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

[redacted]

APPEAL NO. 08N-00090

PETITIONER,

Vs.

Administrator
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on June 25, 2008, at 2:30 p.m., at the above facility, in Melbourne, Florida. The petitioner was not present. Her daughter, [redacted], represented her. [redacted] nursing home administrator, represented the respondent. In attendance for the respondent were: [redacted] social worker; [redacted] director of social services; [redacted] director of clinical services; [redacted] unit manager, and [redacted] ARNP.

The record was left open until the close of business on July 9, 2008 in order for the respondent to have the opportunity to submit into evidence portions of the medical record. The respondent noted at the hearing that it had to secure a clearance from its legal department before giving copies of the exhibits to the petitioner. As a result of not copying the petitioner, the medical records that were submitted as evidence at the

hearing were not made a part of the record and were returned prior to closing the record. No additional evidence was received and the record was closed.

ISSUE

At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations found at 42 C.F.R §483.12. The nursing home is seeking to transfer and discharge the petitioner because "the safety of other individuals in this facility is endangered". The nursing home has the burden of proof to establish that the transfer and discharge action is consistent with the federal regulations.

FINDINGS OF FACT

1. The petitioner is a resident of a nursing home. She entered the facility on November 29, 2007 from home. She is residing at the facility pending the outcome of this appeal. Her date of birth is December 8, 1926. Her primary diagnosis is dementia.

2. On April 18, 2008, the petitioner was given written notice that the facility intended to discharge her to another facility, [redacted] in St. Petersburg, Florida. The reason cited was the safety of other individuals in the facility was endangered (Respondent's Exhibit 1).

3. The respondent alleges that the petitioner has aggressive behavior and outbursts to other residents and staff members. She is being treated by a psychiatrist and a licensed clinical social worker. She has had various visits with her doctor and adjustments in her medications to try to curb the behavior issues. The respondent alleges the outbursts have been ongoing since February 6, 2008 and continued into June 2008. The outbursts have ranged from fighting with her roommate and staff, to

spitting in the hallway. The Respondent's Exhibit 2 is a written statement from the licensed clinical social worker. She was not present at the hearing. It was read into the record by a witness for the respondent. According to the nursing home administrator, it was submitted as an exhibit because it is not part of the petitioner's medical record. The respondent indicates the above discharge reason would be correct because they can no longer meet the petitioner's needs and she should be transferred to a more appropriate secured unit. The respondent; however, did not provide any clinical records from any physician to support the allegations and the facility's position.

4. The petitioner's daughter explains that the petitioner was put in the nursing facility for her own safety. She thought everything was under control now that her medications have been changed. She is more relaxed now. She explained that her mother was accused of hitting her roommate at a time when she was with her in another wing. The facility admitted the incident was questionable. She explains that her mother never used to spit, and believes it may be the result of one of her medications. She has been taking all of her meals in her room now so she can spit in her garbage can if need be. She does not want her mother to move to a facility in St. Petersburg because it is over four hours one way. She visits her often and wants her near her.

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 reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the respondent believes the petitioner should be discharged because the safety of individuals is endangered. Federal Regulations do permit a discharge based on the

potential endangerment of other residents, as set forth at 42C.F.R. §483.12(a)(2)(iii), as follows: "The safety of individuals in the facility is endangered;..."

The petitioner has displayed problem behaviors to include spitting in the hallway, wandering, agitation, and fighting with her roommate and staff. It is noted that these behaviors are not acceptable and need correction. However, there is not the requisite level of clear and convincing evidence that the petitioner's continued stay at the respondent facility endangers other individuals' safety. No competent evidence was presented to support these allegations.

Further, Florida Statutes 400.0255 (7)(b) requires the resident's physician or medical director to document why the petitioner's stay at the facility would endanger the safety of other individuals at the facility, as follows:

> (7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:
>
> (b) **The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.**

The evidence is absent documentation from the resident's physician or medical director that other residents or employees safety is endangered by the petitioner's continued stay at the facility. In sum, the respondent facility has not met its burden by clear and convincing evidence that the petitioner's continued stay at the facility endangers other residents or facility employees. Further, there is no evidence that the facility physician has documented that the petitioner must be discharged for the reason

given. The Respondent's Exhibit 2 was read into the record by someone other than the author and could not be cross-examined and therefore it was considered hearsay evidence. The undersigned cannot rely solely on hearsay when rendering a decision. Without testimony from her physician or documentation from the clinical record by her physician, the undersigned is not able to find that the discharge is consistent with the federal regulations.

DECISION

The appeal is granted. The respondent facility is not permitted to discharge the petitioner pursuant to this discharge action under appeal.

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 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 party 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 4th day of August, 2008,

in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Mr. Joel Libby,
Agency for Health Care Administration

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 08N-00098

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 21, 2008, at 4:00 p.m., at the facility. The petitioner was present. Present representing the petitioner was his stepson, [redacted] Present as witnesses for the petitioner were his wife, [redacted] and his daughter-in-law, [redacted] The facility was represented by [redacted] administrator. Present as a witness for the respondent was [redacted] business office manager.

ISSUE

At issue is whether or not the facility's action of May 22, 2008 to discharge the petitioner was correct on the basis of nonpayment for care and services provided.

The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a resident of a skilled nursing facility. She entered the facility on November 29, 2007 under Medicare. The petitioner's coverage for nursing home care under Medicare has since ended.

2. On December 14, 2007, an application for Institutional Care Program (ICP) Medicaid assistance on behalf of the petitioner was submitted to the Department of Children and Families by the facility staff. The application was denied due to not following through on the application.

2. On February 14, 2008, an application for Institutional Care Program (ICP) Medicaid assistance on behalf of the petitioner was submitted to the Department of Children and Families by the facility staff. The application was denied as the Department of Children and Families did not receive information needed to process his case.

3. Another application for ICP assistance was filed on behalf of the petitioner on April 24, 2008. This application was approved effective May 2008. The Department of Children and Families determined that the petitioner's patient responsibility was $908.14 a month. The patient responsibility is the amount of the petitioner's income that he is to use to pay the nursing facility for the cost of his care. ICP benefits were denied for the months prior to May 2008.

4. As of the date of the appeal, the petitioner's outstanding bill was $34,012.39 for services provided as a private pay resident. The petitioner's representative argued that the facility staff submitted all the applications for ICP assistance and they told him that there would not be a problem in the approval of the application. The representative

stated that after the submission of the last application the facility staff told him that an income trust had to be established in order for the petitioner to meet the ICP eligibility requirements. The income trust was established and funded within five days and the application was subsequently approved. The representative stated that he had very little contact with the Department of Children and Families as the facility staff were submitting the ICP applications on behalf of the petitioner. The representative had power of attorney and used the petitioner's income to pay for the expenses related to the petitioner's home where his wife continues to reside.

5. The nursing facility sent monthly statements for payment of the petitioner's cost of care to the petitioner, his wife and/or the petitioner's representative. The petitioner's representative was aware of the amount due to the facility. However, he did not make any payments as he believed that the cost of the petitioner's care would be paid when the ICP application was approved.

6. On May 22, 2008, the facility, by Nursing Home Transfer and Discharge Notice, notified the petitioner of its intent to discharge him because the bill for services at the facility had not been paid, after reasonable and appropriate notice to pay.

7. The location to which the petitioner was to be discharged was listed on the above notice as the petitioner's home where he resided with his wife prior to the admission to the facility. The nursing facility has stipulated that it will make arrangements through its social services office to insure the safe and orderly transfer of the petitioner to another appropriate living arrangement. The petitioner objects to the discharge, as he wants to be allowed to remain at the facility.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Federal Regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility based on non-payment.

Federal Regulations at 42 C.F.R. § 483.12(a) states in relevant 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...(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;...

The petitioner has an outstanding balance, owed to the facility, for the cost of his care and the facility has notified the petitioner, his wife and/or the representative of the balance due for the cost of his care.

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

DECISION

The appeal is denied. The facility met the burden of proof to show the discharge reason meets the reasons stated in the Federal Regulation. The facility may proceed with the discharge in accordance with applicable Agency for Health Care Administration requirements, when appropriate placement is found.

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 21st day of August, 2008,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
Ms. Cora Kurtz,
Agency for Health Care Administration
[redacted]

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

[redacted]

APPEAL NO. 08N-00102

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on July 17, 2008, at 12:55 p.m., in [redacted] Florida. The petitioner was present and represented himself. [redacted], nursing home administrator, and [redacted], assistant administrator and risk manager, represented the respondent.

ISSUE

At issue is the May 23, 2008 action by the respondent to discharge the petitioner because his health has improved sufficiently so that he no longer needed the services provided by the facility and because his needs cannot be met at the facility. The respondent will have the burden of proof that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12.

FINDINGS OF FACT

1. The petitioner is a resident of the nursing facility and continues to reside there pending the outcome of this hearing. When he was admitted after an accident, he required skilled nursing care.

2. On May 20, 2008, the petitioner's physician authorized the facility to initiate the discharge process for the petitioner as he was found medically ready for discharge. The nursing home administrator signed it on the same day. A Nursing Home Transfer and Discharge Notice was issued on May 23, 2008 citing the petitioner's needs cannot be met at this facility, and that his health had improved sufficiently so that he no longer needed the services provided by the facility. The petitioner signed the notice on the same day (Respondent's Exhibit 1).

3. The facility believes that the petitioner is independent in all of his activities of daily living. The ADL and Nutrition/Hydration Care record shows he is independent on all of his activities of daily living and requires no assistance (Respondent's Exhibit 3). Assessments were completed to see if the petitioner still required occupational therapy, physical therapy, or speech therapy. The assessments revealed that no therapies were indicated as he was observed ambulating in and out of the facility on even and uneven ground with no loss of balance observed, and that he was independent of all tasks and could ambulate. The psychotherapist's recommendation was to discontinue biweekly individual therapy. The Progress Notes of his treating physician show that the petitioner appears to have maximized treatment in a rehabilitative facility and could function in an outpatient basis (Respondent's Exhibits 4, 5, 6, 7, 8, 10).

4. The CARES unit from the Department of Elder Affairs, which is responsible for determining level of care for the state, recommended that the petitioner needed Intermediate II care, not skilled care, effective June 20, 2008 (Respondent's Exhibit 2). This allowed the petitioner to stay in the facility while appropriate placement was found.

5. The discharge location on the notice is the [redacted]. Testimony revealed that the petitioner would be living in an apartment in Melbourne. The facility would pay his deposit and application fee, and his first month's rent. The petitioner would receive his SSI check in August 2008.

6. The petitioner understands his condition has improved. He stated that he had no testimony to give. He acknowledged that he could walk independently however; he was concerned about his equilibrium. He believes that he veers off to the left or the right when he is walking and that he had trembling.

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:

> (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;...
>
> (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; ...

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice to the petitioner on May 23, 2008. The nursing home

administrator and the petitioner's treating physician signed the form, as well as the petitioner. The notice, as required, noted the reason for the discharge. The petitioner's treating physician indicated that the petitioner's health has improved sufficiently and that he no longer needs skilled nursing care. The notice provided a location, but further discharge planning shows the petitioner will reside independently in an apartment.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the respondent's proposed action to discharge the petitioner is in accordance with the controlling authorities, as his health has improved sufficiently that he no longer needs the level of the services provided by the facility.

DECISION

The appeal is denied. The respondent may proceed with the proposed discharge.

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 20th day of August, 2008,

in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To: [redacted], Petitioner
[redacted], Respondent
Mr. Joel Libby,
Agency for Health Care Administration

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

[redacted]

APPEAL NO. 08N-0097

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 25, 2008, at 8:25 a.m., in Miami, Florida. The petitioner, [redacted], was present and represented himself at the hearing along with the assistance of his nephews, [redacted] and [redacted]. Present as translator was [redacted], certified ombudsman. Representing the facility was [redacted], social worker. Present as witnesses for the respondent were: [redacted], facility physician and [redacted], RN, unit manager.

ISSUE

At issue is whether or not the facility's action to discharge the petitioner is an appropriate action, based upon the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because, "Your health has improved sufficiently so that you no longer need the services provided by this facility." The nursing

home has the burden of proof to establish that the discharge action is consistent with federal regulations.

FINDINGS OF FACT

1. The petitioner (67 years old) is a resident of [redacted] in Miami-Dade County. The petitioner was admitted in 2004 with a diagnosis of carcinoma and received radiation. The petitioner had been seen by numerous specialists and has been in stable condition for the last one to two years. The petitioner receives routine follow-ups on an on-going basis.
2. On May 14, 2008, the facility's physician authorized the facility to initiate the discharge process for the petitioner, as he was found medically ready for discharge.
3. A Notice of Discharge was issued to the petitioner with an intended discharge date of June 16, 2008. The petitioner filed for an appeal of that action on May 21, 2008.
4. At the hearing, the physician stated that the petitioner is completely independent in his activities of daily living (ADL). He is ambulatory, can administer his own medication and can feed self, even though he is tube fed. The petitioner also receives aerosol which he can self-administer.
5. The physician states that this decision was not done in haste and had been able to go back into the community a year earlier, but the petitioner did not have the resources to make it on his own and they did not proceed with the discharge.

The petitioner is Medicaid and Medicare eligible and receives Supplemental Security Income (SSI).

6. The physician states that the petitioner is a high functioning individual and would spend time doing garden work in the facility. He states that from a medical standpoint, the petitioner has improved sufficiently and can live in an assisted living facility (ALF) and receive home health services through Medicaid.

CONCLUSIONS OF LAW

42 C.F.R. § 483.12 Admission, transfer and discharge rights states in part:

> (a) *Transfer and discharge-* (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plants or not. (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- (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; (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident ... (iii) Include in the notice the items described in paragraph (a)(6) of this section. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for the transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; ...

The petitioner is concerned about leaving the facility as he "feels good" there. He states that he is worried about the sanitary conditions and the "device connected to the intestine."

The petitioner's family is concerned about the psychological well being of the petitioner and a possible set back.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The notice, as required, noted the reason for the discharge as "your health has improved sufficiently so that you no longer need the services provided by this facility".

The hearing officer finds that the petitioner presented no medical evidence or testimony to contradict the medical opinion presented by the facility's physician. The physician emphasized that the medical issues that remain, can be addressed in the community. The notice issued by the facility provided a location, to which the petitioner was to be discharged and therefore, all requirements were found to have been met by the nursing facility.

DECISION

The appeal is denied. Pursuant to 42 C.F.R. § 483.12(7), the "facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."

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 8th day of August, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
[redacted], Respondent
Harold Williams, Agency for Health Care Admin.

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

[redacted]

APPEAL NO. 08N-00130

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 29, 2008, at 10:12 a.m., in Lake Worth, Florida. The petitioner was present and represented himself. Appearing as a witness was his father, [redacted]. Representing the respondent was [redacted] administrator. Appearing as witnesses were: [redacted], social worker; and [redacted], business office manager. Present as observers were: [redacted] case manager; and [redacted], social services director.

ISSUE

At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to transfer the petitioner for two reasons. First, the "bill for services at the facility has not been

paid after reasonable and appropriate notice to pay". Second, the petitioner's "health has improved sufficiently so that he no longer needs the services provided by the facility".

The nursing home has the burden of proof to establish that the transfer and discharge action is consistent with the federal regulations.

FINDINGS OF FACT

1. The facility's action to transfer the petitioner due to his health improving sufficiently requires that the transfer notice have a physician's written order for discharge or transfer attached. Also, the transfer notice must be signed by a physician. This may be the resident's attending or treating physician, the facility medical director, or a nurse practitioner or physician's assistant as a physician designee.
2. Because there was no appropriate signature or physician's written order attached, this hearing officer is dismissing the cause as noted as health improving sufficiently. The only cause to hear is that of non-payment.
3. The petitioner was admitted to the facility March 4, 2008. A member of the facility's staff submitted an application for Institutional Care Program (ICP) Medicaid benefits to the Department of Children and Families April 25, 2008.

4. A Level of Care (LCC) was requested and completed by the Department. A temporary LOC was granted June 4, 2008 (Respondent Exhibit 3). The temporary LOC did not indicate an end date.
5. ICP Medicaid was authorized effective March 4, 2008. This meant that the facility would be paid through Medicaid and it would accept the Medicaid amount as paid in full.
6. Notices were issued by the Department of Children and Families indicating that the ICP would be authorized through July 31, 2008. As of the hearing date, no other application for recertification was submitted and no other LOC was requested.
7. As of the issuance date for the Nursing Home Transfer and Discharge Notice, July 1, 2008, the petitioner has an outstanding balance owed of $0.00. As noted, the ICP is authorized through July 31, 2008.

CONCLUSIONS OF LAW

42 C.F.R. § 483.12 **Admission, transfer, and discharge rights** states in part:

(a) Transfer and discharge--

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
>
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid....

In this instant case, the hearing officer dismissed one reason for discharge or transfer due as the notice being inadequate. That is, there was no physician's signature or written order.

Now, this hearing officer must note that because there is a $0.00 balance in the petitioner's account and he owes no money to the facility, the facility has acted prematurely in issuing the Transfer and Discharge Notice due to non-payment. The Regulation states that the petitioner must have failed to pay for a stay. This is not the case.

DECISION

The appeal is granted. The facility, at this time, may not transfer or discharge the petitioner. The facility should reapply with the Department of Children and Families for additional ICP and request another LOC. If an LOC is not given, that is the petitioner's health has improved, then a new discharge Notice could be issued.

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 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 party 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 1st day of August, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
[redacted], Respondent
Ms. Diane Reiland, Agency for Health Care Administration

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

APPEAL NO. 08N-00104

PETITIONER,

Vs.

ADMINISTRATOR

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 21, 2008 at 10:36 a.m., in Jacksonville, Florida. The petitioner was present and represented herself. The facility was represented by office manager. Present, as witnesses for the facility was , social services representative and , social services representative.

ISSUE

At issue is the May 27, 2008 notice from the facility proposing to discharge the petitioner for failure to pay for services at the facility. The facility has the burden of proof.

FINDINGS OF FACT

1. On May 27, 2008, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner. The notice indicated that the facility proposed discharging the petitioner on June 27, 2008. The facility proposed discharging the petitioner due to her failure to pay her bill at the facility following reasonable and appropriate notice to pay.
2. The petitioner entered the nursing facility on January 8, 2008. Her bill was covered completely under Medicare for the first 20 days of her stay until January 28, 2008. For another 80 days until March 29, 2008, Medicare paid 80% of the petitioner's monthly facility bill. The petitioner was responsible for the remaining 20% of the facility bill. Effective April 2008, the petitioner's responsibility to be paid to the facility was $995 monthly. The facility bills a month in advance. As of the May 27, 2008 discharge notice, the petitioner's balance due at the facility was $1,459.38. This covers April 1, 2008 through June 1, 2008. The balance reflects bad debt write offs by facility in the amount of $995 on April 30, 2008 and $530.62 on May 31, 2008 ($995 monthly resident bill x 3 months [04/08, 05/08, 06/08] = $2985 - $995 4/30/08 write off - $530.62 5/31/08 write off = $1459.38 balance due).
3. The facility hand delivered monthly bills to the petitioner at the facility notifying her of the charges and balance on her account. The business office spoke with the petitioner on several occasions regarding the balance. The petitioner did not dispute the charges or balance presented by the facility. The petitioner has not made any payments to the facility since February 2008 because she has bills in the community she must pay; also because she feels the facility is not meeting her rehabilitation

needs and some of her personal items are missing from her room. The petitioner wants to remain in the facility only until she can find another place to live. The petitioner offered to pay the facility $5 per month towards balance due. The facility rejected the petitioner's offer.

4. The discharge location shown on the discharge notice is the home where the petitioner was living prior to entering the facility. The petitioner stated that was her mother's home, her mother is no longer living there, she is now living with the petitioner's sister; the exact address is unknown. The petitioner asserted that she would have no place to live if discharged from the facility at this time. The facility was unaware the discharge location shown on the discharge notice was no longer a viable option, but asserted all applicable rules and regulations would be followed in regards to finding an appropriate discharge location for the petitioner.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255. Matters that are considered at this type of hearing are the decisions by the facilities to discharge patients. 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 he would be discharged from the nursing facility in accordance with the Code of Federal Regulations at 42 CFR § 483.12(a):

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

The petitioner was aware that there is an outstanding debt to the facility. The facility has given the petitioner reasonable and appropriate notice of the need to pay for her stay at the facility. The petitioner does not dispute the charges or balance due on the account. The facility established that the petitioner failed to pay the balance following notices to do so. Therefore, the facility may proceed with the proposed discharge action due to the petitioner's failure to pay her bill at the facility.

DECISION

This appeal is denied. The facility's action is upheld. The facility must follow the controlling federal authorities and the Agency for Health Care Administration's guidelines on proper discharge planning and location.

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, and 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party 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 party 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 19th day of August, 2008,

in Tallahassee, Florida.

Leslie Green

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

Copies Furnished To:

Petitioner

Respondent

Ms. Nancy Marsh, AHCA

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

[redacted]

APPEAL NO. 08N-00126

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened at 8:50 a.m. at the [redacted] on August 13, 2008. The petitioner represented herself and the respondent was represented by [redacted], MSW, assisted by [redacted], RN, risk manager; both employed at the facility.

ISSUE

At issue was whether or not intent to discharge was correct based upon failure to pay for services after reasonable and appropriate notice to pay. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner resides at [redacted] and has been there since at least June 2008. Previously she lived at an assisted living facility

and she would like to continue rehabilitation at the nursing center until such time as she could return to an assisted living facility.

2. On June 29, 2008, saying: "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay," discharge notice was issued (Respondent's Exhibit 1).

3. Location of intended discharge was to a family member at a private residence in Casselberry, Florida. The petitioner believes the location is inappropriate due to her needs and the size of the family and she requested a hearing (Petitioner's Exhibit 1). Facility staff explained that discharge to an unsafe location is not permissible and efforts to discharge must involve safe location.

4. On June 30, 2008, the respondent issued a bill to the petitioner for "Amount Due: $6,912.00." The bill was for care from June 8 – June 30, 2008 at $2,944 plus the upcoming full month of July at $3,968 as a private patient. Total was $6,912, shown in Respondent's Exhibit 2. The bill referred to "Coinsurance" but no amount was shown and the respondent's representative explained there was no secondary insurance payer, but that Medicaid might become a coinsurer if Medicaid application were actively pursued and all eligibility requirements were met. Facility staff further noted that Medicaid's eligibility review requirements include review of money gifts.

5. There had been difficulty in Medicaid application efforts and the petitioner had recently given some money to a needy family member. She recently did apply for Medicaid and if her efforts are diligent in the opinion of facility staff, then discharge could be forestalled. However, at point of hearing, the notice of intent to discharge was not revoked and plans to discharge were still intended.

6. The petitioner recently paid an additional $2000 to the facility for her care. That did not achieve full payment of the amount owed and it did not cause the respondent to revoke intended discharge.

CONCLUSIONS OF LAW

Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Additionally relevant is § 483.12 informing as follows:

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
> ...
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.
> ...
> (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.
> ...
> (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;
> (iv) A statement that the resident has the right to appeal the action to the State....

While recognizing that insufficient payment had occurred, the petitioner asserted that discharge to her daughter was unacceptable due to her condition and the family size. This is not a problem for the undersigned to remedy. The petitioner has income of her own and her income may be used for her care at a private residence such as that of

her daughter or at an institution. The respondent may not discharge to an unsafe location and the respondent's staff is aware of such. Therefore unsafe discharge may not proceed.

However, it is concluded that inadequate payment has occurred following reasonable and appropriate notice to pay. On that merit, discharge to a safe location is appropriate. Despite preferences of the petitioner, and difficulties of the situation, burden of proof has been met by the respondent. Intent to discharge has been justified as set forth.

DECISION

The appeal is denied and discharge intent is 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 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 party 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 19th day of August, 2008, in Tallahassee, Florida.

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

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

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

[redacted]

APPEAL NO. 08N-0106

PETITIONER,

Vs.

ADMINISTRATOR
[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 29, 2008, at 12:00 p.m., in Miami, Florida. The petitioner, [redacted], was not present however she was represented by her daughter, [redacted]. Also present on behalf of the petitioner was [redacted] ombudsman. Representing the facility was [redacted], nursing home administrator; [redacted], director social services; [redacted], LPN, nurse supervisor; [redacted] dietetic technician; [redacted], social services assistant; [redacted], consultant; and [redacted], food services director.

ISSUE

At issue is whether or not the facility's action to discharge the petitioner is an appropriate action, based upon the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because, "Your needs cannot be met

in this facility." The nursing home has the burden of proof to establish that the discharge action is consistent with federal regulations.

FINDINGS OF FACT

1. The petitioner (81 years old) has been a resident of [redacted] at [redacted] in Miami-Dade County for approximately six years.
2. The petitioner has been dissatisfied with the food received at the facility for years. Social service progress notes documents the petitioner's dissatisfaction with the meals as early as July 2004 (Respondent's Composite Exhibit 2).
3. The respondent states that they have done everything possible to try to satisfy the petitioner and that they have been unable to do so.
4. The respondent has tried cooking food differently; purchased different cuts of meat and chicken; used different seasoning; used fresh items for her; and has had food catered-in for the petitioner in an attempt to please her and she is not satisfied.
5. The petitioner continuously makes negative comments to the other residents, about the facility's food and it is the facility's position that she has the right to complain, but they do not want the other residents affected by her complaining. The facility clarified that the intended discharge is not as a result of a medical issue.
6. The petitioner's family has been informed of the petitioner's issues with the dislike of the facility's food; the steps taken in trying to please her; and the

petitioner's constant complaining to others. The family themselves have tried to resolve the issue and have not been able to do so.

7. On May 31, 2009, a Notice of Discharge was issued to the petitioner with an intended discharge date of July 1, 2008. The petitioner's complaints and dissatisfaction with the food led the respondent to believe, that it cannot meet the petitioner's needs. The petitioner filed for an appeal of that action on June 4, 2008.

8. When the hearing request was received, the undersigned directed that a review be conducted by the Agency for Health Care Administration (AHCA) to assess current compliance with regulatory requirements associated with the discharge of a resident. The review was conducted however, it is not necessarily controlling for hearing purposes. The review by AHCA determined that "[redacted] was in substantial compliance with federal regulations and with Florida Licensure requirements for Long Term Care, at the time of this survey." The undersigned provided the results of the review to the parties during the hearing.

CONCLUSIONS OF LAW

Jurisdiction to conduct this hearing has been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200.

Regarding transfer and discharge rights from a facility, 42 C.F.R. § 483.12(a) 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; ...

(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.

42 C.F.R.§ 483.10 Resident rights, states in part:

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights: ...
(b)(4) The resident has the right to refuse treatment, or refuse to participate in experimental research, and...

The respondent argues that the petitioner's constant complaining to other residents about the food is "affecting the other residents." They state that the petitioner is aware of everything that is going on, she is hoarding food which is attracting bugs and is refusing to take her medication (antidepressants) prescribed by her psychiatrist that she sees

regularly. The petitioner is not compliant with her plan of care. The administrator noted instances of an outburst by the petitioner and throwing food.

They state that they have standards and requirements related to the care and satisfaction of residents that they must meet. They feel that the petitioner's negative remarks about the food is not helping them achieve this requirement. The respondent feels that the petitioner would be happier and have a better "quality of life" in another facility.

The petitioner's daughter states that she visits her mother frequently and another facility would not be convenient for her, as there is no other facility in the nearby area. She states that her mother does not wish to leave and feels that the dislike of the facility's food will always be an issue for her where ever she goes, because it is food from a nursing home.

The ombudsman indicated that copies of recent doctor's progress notes (Petitioner's Exhibit 1) from the psychologist, attending physician and psychologist indicate an issue with their treatment plan or medical issues.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The notice, as required, noted the reason for the discharge as "your needs cannot be met at this facility".

The hearing officer finds that as the burden of proof is with the respondent, insufficient evidence has been provided to prove that the nursing home cannot meet the petitioner's needs. The fact that the petitioner complains to other residents is unfortunate

and the family needs to continue to assist the facility in minimizing its effects. However, her complaining alone does not rise to a level where her needs are not being met, in fact, the facility has even gone beyond what could be normally expected from them. At this time, it is clear that the petitioner's only issue is her dislike of the food despite the facility's efforts.

The respondent showed no evidence that as a result of the petitioner's dislike to their food she was malnourished, was loosing weight or it was medically affecting her. No evidence was received on any other consequence that resulted from the alleged negative behavior of the petitioner to warrant a discharge from the facility.

Based on all evidence and testimony presented, the hearing officer concludes that the facility's action to discharge the resident is not justified according to Federal Regulations. The petitioner is to be allowed to remain at the nursing facility.

DECISION

The appeal is granted 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 19th day of August, 2008,

in Tallahassee, Florida.

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

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

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

[redacted]

APPEAL NO. 08F-03770

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
DISTRICT: 02 Bay
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 12, 2008, at 1:35 p.m., in Panama City, Florida. The petitioner was not present. She was represented by [redacted] utilization management coordinator, of [redacted] Medical Center. The Agency was represented by D.D. Pickle, program analyst with AHCA, Debra Nussbaum, director of clinical services of [redacted] and Dr. Alan Lipton, medical director of [redacted] Present as observers were Anna Monlyn-Walker, managed care coordinator and Paula Wise-Haddock, director of revenue cycle, both of [redacted] and Margie Martinez, consumer recovery manager with [redacted]

ISSUE

At issue is the agency's April 23, 2008 denial of Psychiatric Inpatient Hospital Services beginning April 20, 2008, under the Florida Medicaid Prepaid Mental Health Plan.

FINDINGS OF FACT

1) The petitioner was enrolled in the Florida Medicaid Prepaid Mental Health Plan at the time of admission to the [redacted]
2) [redacted] reviews mental health treatment for the Florida Prepaid Mental Health Program based on contracted Medicaid coverage.
3) [redacted] denied Psychiatric Inpatient Hospital Services on April 23, 2008 and issued a denial letter to the provider; not the petitioner.
4) Because [redacted] is a contracted provider with [redacted] and because the denied services is a covered service under the plan, the Medicaid recipient is in what is called a "hold harmless" status and the provider will not be able to bill her for the inpatient hospital stay under challenge.
5) The petitioner is not seeking readmission to the hospital. She is currently court ordered into [redacted] as of June 30, 2008. Because of this, she will be disenrolled from the Medicaid Prepaid Mental Health Plan as of June 30, 2008.

CONCLUSIONS OF LAW

Chapter 65-2 of the Florida Administrative Code contains the rules of practice and procedure for the applicant/recipient fair hearing process. The process is for the applicant/recipient to appeal any loss or denial of public assistance benefits, to include Medicaid benefits or services.

According to the Florida Medicaid Provider General Handbook, January 2007, pages 1-5 and 1-6:

> Medicaid Payment Is Payment In Full:
> Prior to rendering a service, a provider must inform the recipient of his responsibility for the payment of any services received that are not covered by Medicaid. The provider must discuss this with the recipient for each service and must document this discussion in writing in the recipient's medical record.
>
> Only those procedures that are not listed on the provider's Medicaid fee schedule (procedure code table) are non-covered services.
>
> Other than Medicaid copayments and Medicaid coinsurance, the provider cannot seek payment from a recipient for a compensable service for which a claim has been submitted, regardless of whether the claim has been approved, partially approved or denied except under the following circumstances:
>
> • The recipient is not eligible to receive Medicaid services on the date of service.
>
> • The service the recipient receives is not covered by Medicaid.
>
> • The provider has verified that the recipient has exceeded the Medicaid coverage limitations or frequency cap. The provider must inform the recipient that he has exceeded the frequency cap for the specific service to be rendered.
>
> • The recipient is enrolled in a Medicaid managed care program and has been informed that the particular service has not been authorized by the recipient's primary care provider.
>
> • The recipient is enrolled in managed care program and has been informed that the treating provider is not a member of the recipient's managed care network.
>
> • The provider has informed the recipient in advance that he does not accept Medicaid payment for the specific service to be

rendered. The provider must document in the recipient's medical record that the recipient was informed and agrees to the service.

The Findings of Fact show that the petitioner's interests have not been substantially affected by the denial action of the inpatient hospital services. In this situation, the provider is prohibited from seeking payment from the Medicaid recipient. Because of that, there is no remedy or corrective action to order in the petitioner's behalf. The undersigned has no jurisdiction over the denial of payment to the provider.

DECISION

The appeal is dismissed as explained in the above conclusions.

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 19th day of August, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Earnie Brewer, AHCA Field Office Manager
Kathy Wilson, AHCA
D.D. Pickle, AHCA
[redacted]

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

[redacted]

APPEAL NO. 08F-03158

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 14 Polk
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 29, 2008, at 1:10 p.m., in Lakeland, Florida. The petitioner was present. He was represented by his mother; [redacted] The respondent was represented by Ann Williams, R.N. Present as witnesses for the petitioner were Erica Sparks, paternal grandmother; and Judy Harick, L.P.N. with Maxim Healthcare services. Present as witnesses for the agency from KePRO were Dr. Rakesh Mittal, physician reviewer; and Gary Erickson, R,N.

ISSUE

At issue is the April 28, 2008 action by the agency denying 102 hours of private duty nursing hours for the petitioner based on failure to meet the "medically necessary" criteria.

FINDINGS OF FACT

1. The petitioner receives private duty nursing (PDN) services through his state plan Medicaid. The Agency for Health Care Administration contracts with Keystone Peer Review Organization (KePRO South) to perform the medical peer review for the Private Duty Nursing and Personal Care Prior Authorization Program for Medicaid beneficiaries in the State of Florida. They review to determine "medical necessity" under the terms of the Florida Medicaid Program. On April 18, 2008, the petitioner filed a request for 3219 hours of private duty nursing hours for the period of April 15, 2008 through October 11, 2008.
2. The petitioner was one year old when the latest request for private duty nursing (PDN) hours was submitted. He suffered birth trauma. He has pyloric stenosis, asthma, and convulsions. As a result he has a tracheotomy and gastrostomy. The petitioner requires medication administration, tube feedings, aspiration precautions, seizure precautions, and tracheotomy care and suctioning. He is on Apnea and an O2 Saturation monitor.
3. The information provided by the nursing agency reported that the father worked 9:00 a.m. to 5:00 p.m., five days per week, and is "on call" on the

weekends. The mother works 8:00 a.m. to 5:00 p.m., Monday thru Friday and goes to school 6:00 p.m. to 9:00 p.m., Monday thru Thursday. Both parents were in the home in the evenings. The petitioner requested private duty nursing services "8a to 5p M-F, 7p to 7a, 5 days per week and 9p to 7a on Sat. and Sun." On April 22, 2008, KePRO determined that at least one parent would be in the home by 7:00 p.m. in the evenings. Therefore, KePRO reduced the night hours to 11:00 p.m. to 7:00 a.m. for seven days per week. They approved the remaining hours. Notices were sent with this determination.

4. On April 23, 2008, the petitioner requested a reconsideration of this determination explaining that "the mother needed time to study after classes and on the weekend." In addition, the father "works 12 hour shifts and needs time to rest and both need time for housework, grocery shopping, and tending to the needs of the household." On April 27, 2008, a KePRO conducted a reconsideration review. The reviewer determined that:

> I suggest to rescind the previous denial for M-F and approve the 21 hours each day Monday through Friday, however, I would uphold the denial of 2 hours each day on Saturday and Sunday and maintain the approval of 8 hours per day on Sat and Sunday as proposed by the physician reviewer. Information submitted by provider support this decision and is supported by the written Home Health Services Coverage and Limitations Handbook, that "Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parent 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. I believe this

> denial is supported by this statement and applies to this recipients medically necessary care and availability of the parents to assist in that care. 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."

Therefore, the reconsideration determination approved the original request except for the hours of 9:00 p.m. to 11:00 p.m. on Saturday and Sunday nights.

5. The petitioner confirms that the sole area of dispute is the total of four hours weekly on Saturday and Sunday nights from 9:00 p.m. to 11:00 p.m. The father works five or six days per weeks in shifts that go from either 5:00 p.m. to 7:00 a.m., or 7:00 a.m. to 5:00 p.m. The mother is pregnant with the baby due in October 2008. Some Saturdays and Sundays, the mother would be the only one caring for the child from 7:00 a.m. until 11:00 p.m. under the proposed plan. The 11:00 p.m. start time is a problem for the parents getting enough sleep. In addition, they would have to stay up to greet the nurse and exchange information.

CONCLUSIONS OF LAW

The Florida Administrative Code 59G-1.010(166) states in relevant part:

> "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 Florida Administrative Code at 59G-4.290(2)(f) discusses Skilled Services and states in relevant 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; and
6. Consistent with the nature and severity of the individual's condition or the disease state or stage.

The Home Health Services Coverages and Limitations Handbook (July 2007) states in relevant part on page 2-17:

Private Duty Nursing Services
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.

Who Can Receive Private Duty Nursing

Medicaid reimburses private duty nursing services for recipients under the age of 21 who:

- Have complex medical problems; and
- Require more individual care than can be provided through a home health nurse visit.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically complex.

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.

The evidence establishes that the petitioner meets the medically necessary criteria to receive PDN hours. The number of PDN hours approved is determined through the peer review process, by a KePRO physician reviewer. The original request was reconsidered and modified. The remaining hours in dispute are four hours weekly, Saturday and Sunday from 9:00 p.m. to 11:00 p.m. The respondent approved the PDN hours to begin at 11:00 p.m. The petitioner requests that the hours begin at 9:00 p.m.

The petitioner did not offer any evidence to establish the medical necessity of the additional two hours other than the difficulty in getting nurses to start at 11:00 p.m. and her spouse's work schedule. There are times that he is called in to work on Saturdays. Some Saturdays she is the sole caretaker from 7:00 a.m. to 9:00 p.m. The evidence supports that the private duty nursing hours are more for the convenience of the parents than for the medical needs of the child. Therefore, the extra four hours are in excess of what has been established as "medically necessary." The agency correctly denied the hours requested due to lack of "medical necessity" for the child.

DECISION

This appeal is denied. The respondent's action is upheld.

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 1st day of August 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
Sue McPhee, Area 6 Medicaid Field Manager

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

[redacted]

APPEAL NO. 08F-4048

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 15, 2008, at 9:20 a.m., in Miami, Florida. The petitioner, [redacted], was represented at the hearing by his mother, [redacted] The respondent was represented by Sandra Moss, program administrator with the Agency for Health Care Administration (AHCA). Lidia Cardelle, AHCA program administrator was present as an observer. Present as witnesses for the respondent, via the telephone, were: Dr. Robert Buzzeo, physician reviewer and Gary Erickson, RN, fair hearing specialist, both with Keystone Peer Review Organization (KēPRO) South.

ISSUE

At issue is the respondent's action of June 3, 2008 and June 11, 2008 (reconsideration), in denying 1,290 hours of personal care services. The hours requested were for the certification period of April 28, 2008 through October 24, 2008. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is four years old and a Medicaid beneficiary in the state of Florida. The petitioner is medically complex with diagnosis as reported to the respondent, "Shaken infant syndrome; Infantile cerebral palsy, unspecified; Other convulsions; Hydronephrosis; Asthma, unspecified." Services have continued throughout the appeals process.
2. The respondent has contracted KēPRO South to perform medical reviews of Private Duty Nursing and Personal Care Prior Authorization Program for Medicaid beneficiaries. This prior authorization review determines medical necessity of the hours requested, under the terms of the Florida Medicaid Program. The request for service is only submitted by the provider, along with all information required, in order for KēPRO to make a determination on medical necessity for the level of service being requested. This review process is performed prospectively for a certification period.
3. On May 19, 2008, the provider (Ambar Home Health Agency Inc.) requested 1,290 hours of personal care (home health aide [HHA]) services for the certification period of April 28, 2008 through October 24, 2008. The request was for 5 hours daily from 3pm-8pm (Monday-Friday) and 5 hours daily from 9am-2pm (Saturday and Sunday). The provider submitted medical information on the petitioner, but more specific social information was lacking along with the possible miscalculation of total number of hours of service that were being

requested. Further information and clarification was requested. Additional information was received through the iexchange system.

4. On June 2, 2008, a physician consultant, board certified in pediatrics documented the following, "Provider is requesting a HHA [home health aide]. This child receives GT feeds and receives prn [as needed] diastat. A HHA cannot do either. There is no explanation of who performs this skilled care when mom not home. In addition, since mom can manage this child's care when a HHA is not in the home, Sunday hours appear as if they may be for respite care.***Denial for request of a HHA to care for this recipient. Paraprofessional care services cannot support the medical needs for this recipient."
5. On June 3, 2008, a PDN/PC Recipient Denial Letter was issued to the petitioner denying 1,290 hours of personal care services.
6. On June 3, 2008, the provider submitted a reconsideration request along with a letter on medical necessity from the petitioner's physician. The letter further emphasized the need for care and the several medications being taken along with the diet and the gastrostomy tube (GT) feeding.
7. The reconsideration request was denied, stating the same reason previously mentioned. The petitioner receives GT feeds and prn diastat and a HHA cannot do either. These duties need to be done by a properly trained person.
8. On June 11, 2008, a PDN/PC Recipient Reconsideration-Denial Upheld notice was issued to the petitioner and provider informing them of the denial. The petitioner appealed the decision on June 13, 2008.

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 Florida Statute, Chapter 120.80.

Fla. Stat. 409.905 addresses Mandatory Medicaid services and states in 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...
>
> (4)(b) 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. ...

Fla. Stat. ch. 409.9132(d) states in part:

> Medical necessity or medically necessary means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity...

Fla. Admin. Code 59G-4.130 Home Health Services states in part:

> (1) This rule applies to all home health agencies licensed under Chapter 400, Part III, 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, July 2007, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. ...

The Home Health Services Coverage and Limitations Handbook (July 2007), page 2-21 states in part:

> Personal Care Services Definition
> Person care services are to provide medically necessary assistance with activities of daily living that support a recipient's medical care needs.
>
> Personal Care Services Requirements
> Personal care services *must* be:
> - Documented as medically necessary;
> - Prescribed by the attending physician;
> - Supervised by a registered nurse;
> - Provided by a home health aide;
> - Consistent with the *physician approved plan of care*; and
> - Prior authorized prior to providing services.

The petitioner stated that she is a single mother, has no family and needs assistance with her son in order to go work and go to school.

The respondent informed the mother that the services required for the petitioner, can only be done by a trained individual and the HHA is not. They stated that the provider is aware of the requirements and the services of a skilled nurse would have to be requested by them.

The hearing officer finds that according to the above-mentioned rules and testimony received from the physician consultant, the services required for the petitioner are out of the scope of tasks that could be performed by the HHA. Therefore, the respondent's denial is affirmed.

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 19th day of August, 2008,

in Tallahassee, Florida.

A. G. Littman

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

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

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

[redacted]

APPEAL NO. 08F-04132

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 23 Hillsborough
UNIT:

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 6, 2008, at 1:17 p.m., in Tampa, Florida. The petitioner was present. The respondent was represented by David Beaven, program analyst.

ISSUE

The petitioner is appealing the following.

1. The respondent's requirement for her to be enrolled in a managed care program.

2. Reimbursement for payment for her appointments with non-Medicaid doctors.

FINDINGS OF FACT

1. The petitioner is a Medicaid eligible individual. She is disabled. She is receiving Supplement Security Income. She is not receiving Medicare. She has

impairments that require medication. She is in pain and needs to see a pain management specialist.

2. As the petitioner is a Medicaid recipient, the respondent enrolled the petitioner in managed care program as of July 1, 2008. The managed care program in Tampa is Citrus Health Plan. Managed care program is also known as HMO (health maintenance organization). Citrus Health Plan has referred the petitioner to pain specialists.

3. The petitioner attested that every pain specialist Citrus Health Plan referred her to she has contacted and every pain specialist has refused to see her. Either they don't take Medicaid or are not taking new patients. The petitioner chose to go to a pain management doctor that was not a Medicaid provider. Due to the problems she is having with Citrus Health Plan referrals, the petitioner requested that she not be required to receive service only from the Citrus Health Plan. She is requesting reimbursement of all payment to the non-Medicaid pain management specialists.

4. The respondent cited the Florida Statutes for mandatory Medicaid managed care enrollment. The respondent attested that Medicaid does not reimburse Medicaid recipients monies paid by the recipients to doctors who are not Medicaid providers. The respondent suggested that the petitioner continue to request a Medicaid pain specialist from Citrus Health Plan and that the petitioner the she does have the right to file a grievance with Citrus Health Plan.

5. The petitioner brought forth a new issue of prescriptions at the hearing. That issue will be heard under another appeal 08F-05208.

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.

I. As to the issue of the respondent's requirement for the petitioner to be enrolled in an HMO.

The Florida Statues at § 409.9122, "Mandatory Medicaid managed care enrollment; programs and procedures", states:

> (2)(a) The agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid recipients who are: in an institution; enrolled in the Medicaid medically needy program; or eligible for both Medicaid and Medicare...

The Florida Statutes specifically state the agency shall enroll in a managed care plan all Medicaid recipients that do not meet an exception. The petitioner is not in an institution, on Medicaid not Medically Needy and is not receiving Medicare. Therefore, the petitioner is not exempt from enrollment in a managed care program. The respondent's action to enroll the petitioner in the Citrus Health Plan is within the rules of the Program.

II. Reimbursement for payment for her appointments with non-Medicaid doctors.

The Florida Medicaid Handbook sets forth the following "Medicaid Basics", page 2:

> Not all providers accept Medicaid.
> Not all services are covered by Medicaid.

Some limitations may apply to covered services.
Providers that choose to accept Medicaid must accept Medicaid payment as payment in full. (This does not include copayments and coinsurance.)
Medicaid has a set fee for each individual type of service.
Providers cannot bill the recipient for any amount in excess of Medicaid payment, other than Medicaid copays and coinsurance.
Medicaid payments are made directly to the provider, not to the recipient.

The Medicaid Program does not provide reimbursement for non-Medicaid provider to Medicaid recipients enrolled in a managed care programs. The petitioner request for reimbursement is not within the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 19th day of August, 2008,

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
Sue McPhee, Area 6 Medicaid Field Manager
David Beaven, AHCA program analyst

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Duval
UNIT: ICP

RESPONDENT.
_____/

APPEAL NO. 08F-02527

CASE NO. 1265290113

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on June 19, 2008, at 11:17 a.m., in Jacksonville, Florida. The petitioner was not present. The petitioner was represented by his daughter-in-law, [redacted] Gloria Jackson, access supervisor, represented the Department. The record was held open for 21 days to allow submission of additional evidence that has been received and entered as Petitioner's Exhibit 9 and Respondent's Composite Exhibits 18 and 19.

ISSUE

At issue is the Department's January 25, 2008 denial of Institutional Care Program (ICP) Medicaid benefits. The petitioner had the burden of proof.

FINDINGS OF FACT

1. On June 27, 2007, an application for Institutional Care Program (ICP) benefits for the petitioner was submitted to the Department by the law firm [redacted] The law firm was hired by the petitioner's daughter-in-law, [redacted]

2. On June 29, 2007, the Department sent the petitioner's attorney a pending letter requesting additional information to complete the eligibility determination process for ICP benefits.

3. On July 16, 2007, the Department received a letter from the petitioner's attorney which explained that all the verification requested by the Department on June 29, 2007 was enclosed with the letter except bank statements and documentation of related spend-downs plus establishment of a Qualified Income trust for July 2007. On July 24, 2007, the Department granted the petitioner's attorney a 10 day extension to provide the remaining verification. Having not received the necessary verification, the Department met with the petitioner's attorney on August 2, 2007 to discuss face to face what additional information was needed to complete the ICP application. During the interview the Department again requested verification of petitioner's bank account balances and documentation of spend-downs from the banking accounts. Additional documentation of the petitioner's multiple bank accounts with multiple financial institutions and the related spend-downs was provided on or about August 8, 2007.

4. On August 9, 2007, the Department sent the petitioner's attorney a letter which explains that the Department was questioning if more than $61,000 had been improperly transferred from three of the petitioner's banking accounts to unknown locations in order make the petitioner eligible for Medicaid benefits and that the

petitioner was potentially ineligible until December 1, 2007 unless clear and convincing evidence was provided by August 29, 2007 which showed resources were not transferred to make the petitioner eligible for Medicaid. On August 30, 2007, the petitioner's attorney requested a 10 day extension to provide rebuttal documentation. The Department extended the deadline through September 9, 2007.

5. The petitioner died on September 12, 2007.

6. On September 19, 2007, the petitioner's attorney provided additional banking documentation and a spend-down schedule for the petitioner. The Department asserted that the documentation shows the petitioner had multiple accounts, at least six, with multiple financial institutions which contained a combined balance of $103,000(+). The spend-down schedule accounted for $50,000, of the $103,000; no explanation was provided for the disposition of the remaining $53,000. On October 16, 2007, the Department sent the petitioner's attorney a pending notice requesting spend-down explanation for the remaining $53,000.

7. The petitioner's attorney sent the petitioner's daughter-in-law a notice terminating representation effective immediately on November 29, 2007. The Department was also sent a copy of the notice. The notice is date stamped as received by the Department on December 3, 2007.

8. The Department met with the petitioner's daughter-in-law on December 20, 2007 to discuss the ICP application. The Department learned that there existed additional banking accounts for the petitioner not previously reported to the Department. On or about December 21, 2007, the Department pended the case for verification of all the petitioner's banking account balances and verification of all spend-downs

(Respondent's Exhibit 11). The petitioner's daughter-in-law acknowledged receiving the pending notice. The Department asserted that the petitioner's daughter-in law provided the same verification that the law firm provided in November 2007 which explains how $50,000 of the petitioner's $103,000(+) was spent-down. The spend-down of the remaining $53,000(+) had still not been explained. The Department met with the petitioner's daughter-in-law again on January 22, 2008 to obtain the required verification. The Department asserted no additional explanation for the missing funds was provided during this meeting and absent any explanation of the $53,000(+) spend-down, the ICP application was denied on January 25, 2008 for transferring assets to become eligible for Medicaid.

9. The petitioner's daughter-in-law asserted that the law firm handled the ICP application exclusively from June 2007 thru approximately October 2007 and that she would call the law firm periodically for status updates. The attorney charged her for each call; over the months this became expensive, so she began to call the Department for status updates instead of the attorney. The attorney terminated representation, explaining that the firm had no knowledge of what transpired between her and the Department during the phone conversations as the reason for termination of services. The petitioner's daughter-in-law admitted that the petitioner's combined banking account balances exceeded $103,000. She was uncertain about the exact number of the accounts. She asserted that she transferred and disbursed the funds as directed by the attorney. She believes there were two spend-down schedules; the first schedule documented a $50,000 spend-down, the second schedule documented a $53,000(+) spend-down. The petitioner's daughter-in-law asserted that only the attorney had the

second schedule, that she could not get the additional spend-down information because the attorney would no longer communicate with her since terminating services in November 2007. During the June 19, 2008 hearing, the Department agreed to request the second spend-down schedule directly from the attorney. The record was held open 17 days for submission of this information. On July 9, 2008, the attorney provided a letter (Respondent's Exhibit 18) which denies the existence of a second spend-down schedule. The attorney also provided a copy of the same spend-down schedule provided in 2007 which documents only a $50,000 spend-down and asserts that this is the only spend-down schedule. There was no evidence provided to explain how the additional $53,000 was spent.

CONCLUSIONS OF LAW

The Florida Administrative Code 65A-1.712(3) SSI-Related Medicaid Resource Eligibility Criteria, states the following regarding transfer of resources and income:

> (3) Transfer of Resources and Income. According to 42 U.S.C. §1396p(c), if an individual, the spouse, or their legal representative disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was done to become Medicaid eligible and impose a period of ineligibility for nursing facility care services or HCBS waiver services. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.
>
> (a) The department follows the policy for transfer of assets mandated by 42 U.S.C. §§1396p and 1396r-5. Transfer policies apply to the transfer of income and resources.
>
> (b) When funds are transferred to a retirement fund, including annuities, within the transfer look back period the department must determine if the individual will receive fair market compensation in their lifetime from the fund. If fair compensation will be received in their lifetime there has been no transfer without fair compensation. If not, the establishment of the fund must be regarded as a transfer without fair compensation. Fair compensation shall be calculated based on life

expectancy tables published by the Office of the Actuary of the Social Security Administration. See Rule 65A-1.716, F.A.C.

(c) No penalty or period of ineligibility shall be imposed against an individual for transfers described in 42 U.S.C. §1396p(c)(2).

1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual under age 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.

2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life expectancy tables noted in (b) above), it is not considered to be established for the sole benefit of the indicated individual and any potential exemption from penalty or consideration for eligibility purposes is void.

3. A transfer penalty shall not be imposed if the transfer is a result of a court entering an order against an institutional spouse for the support of the community spouse.

4. A transfer penalty shall not be imposed if the individual provides proof that they disposed of the resource or income solely for some purpose unrelated to establishing eligibility.

5. A transfer penalty shall not be imposed if the department determines that the denial of eligibility due to transferred resources or income would work an undue hardship on the individual. Undue hardship exists when imposing a period of ineligibility would deprive an individual of food, clothing, shelter or medical care such that their life or health would be endangered. All efforts to access the resources or income must be exhausted before this exception applies.

(d) Except for allowable transfers described in 42 U.S.C. § 1396p(c) (2), in all other instances the department must presume the transfer occurred to become Medicaid eligible unless the individual can prove otherwise.

1. An individual who disposes of a resource for less than fair market value or reduces the value of a resource prior to incurring a medical or other health care related expense which was reasonably capable of being anticipated within the applicable transfer look back period shall be deemed to have made the transfer, in whole or part, in order to qualify for, or continue to qualify for, medical assistance.

2. In cases where resources are held by an individual in common with others in a joint tenancy, tenancy in common, or similar arrangement, the individual is considered to have transferred resources or a portion thereof, as applicable, when action is taken by the individual or

any other person authorized to access the resources that reduces or eliminates the individual's ownership or control of such resource.

(e) Each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the purpose of qualifying for Medicaid eligibility. No period of ineligibility shall be imposed if the individual provides proof that they intended to dispose of the resource or income at fair market value or for other valuable consideration, or provides proof that the transfer occurred solely for a reason other than to become Medicaid eligible.

(f) The uncompensated value of a transferred resource is the difference between the fair market value of the transferred resource at the time of the transfer, less any outstanding loans, mortgages or other encumbrances on the resource, and the amount of compensation received at or after the time of the transfer.

Florida Administrative Code 65-2.060, Evidence, states:

(1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

The Florida Administrative Code Rule 65A-1.712(3) states if a transfer is not specifically excluded, then the Department must presume the transfer occurred to become Medicaid eligible, unless the individual can provide sufficient evidence to prove otherwise. The petitioner held the burden of proof to show that the denial was in error. The undersigned concludes that the burden of proof was not met. As the documentation provided does not show why, when or where funds totaling $53,000 were transferred, the undersigned hearing officer concludes that the Department correctly determined the petitioner was ineligible for ICP benefits.

DECISION

The appeal is denied. The agency 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 8th day of August, 2008,

in Tallahassee, Florida.

Leslie Green

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

Copies Furnished To: [redacted] Petitioner
4 DPOES: Theola Henderson
[redacted]

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

[redacted]

APPEAL NO. 08F-04230

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 5, 2008, at 1:15 p.m., in Tampa, Florida. The petitioner was present. Present on behalf of the petitioner was [redacted] friend of the petitioner. The respondent was represented by David Beaven, program analyst, and Donnette Waul-Santiago. Witnesses for the respondent from Hillsborough County Department of Aging Services were Felicia Southers, manager, and Angela Irby, social worker.

ISSUE

The petitioner is appealing the following.

1. The respondent action to suspend homemaking services. The respondent has the burden of proof.

2. The petitioner is requesting an increase in hours. The petitioner has the burden of proof.

3. The petitioner requested that homemaking services be provided by Medicare. The petitioner also questioned the amount paid by the providers to their employees.

FINDINGS OF FACT

1. The petitioner is 84 year old. The petitioner stated that she needs assistance to get in the shower, to get in and out of her wheelchair, clean her home and pay her bills. The petitioner requested additional hours of homemaker services. When asked how many hours of service the petitioner was requesting, the petitioner did not have a number and stated "I want whatever the Government will pay for". The petitioner wants Medicare to provide her homemaker services. She does not want the county to provide homemaking services. The petitioner does not trust the providers' employees that are sent to her home. She alleged that the homemakers either steal or commit fraud. The petitioner questioned why the State pays the providers $72 and the providers' employees only received $10.

The respondent was concerned that the petitioner was confusing Medicaid and Medicare. The petitioner indicated that she knew what Medicare was and should get her homemaking as a service of her Medicare Part A and B.

The petitioner read a statement of a past homemaker to support that the petitioner was not difficult to work with. The petitioner stated that this was the homemaker stole from her.

2. The respondent approved eight hours of services for the petitioner under the Aged and Disabled Waiver. The petitioner's services approved hours were four hours of homemaking, two hours of companion service, two hours of personal care, case management services and medical alert. The petitioner has not submitted to the respondent a request for any additional hours or any other services than the services the petitioner was approved to receive.

The respondent is the State provider for Medicaid Aged and Disabled Waiver services. The State contracts with Hillsborough County Department of Aging Services for case management of the petitioner's service hours. Hillsborough County Department of Aging Services is the only entity in Hillsborough County that the State contracts with for the Aged and Disabled Waiver. The Medicaid Aged and Disabled Waiver services are not county services. Hillsborough County Department of Aging Services as the case manager contracts with providers to provide homemaking services for the petitioner.

3. The petitioner has had several providers. On November 29, 2006, [redacted] terminated the petitioner's homemaker services after several personnel changes due to treatment of the homemakers by the petitioner. On September 24, 2007, [redacted] terminated the petitioner's homemaker services due to personality conflicts between the petitioner and staff members. On May 23, 2008, [redacted] terminated the petitioner's homemaker services after several staff changes and the petitioner's refusal of services. On June 5, 2008, Tampa Bay Patient Care

Services terminated the petitioner's homemaker services due to personality conflicts and safety issues. The providers also indicated that the petitioner requested that the homemakers provide services that were not homemaker services. The petitioner's requests included cleaning areas of the petitioner's home that was occupied by male tenants, laundry of the tenants and handling of the petitioner's legal matters. On June 23, 2008, the petitioner was assigned a new provider, [redacted]. The petitioner refused services from [redacted]

4. On June 17, 2008, Hillsborough County Department of Aging Services sent the petitioner a suspension notice. The petitioner's homemaking was suspended, as the providers had terminated the petitioner's homemaking. Neither the Hillsborough County Department of Aging Services nor the respondent terminated the petitioner's homemaking eligibility.

5. On June 30, 2008, the petitioner refused an assessment by the Department of Elder Affairs. The petitioner was offered to receive her homemaker services under another Waiver Program, such as Long Term Care Waiver or CDC Waiver services. The petitioner refused any other Waiver Program.

The Hillsborough County Department of Aging Services tried to work with the petitioner. The Hillsborough County Department of Aging Services presented the petitioner with contract as a result of the providers' memos. The petitioner refused to sign the contract.

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.

I. As to the issue of the suspension.

The Florida Administration Code at 59G-8.200, "Home and Community-Based Services Waivers" defines the waiver services and requirements:

> (2)(a)"Agency" means the Agency for Health Care Administration, the Florida state agency responsible for the administration of Medicaid waivers for home and community-based (HCB) services...
> (3) Home and Community-Based (HCB) Waiver Services are those Medicaid services approved by the Health Care Financing Administration...Individuals eligible for the respective HCB services waiver programs may need and receive the following services...
> (e) Case Management, Waiver Case Management, and Support Coordination are services that assist Medicaid eligible individuals in gaining access to needed medical, social, educational and other services, regardless of funding source.
> (g) Companion Services include those activities necessary to assist the recipient in performing household or personal tasks and providing social stimulation to relieve the negative effects of loneliness and isolation.
> (k) Emergency Alert Response, Medical Alert and Response Service, and Personal Emergency Response Systems are methods of monitoring persons, through electronic or other means, in their own home to assure their safety by identifying their need for assistance or medical intervention and dispatching qualified personnel to the home.
> (p) Homemaker, and Homemaker and Personal Care Services provide assistance with daily living activities and household tasks related to supporting clients in a home setting. Services include assistance with bathing, dressing, eating, maintenance of personal belongings, and performance of light housekeeping, and meal planning and preparation.

> (4) Covered Services...The availability of these services to waiver program participants is subject to approval by the Medicaid office and is subject to the availability of the services under the specific waiver program for which a recipient has been determined eligible...
> (6) Program Requirements...The following requirements are applicable to all HCB services waiver programs...
> (i) The Agency or its designee, will disenroll waiver program participants who:
> 1. Do not follow a recommended plan of care, as evidenced by: not keeping two consecutive appointments, or demonstrating multiple failures to avail themselves of offered services.
> 2. Demonstrate behavior that is disruptive, unruly, abusive, or uncooperative to the extent that their participation in the program seriously impairs the provider's ability to furnish services to the participant or other participants.
> Prior to disenrolling participants for the above reasons, the Agency or its designee must provide the participant at least one verbal and at least one written warning that the consequence of their actions, or inactions will be disenrollment from the program.
> (9) Home and Community-Based Services Waiver Programs. The following are authorized HCB services waivers:
> (10) Aged/Disabled Waiver
> (a) Program Summary. The aged/disabled waiver is a long-term care initiative providing HCB services to the aged and disabled as an alternative to institutional care....

The Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook sets forth the description and scope of homemaker services and suspension of services:

> Homemaker Services
> Description Homemaker services consist of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the person regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself or others in the home....
> Scope of Service Homemaker services include the following:
> - Meal planning and preparation.
> - Housekeeping—when the waiver recipient occupies only a portion of the residence, the homemaker must maintain this area only.
> - . Laundry—only the waiver recipient's laundry is the responsibility of the homemaker.

- . Clothing Repair—repair is restricted to the waiver recipient's clothing.
- . Minor home repair such as changing light bulbs or tightening screws on a loose rail.
- . Shopping assistance—this assistance is limited to the waiver recipient's needs.
- . Reporting changes in the recipient's condition to the case manager.
- . Following emergency procedures, when needed.
- . Other related duties as specified in the care plan.

Suspension of Services
Where the recipient does not cooperate with the approved plan of care or is abusive toward service providers, the case manager can suspend services. When either of these situations is present, the case manager will contact the recipient about the situation or behavior and possible consequences if the situation or behavior continues. These contacts must be documented in the case record. If this action does not result in improvement, the case manager will inform the recipient that a behavior management contract is necessary and the timeline involved. The recipient, the case manager and the case manager supervisor must sign the contract. If the executed behavior management contract does not result in improvement, the case manager can suspend services after giving the recipient ten days advance written notice, including fair hearing rights. If the recipient is suspended, the length of the suspension should be stipulated in the notice. Subsequent to the suspension period, if the recipient's behavior does not improve or a new behavioral condition as described above emerges and a second contract is negotiated with continued recipient noncompliance, the case manager may take action to terminate the recipient from the program. Documentation of the situation or behavior and corrective steps taken must appear in the case narrative. The recipient must be given a ten day written notification of the proposed termination and right to a fair hearing.

The case manager received termination of homemaker services from six providers. On June 17, 2008, the petitioner's homemaking services were suspended, as the petitioner did not have a provider. The petitioner was assigned a provider on June 23, 2008. The petitioner refused services. Based

upon the above cited authorities, the respondent's action to suspend the petitioner's homemaking services was within the rules of the Program.

II. As to the issue of increasing the petitioner's homemaker services.

The petitioner has not applied for any increase in hours for homemaker services. The petitioner was not specific as to the number of hours she was requesting to be increased to. The petitioner did not submit any evidence that demonstrated the medical necessity for an increase in homemaking services.

III. As to the issues of homemaking services be provided by Medicare and the amount paid by the providers to their employees.

The basis of hearings is set forth in the Florida Administrative Code at 65-2.056:

> The Hearing shall include consideration of:
> (1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.
> (2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.
> (3) The Hearing Officer shall determine whether the action by the agency was correct at the time the action was taken.

The petitioner is requesting that the homemaker services be provided by the State. The State Agency is contracting the provided services and therefore the homemaking is considered State services. Issues of homemaking services be provided by Medicare and the amount paid by the providers to their

employees are not appealable issues and are outside of the jurisdiction of this venue. The petitioner is referred to the Social Security Administration for her issues regarding Medicare benefits.

As to the petitioner's allegations of fraud, the respondent was instructed to report the petitioner's allegations to Adult Protective Services.

DECISION

This appeal is found as follows.

1. As to the issue of the suspension, the appeal is denied.

2. As to the issue of an increase in hours, the appeal is denied.

3. The hearing officer has no jurisdiction over Medicare or payment by providers.

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 19th day of August, 2008,

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
Sue McPhee, Area 6 Medicaid Field Manager

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

[redacted]

APPEAL NO. 08F-04052

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 August 13, 2008, at 9:59 a.m., at the :r, in Miami, Florida. The petitioner was present and represented himself at the hearing. The Agency was represented by Jeffrey Douglas, program administrator, from the Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Jody Winter, physical therapist and DME prior authorization specialist from the Agency For Health Care Administration. Jody Winter is located in Tallahassee, Florida. Blanca Alvarez was present as an interpreter.

ISSUE

At issue is the Agency's action to deny the petitioner's and his provider's request to pay for repair of his motorized wheelchair by the Agency based on: "Repair/replacement not covered in case of abuse/neglect..." The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient in Miami-Dade County Florida. He is over twenty one years of age. He receives services through State Plan Medicaid. The petitioner ambulates in a wheelchair that has been provided to him by Medicaid through AHCA. The petitioner's latest wheelchair was provided to the petitioner by AHCA in August 2005. It is an electric wheelchair.

2. Approximately in March 2008, the petitioner's wheelchair service provider sent a bill-requisition for repair of the petitioner's wheelchair to AHCA. AHCA denied this request and notified the petitioner in March 2008 that the request was denied based on "Repair/replacement not covered in case of abuse/neglect...", Respondent Exhibit 1.

3. In February 2008, AHCA had paid for the repair of the petitioner's wheelchair, Respondent Exhibit 4. The petitioner's wheelchair had repair work done on it four previous times and AHCA had paid for the repairs. The February 2008 repair was for the replacement of the dual motors on the wheelchair. This repair received a one year warranty by the wheelchair/motor manufacturer. In November 2006, the Agency sent the petitioner a notice of policy advising him that the Agency will not replace equipment that have been abused or neglected, Respondent Exhibit 2.

4. The March 2008 repair request was for the repair of the wheelchair's motors, Respondent Exhibit 5. The manufacturer's warranty service refused to pay for the repair; citing the refusal was based on what was described as the fault of the user by abuse or neglect of the wheelchair. The service provider had indicated, Respondent Exhibit 5, that the damage to the petitioner's wheelchair was due to the petitioner running over an unknown object: "...which broke and short circuited several electric components."

The petitioner explained that he was going to the bank on his wheelchair back in March 2008 and was riding it on the street. When trying to avoid a car, the wheelchair started to go in circles and it just shut off. It would not work after that time.

The Agency also submitted a copy of the Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook. The Agency noted that several reasons for the denial of the request could have been cited other than the denial reason noted above.

The petitioner provided a copy of a letter from the petitioner's treating physician, Petitioner Exhibit 1, in which the physician indicates that the petitioner is in need of an operating wheelchair. The Agency considered this information as not relevant to the petitioner's current situation.

CONCLUSIONS OF LAW

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.

(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

Fla. Admin. Code Rule section 59G-4.070 states in part:

(1) This rule applies to all durable medical equipment and supply providers enrolled in the Medicaid program.

(2) All durable medical equipment and supply providers enrolled in the Medicaid program must comply with the Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, April 1998, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, HCFA 1500 and EPSDT 221, incorporated by reference in Rule 59G-5.020, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

The Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, dated April 2001, page 2-8, states in part:

Service limits can be exceeded only by recipients under 21....
Medicaid requires that equipment be warranted by the provider or manufacturer for a minimum of one year. No replacement or repairs will be reimbursed for equipment within the first year of service.

The Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, dated April 2001, page 2-11, states in part:

Replacement equipment will not be reimbursed in cases of misuse, abuse, neglect, loss, or wrongful disposition of equipment.

As shown in the Findings of Fact, in March 2008, the Agency denied the petitioner's and his provider's request to pay for repair of his motorized wheelchair by the Agency based on: "Repair/replacement not covered in case of abuse/neglect..." The Agency indicated that according to the above noted handbook; the Agency could have also denied the petitioner's repair request, based on the Agency does not pay for a repair that should be paid for by the warranty service of the wheelchair's motors.

The petitioner argued that he did not abuse his wheelchair, as he has no other means of getting himself around other than his wheelchair. He argued that he was real careful with his wheelchair and did not run over anything. He explained that maybe the bus that picks him up from time to time may have caused the damage to his wheelchair.

The Agency argued that the warranty should have covered the repair of the wheelchair's motors as the motors were replaced two month previous to the damage. The Agency argued that along with the abuse or neglect denial reason; the Agency's rules do not allow for payment of repairs as per the Agency noted above Handbook. The Agency thus argued and reiterated that the Agency action is correct. The hearing officer agrees with the Agency's arguments.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer finds that the Agency's action in March 2008, that the request for the payment of repair of the petitioner's wheelchair was denied based on: "Repair/replacement not covered in case of abuse/neglect...", is correct.

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 25th day of August, 2008,

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
Rhea Grey, Acting Prog. Adm., Medicaid Area 11
Health Systems Development Administrator

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

[redacted]

APPEAL NO. 08F-03837

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 August 5, 2008, at 10:35 a.m., in Opa Locka, Florida. The petitioner was not present. She was represented by her mother, [redacted] Jeffrey Douglas, program operations administrator, Agency for Health Care Administration (AHCA), represented the respondent. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Robert Buzzeo, M.D., consulting physician, and Gary Erickson, register nurse, KePRO. Carlos Rodriguez interpreted for the petitioner.

ISSUE

At issue is the respondent's action of May 8, 2008, to deny the petitioner 408 hours of private duty nursing (PDN) services of 3,984 requested for the certification period March 15, 2008 to September 10, 2008. The petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner is a six year old recipient of Medicaid benefits. The petitioner's care is medically complex and she was receiving PDN.

2. Prior to review under challenge, the petitioner received 4,320 hours of PDN services. On April 11, 2008, [redacted], as the provider, submitted a request on behalf of the petitioner for 3,984 hours of private duty nursing for the period of March 15, 2008 through September 10, 2008.

3. Based on the information provided, KePRO approved 3,576 hours of private duty nursing and denied 408 hours.

4. Reconsideration occurred on May 18, 2008, and the original decision was upheld. Denial Letters were issued to the petitioner.

5. The petitioner disagreed with this decision and a hearing was requested on June 3, 2008.

6. The evidence shows KePRO denied 480 hours of private duty nursing because the provider stated that the petitioner's mother refused to care for her child arguing that she suffers post traumatic stress disorder and was taking care of a one year old baby.

7. Dr. Buzzeo explained that the provider did not submit verification by the primary caregiver's physician that she had post traumatic stress or that she was under psychiatric care. Therefore, KePRO made their decision based on the limited information given to them by the provider.

8. Dr. Buzzeo asserted that they were willing to reconsider their decision if the petitioner's mother is able to produce proof that she is receiving psychiatric therapy and that she has been diagnosed with post traumatic stress syndrome.

9. At the hearing the petitioner submitted new documentation that shows she was diagnosed with Dysthymic Disorder and was receiving psychiatric treatment. (Petitioner Composite Exhibit 1)

10. Based on the new information, the respondent reversed their decision and agreed to grant the additional PDN hours that had been requested.

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 Florida Statute, Chapter 120.80.

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

The Home Health Services Coverage and Limitations Handbook (July 2007), page 2-17 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.
>
> *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.

Fla. Admin. Code 65-2.056, **Basis for Hearings**, states in part:

> (3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision.

Due to material evidence submitted by the petitioner at the hearing, the respondent agreed to rescind the denial notice and to approve additional hours of nursing services for the period of March15, 2008 to September 10, 2008. Therefore, the respondent's action to deny the petitioner 408 hours of private duty nursing services is reversed.

DECISION

The 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 19th day of August, 2008,

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
Rhea Grey, Acting Prog. Adm., Medicaid Area 11
Mary Wheeler
Sharon Lang
Karen Kinser, Nursing Consultant

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

[redacted]

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 03 Alachua
UNIT: AHCA

RESPONDENT.

_____/

APPEAL NO. 08F-03455

CASE NO. 352-316-1593

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 10, 2008, at 4:00 p.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was his mother, [redacted] and his stepfather, [redacted]. Present as a witness for the petitioner was [redacted], registered nurse, [redacted]. The respondent was represented by Kelly Loveall, RN with the Agency For Health Care Administration. Testifying by telephone on behalf of the respondent were Dr. Rakesh Mittal, medical reviewer, Keystone Peer Review Organization (KePRO), and Gary Erickson, RN, fair hearing specialist, KePRO.

ISSUE

The petitioner is appealing the respondent's action to deny his request for 24 hour per day, seven days per week, of private duty nursing services under Medicaid as not Medically Necessary.

The petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner was receiving private duty nursing services of 22 hours per day seven days per week. The nursing services were being provided from 7:00 a.m. until 7:00 p.m. and from 9:00 p.m. until 7:00 a.m.

2 Keystone Peer Review Organization (KePRO) is the Peer Review Organization (PRO) contracted by the Agency for Health Care Administration to perform medical review for the private duty nursing and personal care Prior Authorization Program for Medicaid recipients in the State of Florida.

3. A prior authorization review was completed by KePRO. On April 24, 2008, the KePRO denied nursing services on Sunday from 7:00 a.m. to 7:00 p.m. and reduced the number of hours in the evening from 9:00 p.m. until 7:00 a.m. to 11:00 p.m. until 7:00 a.m. The reduction was based on information received by KePRO that the petitioner's mother did not work on Sundays.

4. The petitioner requested a reconsideration because she was working seven days per week including Sundays. On May 10, 2008, a reconsideration review was completed by KePRO. On reconsideration, KePRO approved 22 hours per day of nursing services Monday through Sunday. The hours of nursing services that were denied were from 9:00 p.m. to 11:00 p.m., two hours per day, seven days per week.

The two hours per day were denied because the petitioner's mother and stepfather were at home during those two hours and could care for the petitioner during those two hours.

5. The petitioner's mother is employed as a companion, assisted living coach and behavioral specialist. She works seven days per week and at times is on call when not at work. She leaves for work at about 5:30 a.m. and returns late in the evening. At least four days a week she is at home between 9:00 p.m. and 11:00 p.m.

6. The petitioner's stepfather delivers newspapers. He works seven days per week and his work hours vary during the week. However, he is at home with the petitioner between 9:00 p.m. and 11:00 p.m. seven days per week.

7. The petitioner is 20 years old. He has been diagnosed with Downs Syndrome, apnea, tracheostomy and autism. He requires skilled services of a private duty nurse for medication administration, to perform wound care, to perform bowel program, aspiration precautions and tracheostomy care. The petitioner has dyspnea on exertion and requires intermittent oxygen therapy, nasopharyngeal suctioning, oxygen saturation monitoring and nebulizer treatments. The petitioner requires constant supervision and cannot be left at home alone.

8. The petitioner's mother can care for the petitioner when she is at home between 9:00 p.m. and 11:00 p.m. when nursing services are not being provided. The petitioner's stepfather believes that he would not be able to care for the petitioner between 9:00 p.m. and 11:00 p.m. when nursing services are not being provided.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.9132(d) states in part:

Medical necessity or 'medically necessary means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided."

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.

(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 Florida Medicaid Home Health Services Coverage and Limitations Handbook defines the guidelines for private duty nursing services as follows at page 2-17:

> 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...

The above authorities require that private duty nursing services must be documented as medically necessary to be covered under Medicaid. 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.

The petitioner's mother is at home with the petitioner between 9:00 p.m. and 11:00 p.m. at least four days per week. While at home during the above hours she can provide the care that the petitioner requires. The petitioner's stepfather is at home with the petitioner during the above hours seven days per week. The evidence presented did not establish that the care required by the petitioner was so complex that the stepfather could not care for him during the two hours per day when the private duty nurse or the mother were not available. Based on the above, it is determined that

medical necessity for private duty nursing from 9:00 p.m. until 11:00 p.m., seven days per week, was not established and the petitioner failed to meet the burden of proof. Therefore, it is concluded that the respondent correctly denied the request for Medicaid to cover private duty nursing services from 9:00 p.m. until 11:00 p.m., seven days per week.

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 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 8th day of August, 2008, in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To: [redacted], Petitioner
Marilyn Schlott, Area 3 Medicaid Adm.

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 08F-03843

CASE NO. 1005884277

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 22, 2008, at 9:50 a.m., in Tampa, Florida. The petitioner was present. He was represented by his daughter, [redacted] [redacted] The proceedings were translated by Raymond Carrion, employee of the respondent. The respondent was represented by David Beaven, program analyst. Present, as witnesses for the respondent from was Diane Pobst, senior human service program specialist. Present telephonically were, Marina Zamora, senior social worker with Department of Aging Services, Robin Green, senior CARES assessor with Department of Elder Affairs, and Nestor Bardales, CARES assessor with Department of Elder Affairs.

The record was left open for ten days for additional evidence from the respondent. Any addition evidence was due no later than August 1, 2008. On

July 28, 2008, the hearing officer received a facsimile from the respondent that was entered into record as Respondent Exhibit 4. The record was closed on August 4, 2008.

ISSUE

The petitioner is appealing the notice of May 21, 2008 from the Department of Aging Services to terminate homemaking services and case management. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is 81 years old. The petitioner language is Spanish. The petitioner's impairments are diabetes, heart condition, severe hernia, prostate issues, and hypertension. The petitioner had open heart surgery on February 2, 2002. The petitioner was referred for homemaking services on July 25, 2002. The petitioner had been receiving two hours per week of homemaking services through the Home and Community Based Services Aged/Disabled Adult Services Waiver. The homemaking services could include laundry, cleaning bathroom, mopping, sweeping and keeping the environment clean. The case management services were provided by the Hillsborough County Department of Aging Services.

The petitioner lives with his wife. The petitioner's wife is 64 years old. She has had a stroke, is paralyzed and has great difficulty walking.

2. As the petitioner's term of service was about to expire, the social worker completed an assessment on March 5, 2008. A copy of her assessment was submitted into record. She indicated that the petitioner did not need any

help with functional conditions or Activities of Daily Living. Regarding Instrumental Activities of Daily Living (IADL's), the petitioner is unable to perform heavy chores and needs some help with housekeeping and preparing meals. He did not need help with medication. For nutritional status, the social worker indicated that the petitioner was able to shop, cook and eat meals. The petitioner was not at risk of nursing home placement. It was the opinion of the social worker that the petitioner needed homemaking services for safety purpose to keep his home clean and neat. The social worker forwarded the petitioner's information to the CARES Unit for a Level of Care determination.

3. For cases involving Aged/Disabled Adult Services Waiver services, the CARES Unit makes the determination as to whether or not an applicant or recipient meets a nursing home level of care. The CARES assessor visited the home of the petitioner on March 24, 2008. The assessor attested that he did not have any information regarding the petitioner's wife. The assessor indicated that the petitioner's overall health was good in the past year and the petitioner did not need assistance with activities of daily living. The assessor opined that the petitioner no longer meet a Level of Care. The assessor reviewed his determination a nurse and a physician with Department of Elder Affairs.

The assessor's supervisor concurred with the determination of the assessor. The CARES supervisor's opinion was based on the information provided by the social worker and the home visit. The CARES' review was solely for services for the petitioner. They did not consider the petitioner's wife in their assessment of the petitioner's Level of Care. The CARES Unit indicated that the

petitioner may be in need of homemaking services; however, the petitioner did not meet the criteria for services under the Aged/Disabled Adult Services Waiver.

4. The petitioner's daughter opined that the petitioner needs assistance with homemaking. She attested that the petitioner is unable to clean the home due to his heart condition, hernia, weakness and caring for his wife. Her mother is unable to clean the house.

5. The petitioner does not require assistance with his activities of daily living. The petitioner is able to drive his car. The petitioner does not know how to cook, but he can warm-up food items. The petitioner attested that he needs an additional hour as two hours a week is not enough time for the homemaker to clean two bathrooms. The petitioner has not made request to the respondent for three hours of homemaking submitted.

6. The social worker attempted to obtain homemaking services for the petitioner through the county. The county had no funds to provide homemaking services.

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 original application for services was for the petitioner. Therefore, the service is based on the petitioner meeting the criteria. The petitioner's impairments interfere with his ability to clean his home. All parties agree that the

petitioner would benefit from homemaking services. What is at issue is whether or not the petitioner met the criteria to receive homemaking services under the Aged/Disabled Adult Services Waiver. As this is a de novo hearing, the hearing officer will make the decision based on the evidence submitted at the hearing.

The Code of Federal Regulation gives the basis for home and community based services in 42 C.F.R. § 441.300:

> Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization.

Florida Administrative Code 59.G-8.200, "Home and Community-Based Services Waivers", states the purpose of the waiver:

> (1)Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting...

The criteria for eligibility nursing home services are set forth in the Florida Administrative Code at Fl. Admin. Code 65A-1.711 and states for the medical need:

> (2)(b) Determined to be in medical need of institutional care services according to Rules 59G-4.180 and 59G-4.290...

The criteria for Intermediate Care Services and Skills Services is defined in the Florida Administrative Code at Fl. Admin. Code 59G-4.00:

> 59G-4.180 Intermediate Care Services.

(1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitation services to qualify as intermediate care services and clarifies the criteria that must be met in order for such services to qualify as an intermediate level I or intermediate level II service under Medicaid...
(3) Intermediate Services criteria.
(a) To be classified as requiring intermediate care services, level I or level II in the community or in a nursing facility, the applicant or recipient must require the type of medical, nursing or rehabilitation services specified in this subsection...
(e) To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services including 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital or that meets the criteria for skilled services...

59G-4.290 Skilled Services.
(1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitative services to qualify as skilled services under Medicaid...
(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.
(10) To qualify for placement in a nursing facility, the applicant or recipient must require 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital.

The Florida Administrative Code at 59G-1.010 sets forth the conditions under which services are furnished:

(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 Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook (page 2-3) states "Who Can Receive Services":

> In addition to being Medicaid eligible, individuals receiving A/DA waiver services must meet the following criteria:
> - Be 60 years or older...
> - Have an appropriate nursing facility level of care determination: and
> - Be enrolled in the A/DA Waiver Program...

The evidence does not support that the petition is in current need of rehabilitative services, skilled nursing care or requires 24 hour medical supervision. The petitioner's current medical condition does not meet the nursing home level of care. No evidence was presented that the petitioner would be at risk of institutionalization if the homemaker services were discontinued. The evidence indicates that the petitioner's impairments do not result in the petitioner being substantially impaired in performing any activity of daily living. The petitioner does not know how to cook, but he can warm up meals. The evidence did not demonstrate that the petitioner is at risk of abuse, exploitation or neglect. The criteria did not include an exception as to the applicant caring for a household member. The petitioner no longer meets the criteria for Aged/Disabled Adult Waiver services. Based upon the above cited authorities,

the respondent's action to terminate homemaking services was within the rules and regulations of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 11th day of August, 2008, 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:
Sue McPhee, Area 6 Medicaid Field Manager
Marisol Abrego, representative for the petitioner

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 07 Brevard
UNIT: 88981

RESPONDENT.
_____/

APPEAL NO. 08F-03672

CASE NO. 1275201199

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on July 10, 2008, at 12:00 p.m., in Cocoa, Florida. The petitioner was not present. His son, [redacted], represented him. Bobbie Van Cott, ACCESS supervisor, represented the Department.

The record was left open for the petitioner to have the opportunity to submit additional evidence. It was received timely, entered into evidence as the Petitioner's Exhibit 1, and the record was closed.

ISSUE

At issue is the amount of the petitioner's patient responsibility. The petitioner is seeking a reduction in the amount of his patient responsibility by the amount of court ordered alimony and health insurance premiums he is required to pay from his divorce decree. The petitioner holds the burden of proof.

FINDINGS OF FACT

1. On March 27, 2008, an application requesting Institutional Care Program and Medicaid (ICP) benefits was submitted to the Department on the petitioner's behalf. His marital status is divorced. His income is from Social Security and two additional pensions.

2. To determine the ICP patient responsibility, the Department considered the petitioner's income of $669 for Social Security, $1266 for the United States Office of Personnel Management, and $1751 from a military retirement. His total gross income is $3686. A $35 personal needs allowance and $113.17 for medical insurance was subtracted form the gross income, leaving a patient responsibility of $3537.83 (Respondent's Exhibit 2). No other deductions were allowed.

3. The petitioner's representative believes the patient responsibility should be reduced by the amount of the court ordered payments his father has to pay each month. His divorce decree states he must pay $350 a month in alimony, and maintain insurance through his Navy retirement Survivor Benefit Plan (Petitioner's Exhibit 1).

4. The petitioner's son challenges the validity of the Department's position that these payments cannot be deducted to reduce the patient responsibility. He does not understand how the Department's policy can override a court document. He does not dispute the gross income used in the calculation of the patient responsibility; he disputes not using the net amount. His father's patient responsibility is more than the money he actually receives each month.

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.701 defines patient responsibility as:

> (23) Patient Responsibility: That portion of an individual's monthly income which the department determines must be considered as available to pay for the individual's institutional care, ALW/HCBS or Hospice care.

Florida Administrative Code 65A-1.7141 SSI-Related Medicaid Post Eligibility Treatment of Income, defines allowable deductions from income to determine patient responsibility and states:

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income.
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance...
> (g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.

Florida Administrative Code 65A-713, SSI-Related Medicaid Income Eligibility Criteria, states in relevant part:

> (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income...

20 C.F.R. §416.1123, How we count unearned income, states in relevant part:

> (a)(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligaton, *{sic}* or to make any other payment such as payment of your Medicare premiums.

The Department's Integrated Public Assistance Policy Manual, 165-22, at passage 1840.0102, Deductions from Gross Income states:

> Some deductions withheld from gross income must be included as income. Examples of these deductions include:
> 1. premiums for Supplemental Medical Insurance (SMI/Medicare) from a Title II (Social Security) benefit,
> 2. premiums for health insurance or hospitalization,
> 3. premiums for life insurance,
> 4. federal and state income taxes,
> 5. Social Security taxes,
> 6. optional deductions,
> 7. a garnished or seized payment,
> 8. guardianship fees, and
> 9. child support if redirected irrevocably from the source.

And at passage 1840.0705 Alimony (MSSI, SFP) of the same reference, it states:

> Alimony is court ordered payment by a spouse or former spouse to an individual. An individual's countable income cannot be reduced because the court has ordered part of that income to be paid to a spouse. Court ordered support received by the spouse is unearned income. This applies even if the individual is institutionalized.

The above cited rules allow for specific deductions from income to determine the patient responsibility in the ICP Program. The petitioner is divorced and court ordered to pay alimony and insurance premiums for his ex-wife. No provision could be found to allow alimony as a deduction in determining ICP patient responsibility. The above federal regulation directs that income will be counted even if it is more than the individual actually receives due to paying a debt or other legal obligation. A personal needs allowance and actual amounts of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, are the only allowable deductions found in the above authorities for a single individual in the

petitioner's situation. The Department allowed both a personal needs allowance and the petitioner's insurance premium when determining his patient responsibility.

After a review of the Department's policies and the controlling authorities, the hearing officer finds the Department correctly determined the petitioner's patient responsibility when determining his eligibility for ICP benefits.

DECISION

The appeal is denied. 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 15th day of August, 2008, in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To: [redacted] Petitioner
District 7 ACCESS Cassandra Johnson
[redacted]

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

[redacted]

APPEAL NO. 08F-03997

PETITIONER,

Vs.

CASE NO. 1271469511

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 07 Osceola
UNIT: 66292

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on July 18, 2008, at 2:35 p.m., in Kissimmee, Florida. The petitioner was not present but was represented by her daughter, [redacted] also testified. The respondent was represented by Reggie Schofield, DCF supervisor.

ISSUE

At issue is the respondent action of April 30, 2008 to deny Institutional Care Program (ICP) Medicaid benefits for the months July 2007 through December 2007 based on excess counted income. Specifically, the respondent asserts that an income trust established in October 2007 was not sufficiently funded until January 2008 to permit ICP eligibility.

FINDINGS OF FACT

1. The petitioner has been a resident of the [redacted] nursing facility since at least July 2007. There is no community spouse.
2. On October 3, 2007, the petitioner's daughter and power of attorney, [redacted] applied for ICP benefits for the petitioner. The petitioner receives $1,197 monthly Social Security, and two pension checks that total $985.04. The petitioner has total income of $2,182.04 monthly. The respondent became aware of the amount of SSA income in October 2007. The respondent became aware of the pension income amount after verification was received in November 2007.
3. On October 5, 2007, the petitioner executed an income trust. On October 15, 2007, the petitioner deposited $25.00 in the income trust account.
4. On October 8, 2007, the respondent sent the petitioner a verification list of needed verification. This list included a request for a copy of a bank account activity statement or bank receipt that the irrevocable income trust had been funded. This written request did not advise of the amount needed to fund the trust.
5. The trust was submitted to the district legal office and approved on January 8, 2008. However, the bank account showed that the trust had only been funded with $25. The [redacted] contacted the respondent and requested information on the status of the application. On January 10, 2008, an email reply was given to

[redacted] that the application had been denied. However, there was no written notice of the denial.

6. After conversation with nursing home staff on January 11, 2008, the petitioner's representative deposited $2,930.57 into the trust account.
7. On April 30, 2008, the respondent approved the petitioner for ICP benefits for the months of January 2008 and ongoing. The respondent denied ICP for July 2007 to September 2007 due to excess income. The respondent denied ICP for October 2007 to December 2007 because the income trust account was not funded in a sufficient amount to create ICP eligibility. The petitioner seeks ICP eligibility to include the months of July 2007 to December 2007.
8. The respondent processed the application without an interview. The respondent testified that interviews are not done for an ICP application. The only communication from the respondent to the petitioner occurred in writing. The respondent further believed that there was no obligation to provide information regarding the ICP program unless the petitioner requested that information.

CONCLUSIONS OF LAW

The Florida Administrative Code (F.A.C.) 65A-1.713 **SSI-Related Medicaid Income Eligibility Criteria** states in part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.

F.A.C. 65A-1.702 **Special Provisions** states in part:

(15) Trusts.

(a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

The Respondent's interpretive FLORIDA Integrated Public Assistance Policy Manual, passage 1840.0110 Income Trusts (MSSI) states:

The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

it is established on or after 10/01/93 for the benefit of the individual;

it is irrevocable;

it is composed only of the individual's income (Social Security, pensions, or other income sources); and

the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The above-cited F.A.C. rule shows that countable income may not exceed 300% of the federal benefit rate to be eligible for ICP benefits. This amount is

interpreted as $1,869 per Attachment 8 of the respondent's interpretive manual, for the months in question. Findings show that the petitioner's total $2,182.04 income exceeded this amount for ICP eligibility.

F.A.C. Rule 65A-1.713 permits the establishment of a qualified income trust to potentially create ICP eligibility by reducing countable income to an amount below the income standard. A qualified income trust was established by the petitioner's representative in October 2007. However, an ICP applicant must also fund the trust account by an amount sufficient to reduce countable income below the income standard. Sufficient trust funding did not occur until January 2008, to reduce income below the $1,869 income limit.

A decision by the Fourth District Court of Appeal (DCA) (**Forman v. DCF**, 956 So.2d 477 (2007)) is similar to this appeal and addresses the respondent's requirement to advise ICP applicants, in part as follows:

> where, as here, a caseworker is presented with specific and revealing information regarding the applicant's eligibility for benefits, that caseworker has an affirmative duty under 45 CFR 206.10(a)(2)(i) to inform that applicant at least orally of the conditions relevant to her eligibility.

The respondent received verification of all the petitioner's income sources by November 2007. This income information is specific enough to reveal the need to establish an income trust, and the amount needed to fund the trust below the income limit. Therefore, the respondent had an affirmative duty to advise the petitioner by at least November 2007 of the federal benefit rate to be eligible for

ICP benefits. With that information, the petitioner could determine the correct monthly amount to put in the trust account.

The Respondent ACCESS Customer Service Center defines ICP cases in need of an income trust as a case that requires an interview. The rationale for the policy is that these cases have a greater tendency to be error prone. Cases involving income trust are defined as having a greater chance to be error prone. While a face-to-face interview is not requirement, the respondent must conduct at least a directed interview (Access Customer Service Center Guide, page 7) The Guide further states that the interview should focus on areas that are likely to be error prone.

The Respondent's interpretive FLORIDA Integrated Public Assistance Policy Manual, passage 1840.0110 Income Trusts (MSSI) states:

> The eligibility specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received. (This may require the individual to begin funding an executed income trust account prior to its official approval by the District Legal Counsel.)

In accordance with this policy, the petitioner should have received a directed interview. During that interview the petitioner should have been informed of :

- the requirements of an income trust;
- the federal benefit rate to be eligible for ICP benefits;

- the need for the trust to be funded; and

- to fund the trust immediately and not wait for approval of the trust from the respondent.

While the respondent is not responsible for providing the amount the trust should be funded, it was necessary to advise that the trust should be funded as soon as possible and that eligibility would commence from the time the trust was executed and funded.

The petitioner fully funded the trust once informed of the requirement; therefore, it can be assumed that she would have fully funded the trust whenever she was informed of the requirement. Since the petitioner was not informed of the requirements of the income trust, the denial of ICP benefits beginning October must be reversed. The respondent is ordered to redetermine ICP eligibility on relevant factors other than income beginning in October 2007 and ongoing.

DECISION

The appeal is remanded and partially granted. The respondent is ordered to redetermine ICP eligibility for the months of October 2007 thru December 2007 on factors other than income. This appeal is partially denied in that the respondent is correct to deny ICP eligibility for the months of July 2007 through September 2007, due to excess income.

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 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 1st day of August, 2008,

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
District 7 ACCESS Cassandra Johnson
[redacted]

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

[redacted]

APPEAL NO. 08F-03456

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 June 27, 2008, at 8:30 a.m., in Fort Lauderdale, Florida. The hearing was rescheduled from June 19, 2008, at the petitioner's request. The petitioner was not present. She was represented by her mother [redacted]. The respondent was represented by Lorraine Wasserman, registered nurse specialist. Present on the telephone from Kepro was Dr. Ratish Mittel, and Gary Erickson, registered nurse reviewer.

ISSUE

At issue is the Agency's April 18, 2008 action of approving the petitioner's skilled home nursing services for 3,652 hours, and denying 256 hours for May 7, 2008 to November 2, 2008. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, da , is nine years old. She is a Medicaid benefits recipient in Broward County, Florida.

2. Included in the evidence is a copy of a Recipient Denial Letter, dated April 18, 2008, stating that 3,652 hours of skilled home nursing services were approved, and 256 hours were denied for the petitioner for May 7, 2008 to November 2, 2008.

3. Included in the evidence is copy of another Recipient Denial Letter dated May 1, 2008, stating the same information as the April 18, 2008 Recipient Denial Letter. Mr. Erickson explained that there was an address change for the petitioner, therefore another Recipient Denial Letter was sent to her with her correct address.

4. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld notice dated May 9, 2008. This notice informs the petitioner that upon reconsideration, the approval of 3,652 hours of skilled home nursing services, and the denial of 256 hours from May 7, 2008 to November 2, 2008, was upheld.

5. Included in the evidence is a copy of a Internal Focus Review Findings form from Kepro dated April 17, 2008, stating that the petitioner requested skilled home nursing services 24 hours daily on Saturdays, Sundays, and Mondays, and 20 hours daily from 7:00 a.m. to 5:00 p.m., and 9:00 p.m. to 7:00 a. m. on Tuesdays, Wednesdays, Thursdays, and Fridays.

6. Included in the evidence is a copy of a Synopsis Of Case form Kepro explaining the denial of skilled home nursing services for the petitioner for 5:00 p.m. to 9: p.m. on Mondays, and the denial of 9:00 a.m. to 12:00 noon on Saturdays and Sundays.

7. According to the Kepro Internal Focus Review Findings report, the petitioner was diagnosed with autosomal deletion syndrome, a lack of expected normal physiological development in childhood, other diseases of the lung, esophageal reflux, and a cleft palate with a cleft lip.

8. The parties agreed at the hearing to compromise on the number of nursing care hours for the petitioner. Mr. Erickson agreed to have the petitioner provided with a written notice informing her of the new approved and denied skilled home nursing hours.

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 Chapter 120.80 F.S. 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. Physicians at Kepro for the Agency, approved the petitioner for skilled home nursing services of 3,652 hours, and denied 256 hours for the time period of May 7, 2008 to November 2, 2008. The parties agreed at the hearing to compromise on the number of nursing care hours for the petitioner. The respondent agreed to have the petitioner provided with a written notice informing her of the new approved and denied skilled home nursing hours.

DECISION

The appeal is partially granted, as explained in the Conclusions Of Law. The respondent is ordered to provide the petitioner with a determination of the new hours of home skilled nursing care.

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 1st day of August, 2008,

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: [redacted] Petitioner
Rafael Copa, Area 10 Medicaid Adm.
Mary Wheeler
Karen Kinser, Nursing Consultant

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

[redacted]

APPEAL NO. 08F-03663

PETITIONER,

Vs.

CASE NO. 1132906709

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 June 19, 2008, at 2:30 p.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by [redacted], plenary guardian. Present from the [redacted] was [redacted] administrator, [redacted] business office manager, and [redacted] resident associate. The respondent was represented by Verma Jordan, Florida Access specialist.

ISSUE

At issue is the Department's May 1, 2008 action of not approving the petitioner's March 24, 2008 application for Institutional Care Program (ICP) Medicaid benefits for September 2007 through February 2008, because the value of her assets exceeded the program's eligibility limit. The petitioner has the burden of proof.

FINDINGS OF FACT

1. Included in the evidence is a copy of a Notice of Case Action form dated May 1, 2007, stating that the petitioner's March 24, 2008 application was approved for Institutional Care Program Medicaid benefits effective April 2008.

2. According to information from the parties at the hearing, the ICP application was actually approved effective March 2008.

3. The petitioner was admitted to the [redacted] in Fort Lauderdale, Florida, on April 9, 2007, and she resided there as of June 19, 2008.

4. Included in the evidence is a copy of the petitioner's Bank of America statement with an ending balance as of September 17, 2007, of $36,904.94. This includes a checking account with interest $4,281.90, a money market account $18,407.15, and a certificate of deposit account $14,215.89.

5. The balance of the petitioner's Bank of America accounts exceeded the Institutional Care Program Medicaid benefits $2,000.00 asset limit until March 2008, therefore the application was approved effective March 2008.

6. 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 ICP Medicaid benefits for the petitioner for September 2007 through February 2008, claiming that the funds in the bank accounts were not available.

7. The petitioner's representative submitted into evidence copies of court orders indicating that the petitioner's funds were restricted.

8. Subsequent to the hearing, the respondent's representative submitted into evidence information showing that the Department's attorney was consulted regarding the

petitioner's eligibility for the ICP Medicaid benefits. Included in this evidence is a copy of a statement from Terry Verduin, the Department's attorney, dated June 27, 2008. She states, "Consider them restricted to use for compensation of the guardian and grant eligibility for the period. They are restricted as of the date of the order, which covers a retroactive period. The Department must respect court orders."

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 ICP Medicaid benefits application was approved effective March 2008, because the value of her assets in her bank accounts exceeded the $2,000.00 asset limit prior to that month. The petitioner's representative was seeking the ICP Medicaid Program benefits for the petitioner for September 2007 through February 2008.

The petitioner's representative argued that the funds were restricted by court order, and were not available to the petitioner. The findings show that the Department's attorney agreed that the funds were restricted, and she advised the eligibility worker to approve the request for ICP Medicaid benefits for the retroactive period. The hearing officer agrees with this plan that the petitioner be approved for ICP Medicaid benefits for September 2007 through February 2008.

DECISION

The appeal is granted, and the Department is ordered to approve the petitioner for Institutional Care Program Medicaid benefits for September 2007 through February 2008.

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 7th day of August, 2008,

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: [redacted] Petitioner
10 DPOES: Lisa Henson