uncle will be "dismissed" from the facility on May 28th. When she stated that "I do not have the means to care for him at this time due to my husband's injury as he was uncle [redacted] caretaker...." The proxy then states that she inquired about him remaining at the facility and was informed that it would cost $325 a day and "I immediately stated that I do not have the means to pay that amount." She goes on to say that she was then called back by the facility and informed that another facility would accept him. The petitioner was transferred to another facility on May 28th and [redacted] (petitioner's caretaker prior to admissions to the facility) accompanied the petitioner.

On May 30, 2007, the Office of Appeal Hearings received a request for a hearing from the Ombudsman Council on behalf of the petitioner.

CONCLUSIONS OF LAW

Fla. Stat. 400.0255, Resident transfer or discharge; requirements and procedures; hearings; and states in part:

> (10)(a) A resident is entitled to a fair hearing to challenge a *facility's* proposed transfer or discharge. ...
>
> (17) The provisions of this section apply to transfers or discharges that are initiated by the nursing home facility, and *not* by the resident or by the resident's physical or legal guardian or representative.

Code of Federal Regulations appearing in 42 C.F.R. § 431.241, sets forth matters to be considered at the hearing and states in part:

> The hearing must cover--
>
> ...(c) A decision by a skilled nursing facility or nursing facility to transfer or discharge a resident and...

The facility states that this was not a transfer initiated by them and no discharge/transfer notice was issued. They contend that the petitioner's proxy consented to the transfer effective May 28th as Medicare skilled services would end. They state that when informed that long term care was needed, because the caretaker was unable to care for the petitioner, names of other facilities that accept Medicaid pending patients were requested by the proxy. Transfer of the petitioner was accepted at a facility and the petitioner was sent, via ambulance accompanied by the proxy's husband on May 28th.

The facility argues that the transfer was planned and done at the family's request and with their approval. The facility contends that the family, since the date of admission failed to come to the facility in order to explore any possibility of long term care with them, or to sign and pick up an admissions packet. The petitioner could have been considered to stay in their facility and would have had to go through their admissions process.

The petitioner's representative argues that she did not consent to the petitioner's transfer to another facility and that no notice was provided for the discharge. She was informed on May 25, 2007, that he would be "dismissed" on May 28th and that it would

cost $325 daily as private pay and she responded that she was unable to pay that amount.

After careful review, the hearing officer finds that the petitioner's transfer to another nursing facility was voluntary and not initiated by the facility. The petitioner was presented with the option to pay for the stay, beyond what Medicare Advantage covered (through May 28th) and the representative accepted another placement that would accept other means of payment.

According to the above-mentioned authorities, hearing rights applies only to transfers or discharges that are initiated by the facility and not by the resident or by the resident's physical or legal guardian or representative. Therefore, the hearing officer concludes that because the discharge was voluntary, there are no hearing rights and there is no appealable issue. The appeal is hereby dismissed.

DECISION

The appeal is dismissed as stated in the Conclusions of Law.

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 22nd day of August, 2007, in Tallahassee, Florida.

A. G. Ramos
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
[redacted] Agency for Health Care Administration
[redacted] Esq.
[redacted] Ombudsman

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

[redacted]

APPEAL NO. 07N-00061

PETITIONER,

Vs.

CASE NO.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Per notice, a nursing home discharge hearing was held before the undersigned hearing officer on June 21, 2007, at 11:35 a.m., at the nursing facility. The facility was represented by [redacted] attorney. The petitioner was not present, but was represented by his daughter, [redacted], who also testified. The facility administrator, [redacted] appeared as a witness for the facility. [redacted] Medicaid specialist with the facility, also appeared as a witness. [redacted] regional director of operations, and [redacted] director of reimbursements, observed. [redacted], ombudsman manager, also observed.

ISSUE

At issue is the correctness of the facility's discharge action of March 12, 2007, to discharge the petitioner based on non-payment. The nursing facility has the burden of proof.

FINDINGS OF FACT

1. The petitioner was admitted to the respondent nursing facility on December 14, 2006 from [redacted] The petitioner was in the care of her daughter, [redacted] sometime prior to the nursing home admission. The petitioner's birth date is [redacted].
2. The petitioner's daughter and representative, [redacted] has applied for Institutional Care Program and Medicaid (ICP) Medicaid benefits for the petitioner three times since the petitioner was admitted to the nursing home, per testimony. Each of these applications was denied. The petitioner was not approved for ICP Medicaid benefits as of the hearing date. The petitioner had not requested a hearing on the ICP Medicaid denial actions as of the hearing date. There is question of whether a quit-claim deed of the petitioner's home to her son may affect potential ICP eligibility.
3. The petitioner owed an undisputed balance of $30,574.11 to the facility as of the hearing date. The petitioner's representative has been receiving statements once monthly on the account balances. The facility is the payee of the petitioner's approximate $883 monthly Social Security check. The petitioner is billed at the private pay rate of $183 daily before July 1,

2007, and $196 daily after July 1, 2007. The facility has received the $883 monthly Social Security check against the private pay billing rate of over $5,000 monthly. The petitioner's representative offers a Greyhound pension amount of $109 monthly as additional payment.

4. The petitioner's representative was provided notice of the intended discharge action on March 12, 2007. The discharge location is listed as the residence of the petitioner's daughter and representative, [redacted] believes it would be detrimental to the petitioner and herself to provide care for her mother at her home.

5. The nursing facility intends to proceed with the discharge action. The petitioner remains a resident of the facility pending the outcome of this instant appeal decision. The petitioner desires to remain at this facility.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42C.F.R.§431.200. Federal Regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility because of non-payment. Federal Regulations do permit a discharge for this reason, as set forth at 42C.F.R. §483.12(a)(2)(v), as follows:

> 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;..

The petitioner has not been determined eligible for ICP Medicaid benefits. Furthermore, the petitioner had an unpaid past due balance of $30,574.11 owed the facility as of the hearing date. The petitioner's representative daughter received billing statements during the petitioner's stay at the facility. Therefore, it is concluded that the petitioner received "reasonable and appropriate" notice to pay for her stay at the facility, as required in the language of the above federal regulation.

The Code of Federal Regulations at 42 C.F.R.§483.12(a)(6)(iii) requires the content of the discharge notice to include "the location to which the resident is transferred or discharged." Further, paragraph (a)(7) entitled "Orientation for transfer or discharge" shows that the facility "must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility." The the facility listed the petitioner's daughter's address as the discharge location.

In summary, the respondent nursing facility has valid reason to discharge the petitioner based on non-payment. However, the nursing facility must provide the petitioner sufficient preparation and orientation to a suitable discharge location before proceeding with this discharge action. Therefore, the nursing facility is concluded to have met its burden of proof in this specific discharge action based on non-payment.

DECISION

The appeal is denied. The facility is concluded to have met its burden to discharge the petitioner based on non-payment. However, the respondent facility must provide the petitioner sufficient preparation and orientation to a suitable discharge location before proceeding with this discharge action.

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 17th day of August, 2007,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner

Respondent [redacted]

Agency for Health Care Administration

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

[redacted]

PETITIONER,

APPEAL NO. 07N-00096

Vs.

[redacted],

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 16, 2007, at 9:39 a.m., at the [redacted] in Dania Beach, Florida. The petitioner was present and represented himself at the hearing. Also present on behalf of the petitioner was [redacted], ombudsman. The respondent was represented at the hearing by [redacted], administrator, [redacted]. Also present on behalf of the facility was [redacted] business office manager.

ISSUE

The respondent provided notice(s) the petitioner was to be discharged for the following reason: "Your bill for services at the facility has not been paid after reasonable and appropriate notice to pay..." The respondent will have the burden of proof to establish

by clear and convincing evidence that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and Fla. Stat. § 400.0255.

FINDINGS OF FACT

The facility notified the petitioner on or about June 4, 2007 that he was to be discharged in thirty days from that date. No discharge location was provided on the notice. At the hearing the facility indicated that two locations were considered and specifically, the [redacted] located in the north end of Miami-Dade County was the first location considered. The petitioner currently resides at [redacted]

The petitioner received an outstanding bill from the facility based on his failure to pay for his stay at the facility. As of June 30, 2007, the outstanding bill was about $870.18. The petitioner had been assigned a patient responsibility that had not been paid to the facility by the petitioner. The facility caught this discrepancy in May 2007. The petitioner currently pays his patient responsibility.

CONCLUSIONS OF LAW

The Code of Federal Regulations at 42 C.F.R. § 483.12(a)(2) sets forth reasons for which a resident may be discharged, and states in part:

> (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;...

This regulation continues and states in part:

> (4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident... (6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include

the following:...(iii) The location to which the resident is transferred or discharged...

As shown in the Findings of Fact, the facility notified the petitioner on or about June 4, 2007 that he was to be discharged in thirty days. The facility had provided at the hearing; a discharge location, which is the [redacted] located in the north end of Miami-Dade County. Currently the petitioner resides at [redacted] The discharge reason is: "Your bill for services at the facility has not been paid after reasonable and appropriate notice to pay..."

The petitioner argued that the facility's social worker (who is no longer employed at the facility) had told him when asked; that he did not have to pay any money for his stay at the facility. He argued that he gave the money that was supposed to be his patient responsibility, to his son as a wedding gift. The respondent argued that even though there is a plan for the petitioner to pay $20 a month toward the outstanding bill; it would take approximately four years for the petitioner to pay what he owes. The respondent offered that the petitioner needs to come up with a better pay back plan that does not include the petitioner paying more out of what he allowed through Medicaid, or he should be discharged based on the overdue nursing home bill.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the facility's action to discharge the petitioner is appropriate as the petitioner has failed to, after reasonable and appropriate notice, to pay the his bill at the facility. The facility has met its burden of proof and is in compliance with the appropriate federal regulation noted above for the discharge.

DECISION

This appeal is denied and the facility's action upheld.

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 6th day of August, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner

[redacted] Respondent

Agency for Health Care Administration

[redacted]

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

[redacted]

PETITIONER,

APPEAL NO. 07N-00087

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 20, 2007, at 3:00 p.m., in Pensacola, Florida. The petitioner was present and was represented by [redacted] district Ombudsman Manager, North West Florida Long Term Care Ombudsman Committee (LTCOC) and [redacted] ombudsman, LTCOC. Testifying on behalf of the petitioner was the petitioner's brother, [redacted] The respondent was represented by [redacted] Esq. [redacted]. Testifying on behalf of the respondent was [redacted] administrator, [redacted] Also testifying on behalf of the respondent was [redacted] risk manager, [redacted] Director of Nursing, [redacted], Certified Nursing Assistant(CNA), [redacted] LPN, [redacted] RN and [redacted] LPN., [redacted], was present as a court reporter.

The record was held open for 14 days or until July 5, 2007 to permit both parties to submit proposed orders.

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of Federal Regulation at 42 C.F.R. §483.12(a).

FINDINGS OF FACT

The petitioner has been a resident of [redacted] since September 5, 2006 until his admission to [redacted] on May 12, 2007 and his subsequent discharge to [redacted] on May 14, 2007. The petitioner is 61 years old and is diagnosed with Lou Gehrig's disease, hypertension, chronic obstructive pulmonary disease, hyperlipidemia, gastroesophageal reflux disease and a long history of psychiatric problems as a result of depression, mood lability, irritability, anhedonia, anergia, insomnia and psychomotor agitation (Petitioner's Composite Exhibit 1). The petitioner suffers significant impairment in his daily functioning due to his medical problems.

The respondent entered into evidence records of incidents of verbal and physically abusive behavior to staff members of the facility. In addition the respondent presented testimony to show that the petitioner made threats to harm staff and their family members as well as behavior potentially dangerous to the safety and well being of the facility. Some of the incidents occurred on the following dates: March 14, 2007,

April 20, 2007, April 22, 2007, May 1, 2007, May 4, 2007, May 5, 2007, and May 7, 2007 (Respondent's Exhibit 3). On April 30, 2007, the petitioner left the facility with a family member and without checking out of the facility. He returned later in the evening in an apparent inebriated state. The petitioner was sent to the emergency room and was admitted to [redacted] on May 1, 2007 (Respondent's Exhibit 4). Upon admission to the emergency room, the petitioner's ETOH level was 251. His discharge diagnosis, dated May 3, 2007, indicated a change in mental status, acute alcohol intoxication, elevated cardiac enzymes, hypertension, mood disorder and organic defective disorder due to multiple medical problems. The petitioner curses staff, has made inappropriate sexual suggestions to the female staff and threats of violence against the staff.

The petitioner has continued his offensive and inappropriate behavior to the facility staff. The facility attempted to alleviate the inappropriate behaviors to female staff by assigning male staff to provide for his care or by requiring two staff members to be present whenever care was provided to the petitioner, changing his room assignment at his request and other attempts to meet the petitioner's needs. In addition, the facility physician and psychologist reviewed the medication taken by the petitioner to determine if this was a source of his behavioral issues. The facility staff tried to redirect the petitioner when his behavior was inappropriate. These actions have not been successful in stopping the petitioner's abusive and inappropriate behavior.

On May 7, 2007, the respondent, by Nursing Home Transfer and Discharge Notice, notified the petitioner that it was their intent to discharge him, effective June 5, 2007, because the safety of other individuals in the facility was endangered. On May 7, 2007, the petitioner threatened to "blow away" a staff member.

After the petitioner was notified of the intent to discharge he continued to behave in an offensive and inappropriate manner. On May 12, 2007, the facility's progress notes indicated the petitioner attempted to pull the fire alarm and again threatened to "blow everyone in [redacted] away". In addition, the petitioner threatened to burn down the building with everyone in it. Finally, testimony indicated the petitioner pulled a fax machine off a table and slammed it to the floor. The petitioner then accused the staff of throwing it at him. Shortly after this incident, the petitioner complained of chest pains and asked to go to the hospital. The petitioner was transported to [redacted] by ambulance but refused care there and was transported to [redacted] instead.

On May 13, 2007, the petitioner was Baker acted by a physician at [redacted] and was transferred to the psychiatric portion of the [redacted] Center. The petitioner was discharged to [redacted] on June 6, 2007. His discharge medications included Lipitor, Toprol, Prinivil, Prevacid, Remeron, Prednisone, aspirin, Imdur, Plavix and Ziac. He previously took Depakote.

At the time the Notice of Transfer and Discharge was issued to the petitioner, the facility indicated that he was to be discharged to his brother's address in the community.

The petitioner's brother has medical problems and is not in a position to provide proper care for the petitioner. Given the petitioner's limitations, it is not possible to permit him to live alone in the community. The facility stipulated at the hearing that it would have pursued a more appropriate placement for the petitioner. However, discharge plans were not completed, as the petitioner was admitted to the hospital because of chest pain and was subsequently Baker Acted and involuntarily placed in [redacted]

The petitioner argued that the Notice of Transfer and Discharge was inadequate because it did not show that the facility provided sufficient preparation and orientation to the petitioner to ensure safe and orderly transfer or discharge from the facility.

When asked if he wanted to return to [redacted] nursing home, the petitioner did not respond. However, his brother stated that, if it were up to him, he would not have the petitioner return to the facility where he was not wanted. The petitioner is currently a resident at [redacted], located next door to the [redacted]. The petitioner's representative indicated that he was doing well at [redacted]

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by federal regulations appearing in 42 C.F.R. §431.200. Additionally, federal regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient.

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;...

In this case, the notice of discharge specifies the reasons for discharge that appear in 42 C.F.R. §483.12(a)(2)(iii), which states, in part:

> 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--...(iii) The safety of individuals in the facility is endangered....(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

The Findings of Fact show that the petitioner's behavior includes verbal abuse, threats against the staff and the facility, inappropriate sexual comments directed at the staff and cursing at staff. The facility has counseled with the family and the petitioner, completed medication reviews, and made changes to staff to meet his needs and modify his behavior. In spite of the facility's efforts, the petitioner continued to act aggressively and make threats against the staff and the facility.

The Findings show that the petitioner was admitted to the hospital on May 12, 2007 because of chest pain. From there he was Baker Acted and involuntarily admitted to [redacted] psychiatric wing for treatment. He has subsequently been transferred to a nursing home facility located next door to the respondent facility.

The petitioner argued that the notice of discharge was invalid as it did not list a discharge location that was appropriate to meet his needs. According to the above authorities, a facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. While orientation and preparation for the transfer or discharge from the facility was not completed because of the onset of a medical emergency, it does not appear that the petitioner was harmed. The petitioner is living in a facility that is located next door to the respondent's facility. Therefore, the respondent's lack of completing discharge planning is considered unavoidable and harmless.

Based on the above findings, it is determined that the petitioner's behavior and threats have endangered the safety of other residents in the facility. Therefore, the respondent's proposed discharge of the petitioner from the facility, dated May 7, 2007, is in accordance with the reasons stated in the Federal Regulations.

DECISION

The appeal is denied. The respondent met the burden of proof to show the discharge reason meets the reasons stated in the Federal Regulation.

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 17th day of August, 2007,

in Tallahassee, Florida.

Linda Garton
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Agency for Health Care Administration
[redacted]

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

[redacted]

PETITIONER,

APPEAL NO. 07N-00105

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 18, 2007, at 10:51 a.m., at [redacted] in Clearwater, Florida. The petitioner was present. Witnesses for the petitioner were [redacted] ombudsman, [redacted] neighbor of the petitioner, and [redacted] neighbor of the petitioner. The respondent was represented by [redacted] business manager. Witnesses for the respondent were [redacted] administrator, and [redacted] social service director.

As the petitioner did not have an opportunity to review the evidence submitted by the respondent, the hearing office left the record open for 10 days for the petitioner to review the evidence and provide any response regarding the evidence submitted by the facility. As the petitioner indicated that she was not

feeling well, the hearing officer allowed for any closing statements to be in writing. Any response from the petitioner regarding the evidence submitted by the facility or closing statement from the respondent and petitioner were due within ten days of the hearing.

On July 23, 2007, closing statement was received from the respondent. The facility indicted in that facsimile that that the petitioner left the facility. On July 24, 2007, response to evidence and closing statement were received from the petitioner. In the facsimile, the petitioner provided her new address. The record was closed on July 30, 2007.

The record was reopened to review additional information that was received on July 31, 2007 by facsimile and then by hard copy. The record was closed on August 8, 2007.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of June 18, 2007 is in accordance with the requirements of 42 C.F.R. § 483.12(a):

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

FINDINGS OF FACT

On June 18, 2007, the petitioner was given a Nursing Home Transfer and Discharge Notice. The reason listed in the discharge was: "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".

1. The petitioner is 71 years old and ambulates with a power wheelchair. The petitioner was admitted to the facility from [redacted] on May 12, 2007.

2. The expenses incurred by the petitioner at the facility were paid by Medicare from May 12, 2007 through June 18, 2007. The petitioner was notified by certified letter from the Social Security Administration that Medicare payment would stop on June 15, 2007. As Medicare was no longer paying, the petitioner was then considered "private pay" by the facility for the expenses she would incur at the facility.

3. Upon notification that the reviewed by Medicare was denied, the facility verbally requested private payment from the petitioner for service incurred after June 18, 2007. The petitioner refused to pay for services that she would incur after June 18, 2007. The facility sent the petitioner notification on June 18, 2007, advising her of the facility's decision to discharge the petitioner on July 18, 2007. The basis of that discharge was that there had been lack of payment of her bill for services and after reasonable and appropriate notice the financial situation had not been resolved.

4. The facility sent the petitioner a letter on June 21, 2007 notifying the petitioner that private pay residents are required to pay a month up front and as of June 21, 2007 the petitioner was to pay the amount owed of $2,030.00. The petitioner was billed on June 25, 2007. The petitioner was sent another bill on July 16, 2007. The petitioner has an outstanding obligation to the nursing home in the amount of $10,701.04, for services through July 31, 2007. From June 18,

2007 to July 18, 2007, the respondent has not received payment from the petitioner. The petitioner requested a hearing on June 20, 2007. As a result of the hearing, request, the discharged was stayed until the Final Order.

5. The petitioner receives $573.70 in Social Security Administration benefits and alimony payments. The petitioner alleged that she does not have the money to pay the facility. She opined that Medicare should have paid the first 100 days. She has applied for Medicaid for Institutional Care Program benefit to pay for skilled care services at the facility. She opined she was accepted by the facility under Medicare and Medicaid payment and that she should not have to pay the facility.

6. The petitioner testified that she only received a bill within three days of the hearing and the facility never gave her a bill on June 25, 2007. In the evidence received from the petitioner by the hearing officer on June 27, 2007 and marked by the petitioner as "Exhibit C" was a copy of the June 25, 2007 bill from the facility. The petitioner resent the June 25, 2007 bill to the hearing officer on July 17, 2007. Therefore, the petitioner's testimony that she did not receive a June 25, 2007 bill from the facility is not credible.

7. The facility indicted in their July 23, 2007 facsimile that that upon requested of the petitioner, the petitioner was discharged on July 18, 2007.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255 F.S. Matters that are considered at this type of hearing are the decision by the facility to discharge the patient.

Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that she would be discharged from the facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a):

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

Upon notification that the reviewed by Medicare was denied, the facility verbally requested private payment from the petitioner for service incurred after June 18, 2007. The petitioner refused to pay for services that she would incur after June 18, 2007. The hearing officer must consider that the petitioner's testimony at the hearing on July 18, 2007 that she intended to remain at the facility and her intent was to not pay the facility from her funds. The petitioner left the facility at her own request on July 18, 2007. There was no indication that the petitioner made payment arrangements for services incurred from June 18, 2007 through July 18, 2007.

The evidence submitted indicated that Medicare would no longer pay for the debt incurred by the petitioner at the facility. The petitioner opined that payment should be made by either Medicare or Medicaid. The hearing officer has no jurisdiction over determination by the Social Security Administration for Medicare issues of payment. Therefore as Medicare will no longer pay for the petitioner's expenses incurred at the facility after June 18, 2007, there is no intent of payment from Medicare. Medicaid payment has not been approved for Institutional Care Program benefits. Therefore, there is no guarantee of payment

from Medicaid for room and board at the facility. Even if the petitioner was approved for Medicaid for Institutional Care benefits, the petitioner would still incur a patient responsibility payment to the facility in addition to the amount paid by Medicaid. The petitioner has not even made a payment to the facility that would equal a patient responsibility payment. There was no indication that the petitioner made payment arrangements for services incurred from June 18, 2007 through July 18, 2007. Therefore, there is no evidence of intent by the petitioner to pay for any expenses incurred at the facility.

The facility has given the petitioner reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial arrangement have not resulted. There is no evidence of intent of payment by petitioner. Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a)(2)(v).

The petitioner's issues regarding any determination of payment by Medicare are outside of the jurisdiction of this venue and are referred to the Social Security Administration. The petitioner's issues with the facility as stated at the hearing and in her facsimiles are outside of the jurisdiction of this venue and are referred to the Agency for Health Care Administration. The petitioner's issues with [redacted] and Medicaid Waiver will be address under a separate appeal with the Department of Children and Families.

DECISION

This appeal is denied. The facility's action to discharge the petitioner is in accordance with federal regulations.

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 17th day of August, 2007,

in Tallahassee, Florida.

Linda Jo Nicholson
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [redacted] Petitioner
[redacted], Respondent
[redacted] Agency for Health Care Admin
[redacted] supervisor