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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-06648

PETITIONER,

Vs.

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 31, 2008, at 10:39 a.m., in St. Petersburg, Florida. The petitioner was present. The petitioner was represented by his mother. The respondent was represented by Stephanie Lange, registered nurse specialist. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Rakesh Mittal, M.D. physician reviewer, and Edna Clifton, operations manager.

ISSUE

The petitioner is appealing the notices of September 22, 2008 and October 3, 2008 for the respondent's action to decrease private duty nursing from ten hours per day to eight hours per day for the period of September 8, 2008 through March 6, 2008. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Denial Letter on September 22, 2008. The notice informed the petitioner that for the requested 1,800 hours of private duty nursing for the period of September 8, 2008 through March 6, 2009, 1,440 hours were approved and 360 hours were denied. This reduced the private duty nursing from ten hours a day to eight hours a day for the September 8, 2008 through March 6, 2009 period.

1. The petitioner is one year old. The petitioner's care is medically complex. The petitioner is total care and dependent on a caregiver for all needs. The petitioner is considered medically fragile. The petitioner was receiving private duty nursing private duty nursing ten hours a day for the period that ended September 7, 2008 having been reduced from twelve hours a day. The petitioner lives with his mother and father. The petitioner has no sibling. The father regularly works twelve hours a day Monday though Friday. Once a month, he works an additional twelve hours on Friday and Saturday. Occasionally he works out of town, as he is on call for electrical emergencies. The mother does not work. The mother is the primary caregiver.

2. The nursing agency requested 1,800 hours of private duty nursing for the petitioner for the period of September 8, 2008 through March 6, 2009. This request would be ten hours a day of private duty nursing.

3. Prior authorization for private duty nursing is reviewed every 180 days. KePRO is the contract provider for the respondent for the prior authorization decisions for private duty nursing. The request for private duty nursing is

reviewed by a nurse reviewer and a physician consultant. The KePRO screened the petitioner's request for private duty nursing using the Internal Focus Finding. The Internal Focus Finding provides information to KePRO of case identifiers and additional information regarding the petitioner. This information is generated to the computer for review by KePRO from the information entered by the petitioner's home health agency via computer. The request was then referred to the board certified pediatric specialty physician reviewer consultant.

4. The initial physician reviewer determined that it was medically necessary for the petitioner to have eight hours of private duty nursing. That determination was based on the provider request, caregiver ability and caregiver availability. A PDN/PC Recipient Denial Letter was sent to the petitioner on September 22, 2008. The notice informed the petitioner that for the requested 1,800 hours of private duty nursing for the period of September 8, 2008 through March 6, 2009, 1,440 hours were approved and 360 hours were denied.

5. The home health care agency on behalf of the petitioner requested a reconsideration of the 360 hours that were denied. The reconsideration was reviewed by a second nurse reviewer and a second physician consultant. The reconsideration was denied. A PDN/PC Recipient Reconsideration - Denial Upheld notice was sent to the petitioner on October 3, 2008.

6. The petitioner's mother has significant depression. Because of that depression, she requires a time for herself before she gets ready and goes to bed after caring for the petitioner all day. The petitioner is seeing over eleven specialists and has therapy appointments three times week. The mother opined

that this was a lot of driving. The mother drives the petitioner to all of his appointments. He requires as needed suction, which is difficult when the mother is alone and driving. Therefore, she must leave hours before an appointment, so she can stop often. If the petitioner only receives eight hours a day of private duty nursing, she opined she would not get enough sleep, as she would not get 8 hours of sleep. If she is sleep deprived, mother is concerned that a reduction of hours would adversely affect the petitioner as she would not be as able to provide care for the petitioner for 16 hours a day. The mother needs to give information to the nurse coming on duty from 9:00 p.m. to 10:00 p.m. If the nurse has never been there before sometimes it takes an hour and a half. If the petitioner's private duty nursing is reduced, the time she spends with the nurses would take from the hours she has to sleep.

7. The petitioner's impairments are tracheal stenosis, epilepsy, reflux, oral dysphagia, cardiac problems, hydrocephalus and hypertension. He needs his medication administered through the day. He requires tube feedings and tracheostomy care. He needs to be monitored for aspiration, blood pressure and seizure. The petitioner remains a very high risk for aspiration. The seizure disorder is a new diagnosis after the petitioner had an hour long seizure in June 2008. The petitioner has not had a recent seizure, but requires seizure precautions maintained at all times. In addition to his impairments and care, the petitioner has apnea. In September 2008, the petitioner needed to be shocked five times to breathe. In October 2008, the petitioner needed to be shocked four times to breathe. Occasionally, the petitioner pulled out the lead. The petitioner

requires intermittent oxygen therapy, nebulizer treatments, chest physiotherapy, dynamap blood pressure machine, apnea monitoring and tracheostomy care. The petitioner is high risk for frequent and unpredictable changes in his medical status.

CONCLUSIONS OF LAW

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

Florida Administrative Code 59.G-1.010, "Definitions", states for medical necessity:

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

The Home Health Services Coverage and Limitation Handbook under Private Duty Nursing, on page 2-15 "Parental Responsibility", states:

> 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 Home Health Services Coverage and Limitation Handbook under Private Duty Nursing, on page 2-18 "Authorization Process" states:

> Private duty nursing services are authorized by the Medicaid peer review organization if the services are determined to be medically necessary.
> Private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child's condition improves.

The medical opinion of the physician reviewers for the period of September 8, 2008 through March 6, 2009 was that medical necessity was demonstrated for eight hours. The hearing officer must consider the weight of expert testimony. No expert testimony was offered to rebut the medical opinion that eight hours of private duty nursing was medically necessary. The hearing officer concludes that medical necessity has been demonstrated for private duty nursing for the petitioner for eight hours a day.

The hearing officer notes that the mother attested that she has a need for additional assistance during the day especially when she is driving the petitioner to appointments. The mother is referred to her son's home health provider to request from the respondent any additional less costly assistance that the petitioner may be potentially eligible as set forth in the Home Health Services Coverage and Limitations Handbook.

DECISION

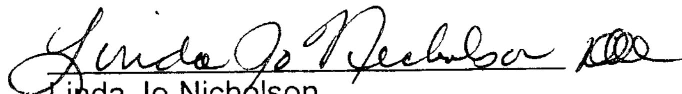
This appeal is denied.

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 23rd day of December, 2008,

in Tallahassee, Florida.



Linda Jo Nicholson
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Copies Furnished To: Petitioner
Noreen Hemmen, Area 5 Medicaid Adm.

FILED
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OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-04426

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 St. Johns
UNIT: AHCA

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened telephonically before the undersigned hearing officer on November 7, 2008, at 1:50 p.m. The petitioner was represented by consulting psychologist for the appeared as a witness for the petitioner. The respondent was represented by Karen Dexter, assistant general counsel with the Agency for Health Care Administration (AHCA). Margaret Dorceus, medical health care program analyst with AHCA; Debra Nussbaum, director of clinical services with Magellan Health Care of Florida, Inc. (Magellan); and Dr. Alan Lipton, M. D. and medical director for Magellan of Florida appeared as witnesses for the respondent. Kaleema Muhammad, prepaid mental health plan coordinator with AHCA and Stephanie Dovsky, senior account executive with Magellan observed.

The record was held open for both parties to submit proposed orders. Proposed orders were received from the respondent; not from the petitioner.

ISSUE

The petitioner is appealing termination of psychosocial rehabilitation services under Medicaid. The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 34 year old male diagnosed with Impulse Control Disorder not otherwise specified (NOS) and Mild Mental Retardation. The Impulse Control Disorder is the principal diagnosis for which petitioner has been receiving psychosocial rehabilitation services at the through the Medicaid Prepaid Mental Health Program (PMHP) since at least January 2007. In addition to psychosocial rehabilitation, the petitioner also receives day treatment, individual therapy, group therapy and medication management services. The petitioner lives in a group home in Saint Augustine, Florida.

2. Psychosocial rehabilitation services are intensive, short term, outpatient rehabilitative services. The purpose of these services is to restore functioning skills lost due to mental illness. To qualify for coverage under the PMHP, the psychosocial rehabilitation services must be medically necessary. Medical necessity is determined by a prior authorization review. Magellan is a specialized managed care organization contracted by AHCA to perform prior authorization reviews for psychosocial rehabilitation services.

3. On June 11, 2008, the submitted an authorization request for continued psychosocial rehabilitation services for the petitioner to Magellan.

The request was reviewed by a Magellan clinician who concluded the medical necessity criteria were not met. The clinician consulted with psychiatrist Dr. Michael Bojkovic (only a psychiatrist can make a non-authorization decision); Dr. Bojokovic is a contracted consultant with Magellan. He concurred with the clinician's assessment and assumed responsibility for completing the petitioner's authorization review. After reviewing the medical records submitted by the and discussing the case with one of the center's clinician's, Dr. Bojokovic concluded that the petitioner's psychiatric condition was stable and that the petitioner would not benefit from further treatment thus rendering psychosocial rehabilitation services no longer medically necessary. On June 18, 2008, a non-authorization (termination) notice was sent to the petitioner terminating psychosocial rehabilitation services under Medicaid, effective June 30, 2008. A hearing was requested by the petitioner's representative on June 30, 2008; the psychosocial rehabilitation services have been continued pending the hearing decision.

4. Dr. Alan Lipton appeared telephonically as a witness for the respondent. He is the medical director for Magellan of Florida and reviews all non-authorization decisions which are appealed. Dr. Lipton concurs with the non-authorization decision reached by the reviewing physician. In opposition to the clinical diagnosis, it is Dr. Lipton's opinion that the petitioner's mental retardation is the principal impairment; not the petitioner's mental illness. His opinion is based on a review of the petitioner's clinical records provided by the Dr. Lipton believes all the presenting symptoms (social distance, physical aggression and anger management) recorded in the petitioner's clinical file can be attributed to his mild mental retardation.

Dr. Lipton argued that the petitioner's unsuitability for psychosocial rehabilitation services is evidenced by the length of time (twenty-two months as of the date of the hearing) he has received the services and by the petitioner's lack of consistent, sustained progress. He referenced specifically the petitioner's unchanged Global Assessment of Functioning (GAF) score of 36 as an example of the petitioner not benefiting from the psychosocial rehabilitation services which have been ongoing for almost two years. The Global Assessment of Functioning is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. Dr. Lipton explained that in layman's terms a score of 36 is equivalent to the cognitive functioning of a 6th grader (a pre-teen child approximately age 12). Dr. Lipton believes the petitioner lacks the cognitive skills necessary to ever achieve the ultimate goal of psychosocial rehabilitation services; to live independently, without daily support of any kind. Dr. Lipton believes the petitioner's presenting symptoms would be more appropriately served in a program designed for the developmentally disabled.

6. [redacted] appeared telephonically as a witness for the petitioner. [redacted] is a consulting psychologist who works with the treating clinicians at the [redacted] In her capacity as a consultant, she provides oversight services such as assisting clinicians with assessing the progress of patient treatment plans. In her position, [redacted] has the opportunity to observe the petitioner daily Monday through Friday during working hours. Based on her observations and review of the petitioner's clinical records, [redacted] believes that the petitioner is benefiting from psychosocial rehabilitation and that the clinical daily progress notes are corroborative

evidence. She believes that the petitioner makes progress, suffers a setback and then again makes progress, but overall, the petitioner is progressing. She admitted the petitioner's mental health has deteriorated recently due, in part, to losing his job. [redacted] dmitted that she does not provide psychosocial rehabilitation therapy at the [redacted] and has never treated the petitioner for his mental illness. [redacted] disagrees with Dr. Lipton's assertions that the petitioner will never be able to live independently. [redacted] does not believe independence requires living without any support system; she believes all human beings require some form of support regardless to their living environment. She believes independent living is accomplished by the individual living up to his maximum level of functioning. [redacted] admitted that the petitioner is not capable of living independently at this time, but that this is one of his goals and she believes with continued psychosocial rehabilitation the petitioner will accomplish this goal. [redacted] stipulated that psychosocial rehabilitation services are intended to be short term services only; she could not provide a date (exact or approximate) by which the services should or could be terminated for the petitioner.

7. The petitioner's treating psychiatrist at the [redacted] did not appear as a witness, however, the respondent's representative offered into evidence a prescription reportedly written by Dr. Ameil on July 21, 2008 prescribing psychosocial rehabilitation for the petitioner. No additional evidence was offered from the treating psychiatrist in regards to the petitioner's continued need for psychosocial rehabilitation services.

8. The petitioner's psychosocial rehabilitation progress is charted by, among other things, Master Treatment Plans, Treatment Plan Reviews, and the GAF scores.

The Master Treatment Plan is comprised of major goals and goal objectives created annually by the petitioner and the petitioner's treating clinicians. The goals are categorized by functioning skills lost due to the participant's mental illness. Treatment Plan Reviews are conducted quarterly to access the progress made in meeting the main goals and goal objectives of the Master Treatment Plan. At the time of the non-authorization decision in June 2008, the petitioner had not met the goals of his September 10, 2007 Master Treatment Plan and his GAF score remained unchanged at 36.

CONCLUSIONS OF LAW

Medical services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Florida Administrative Code Rule 59G-1.010(166)(a)(c) as follows:

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

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The Medicaid Handbook is incorporated by reference in Fla. Admin. Code 59G-4.050. The service exclusions section states in relevant part:

Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation.

Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

Fla. Admin. Code 65-2.056 (3) in parts states:

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.

Fla. Admin. Code 65-2.060 in parts states:

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 office

The agency terminated psychosocial rehabilitation services for the petitioner under Medicaid. The controlling legal authority cited above makes it clear that the burden of proof rests with the agency to prove the correctness of this action by a preponderance of the evidence. Evidence submitted by the respondent shows the

petitioner has been receiving psychosocial rehabilitation services since January 2007 without successfully meeting the goals of his Master Treatment Plan or improving his cognitive functioning level on the GAF assessment. The respondent argued that the after nearly two years of intensive psychosocial rehabilitation, it can not be reasonably expected that the petitioner will receive additional benefit from these services. It is the opinion of the respondent's expert witness, medical director, Dr. Lipton, that all of the petitioner's presenting symptoms could be attributed to his mental retardation. The petitioner's witness, [redacted] admitted that the petitioner's mental health has recently deteriorated. However, [redacted] believes the accomplishment of some of the goals of his treatment plan demonstrates that with continued rehabilitation services, the petitioner will someday achieve the goal living independently. The petitioner's treating psychiatrist did not testify during the hearing. As the only licensed psychiatrist to testify at the hearing was Dr Lipton, his expert medical opinion was given comparatively significant weight in the overall conclusions.

It is the respondent's opinion that the undersigned hearing officer is limited to consideration of evidence available at the time of the agency adverse action under appeal. However, the legal authority cited above makes it clear that the hearing is a de novo proceeding; either party may present new or additional evidence not previously considered by the agency in making its decision. The undersigned hearing officer considered all the evidence and testimony presented by both parties.

After carefully reviewing the testimony, evidence, and controlling legal authorities, the hearing officer finds that the respondent met its burden of proof by presenting evidence that established that it was not medically necessary for the

petitioner to continue to receive psychosocial rehabilitation services under Medicaid, because the services have not produced any significant or long term benefit.

DECISION

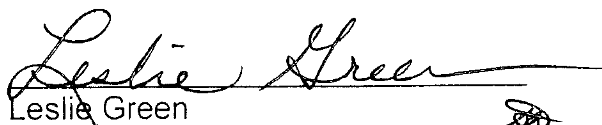
The appeal is denied. The agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 3rd day of December, 2008,

in Tallahassee, Florida.



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OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-5896

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 October 28, 2008, at 11:50 a.m., in Miami, Florida. The petitioner was present and represented herself. The respondent was represented by Phyllis Bentyl, program specialist with the Agency for Health Care Administration (AHCA). Telephonically present, as witnesses for the respondent was Dr. Stuart B. Chesky, medical director and Edna Clifton, operations manager, both with Keystone Peer Review Organization (KēPRO) South. Blanche Rodriguez served as translator. The hearing was previously scheduled for October 7, 2008, but was continued at the request of both parties.

ISSUE

At issue is the respondent's action of August 19, 2008, in denying skilled nurse visits twice a day and approving 14 skilled nurse (SN) visits for the certification period of

July 4, 2008 through September 1, 2008 (60 days). The respondent notes that 120 home health aide (HHA) visits were approved. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is sixty three years old and a Medicaid beneficiary in the state of Florida. The petitioner's diagnosis as reported to the respondent, "Diabetes Mellitus without mention of complication, Type II or Unspecified Type; Osteoarthrosis involving, or with mention of more than one site; Benign Essential Hypertension; Mixed Incontinence; Obstructive Chronic Bronchitis, with (acute) Exacerbation)." 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.
3. On July 31, 2008, the provider [redacted] requested 120 (twice daily) SN visits for the certification period. The provider submitted some medical information on the petitioner. However, more specific medical and social information was requested through the iexchange system which is KēPROs method of

communication with the provider. Additional information was received from the provider.

4. On August 7, 2008, the request was forwarded to a board certified family practice physician consultant for review. Based on the information (social and medical) provided 14 SN visits were approved for education and instruction in order to teach the petitioner to administer her insulin. The medical needs of the petitioner did not support the need for the level of care being requested. The physician consultant approved 120 HHA visits (twice daily) for 60 days.

5. On August 19, 2008, a notice of denial was issued to the petitioner and provider informing them of the denial. The petitioner appealed the decision on September 5, 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 petitioner explained that she now receives an injection twice a day and previously was receiving five a day. She states that the nurses are very good and since she has arthritis has not tried to inject herself.

The physician consultant recommended that she receive oral medications or use a pre-filled injection which requires no strength to do. The petitioner agreed to attempt to use the pre-filled injections and receive training.

The hearing officer finds that according to the above-mentioned rules and testimony received from both parties, the respondent's action to deny SN visits of twice a day and approve 14 SN visits was correct, as medical necessity was not demonstrated.

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 indecency 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 16th day of December, 2008, in Tallahassee, Florida.

A. G. Littman

A. G. Littman
Hearing Officer
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DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-04428

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 St. Johns
UNIT: AHCA

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened telephonically before the undersigned hearing officer on November 7, 2008, at 9:05 a.m. The petitioner was represented by consulting psychologist for appeared as a witness for the petitioner. The respondent was represented by Karen Dexter, assistant general counsel with the Agency for Health Care Administration (AHCA). Margaret Dorceus, medical health care program analyst with AHCA; Debra Nussbaum, director of clinical services with Magellan Health Care of Florida, Inc. (Magellan); and Dr. Alan Lipton, M. D. and medical director for Magellan of Florida appeared as witnesses for the respondent. Stephanie Dovsky, senior account executive with Magellan observed.

The record was held open for both parties to submit proposed orders. Proposed orders were received from the respondent; not from the petitioner.

ISSUE

The petitioner is appealing termination of psychosocial rehabilitation services under Medicaid. The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 32 year old female diagnosed with Psychotic Disorder not otherwise specified (NOS) and Moderate Mental Retardation. The Psychotic Disorder is the principal diagnosis for which petitioner has been receiving psychosocial rehabilitation services at the through the Medicaid Prepaid Mental Health Program (PMHP) since at least January 2007. In addition to psychosocial rehabilitation, the petitioner also receives day treatment, individual therapy, group therapy and medication management services. The petitioner lives at the Group Home which is located on the same grounds as the

2. Psychosocial rehabilitation services are intensive, short term, outpatient rehabilitative services. The purpose of these services is to restore functioning skills lost due to mental illness. To qualify for coverage under the PMHP, the psychosocial rehabilitation services must be medically necessary. Medical necessity is determined by a prior authorization review. Magellan is a specialized managed care organization contracted by AHCA to perform prior authorization reviews for psychosocial rehabilitation services.

3. On June 11, 2008, the center submitted an authorization request for continued psychosocial rehabilitation services for the petitioner to Magellan. The request was reviewed by a Magellan clinician who concluded the medical necessity criteria were not met. The clinician consulted with psychiatrist Dr. Michael Bojkovic

(only a psychiatrist can make a non-authorization decision); Dr. Bojokovic is a contracted consultant with Magellan. He concurred with the clinician's assessment and assumed responsibility for completing the petitioner's authorization review. After reviewing the medical records submitted by the [redacted] and discussing the case with one of the center's clinician's, Dr. Bojokovic concluded that the petitioner's psychiatric condition was stable and that the petitioner would not benefit from further treatment thus rendering psychosocial rehabilitation services no longer medically necessary. On June 18, 2008 a non-authorization (termination) notice was sent to the petitioner terminating psychosocial rehabilitation services under Medicaid effective June 30, 2008. A hearing was requested by the petitioner's representative on June 30, 2008, the psychosocial rehabilitation services have been continued pending the hearing decision.

4. In August 2008 a reconsideration review was completed by Magellan. The reviewing physician again determined the petitioner's psychiatric condition was stable and therefore the medical necessity criteria required to receive psychosocial rehabilitation services was not met. On August 27, 2008 a reconsideration non-authorization notice was sent by Magellan to the petitioner.

5. Dr. Alan Lipton appeared telephonically as a witness for the respondent. He is the medical director for Magellan of Florida and reviews all non-authorization decisions which are appealed. Dr. Lipton concurs with the non-authorization decision reached by the reviewing physician. In opposition to the clinical diagnosis, Dr. Lipton believes the petitioner's mental retardation is the principal impairment. He reviewed the clinical records provided by the [redacted] for the petitioner and believes the

diagnosis of mental illness may have been misappropriate; he believes all the symptoms (repetitive statements, social distance, attention seeking behaviors, physical aggression and anger management) recorded in the petitioner's clinical file can be attributed to her moderate mental retardation. Dr. Lipton argued that the petitioner's unsuitability for psychosocial rehabilitation services is evidenced by the length of time (twenty-two months as of the date of the hearing) she has received the services and by the petitioner's lack of consistent, sustained progress. He referenced specifically the petitioner's hospitalization due to mental instability in early 2008 as an example of her not benefiting from the psychosocial rehabilitation services which had been ongoing for at least a year at the time of her hospitalization. Dr. Lipton believes the petitioner lacks the cognitive skills necessary to ever achieve the ultimate goal of psychosocial rehabilitation services; to live independently, without daily support of any kind.
Dr. Lipton believes the petitioner's presenting symptoms would be more appropriately served in a program designed for the developmentally disabled.

6. appeared telephonically as a witness for the petitioner. is a consulting psychologist who works with the treating clinicians at the In her capacity as a consultant, she provides oversight services such as assisting clinicians with assessing the progress of patient treatment plans. In her position, has the opportunity to observe the petitioner daily Monday through Friday during working hours. Based on her observations and review of the petitioner's clinical records, believes that the petitioner is benefiting from psychosocial rehabilitation. She explained that the aggressive behavior caused by the petitioner's mental illness once necessitated that a staff member at the

center be with her at all times, one-on-one. The petitioner no longer requires that level of supervision. In opinion, this improvement is a direct result of the psychosocial rehabilitation services. admitted that she does not provide psychosocial rehabilitation therapy at the and has never treated the petitioner for her mental illness, however, she disagrees with Dr. Lipton's opinion that the petitioner's diagnosis of mental illness was misappropriate. also disagrees with Dr. Lipton's assertions that the petitioner will never be able to live independently. does not believe independence requires living without any support system; she believes all human beings require some form of support regardless to their living environment. She believes independent living is accomplished by the individual living up to their maximum level of functioning. stipulated that psychosocial rehabilitation services are intended to be short term services only; she could not provide a date (exact or approximate) by which the services should or could be terminated for the petitioner.

7. The petitioner's treating psychiatrist at the , did not appear as a witness, however, the respondent's representative offered into evidence a prescription reportedly written by , on October 30, 2008 prescribing six months of psychosocial rehabilitation for the petitioner. No additional evidence was offered from the treating psychiatrist in regards to the petitioner's continued need for psychosocial rehabilitation services.

8. The petitioner's psychosocial rehabilitation progress is charted by, among other things, Master Treatment Plans and Treatment Plan Reviews. The Master Treatment Plan is comprised of major goals and goal objectives created annually by the

petitioner and the petitioner's treating clinicians. The goals are categorized by functioning skills lost due to the participant's mental illness. Treatment Plan Reviews are conducted quarterly to access the progress made in meeting the main goals and goal objectives of the Master Treatment Plan. At the time of the non-authorization decision in June 2008, the most current Treatment Plan Review (dated February 28, 2008) shows the petitioner did not meet any of her treatment goals. The review states in part: "[redacted] still needs to continue to work harder on many of her goals and objectives. [redacted] has not met any of her goals... [redacted] has room for improvement mainly focusing in the areas of mood management, impulsivity and lack of proper social skills... By the next review, [redacted] should be ready to move to the next level of her goals and objectives... Within the last few months, [redacted] has been hospitalized due to her mental instability and physical aggression..."

CONCLUSIONS OF LAW

Medical services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Florida Administrative Code Rule 59G-1.010(166)(a)(c) as follows:

> 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) 'Medically necessary' or 'medical necessity' for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The Medicaid Handbook is incorporated by reference in Fla. Admin. Code 59G-4.050. The service exclusions section states in relevant part:

Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation.

Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

Fla. Admin. Code 65-2.056 (3) in parts states:

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.

Fla. Admin. Code 65-2.060 in parts states:

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 office

The agency terminated psychosocial rehabilitation services for the petitioner under Medicaid. The controlling legal authority cited above makes it clear that the burden of proof rests with the agency to prove the correctness of this action by a preponderance of the evidence. Evidence submitted by the respondent shows the petitioner has been receiving psychosocial rehabilitation services since January 2007 without successfully meeting any of the goals of her Master Treatment Plan. The respondent argued that the after nearly two years of negligible results, it can not be reasonably expected that the petitioner will receive additional rehabilitative benefit from these services. It is the opinion of the respondent's witness, medical director, Dr. Lipton, that all of the petitioner's presenting symptoms could be attributed to her mental retardation and the mental illness diagnosis may have been inappropriate. The petitioner's witness, admitted that the petitioner has not met any of her treatment goals, however, she argued the fact that the petitioner has accomplished some of the objectives of each goal is proof progress is being made and that with continued rehabilitation services, the petitioner will someday achieve the goals of her treatment plan. The petitioner's treating psychiatrist did not testify during the hearing. As the only licensed psychiatrist to testify at the hearing was Dr Lipton, his expert medical opinion was given comparatively significant weight in the overall conclusions.

It is the respondent's opinion that the undersigned hearing officer is limited to consideration of evidence available at the time of the adverse action under appeal. However, the legal authority cited above makes it clear that the hearing is a de novo

proceeding; either party may present new or additional evidence not previously considered by the agency in making its decision. The undersigned hearing officer considered all the evidence and testimony presented by both parties.

After carefully reviewing the testimony, evidence, and controlling legal authorities, the hearing officer finds that the respondent met its burden by presenting evidence that established that it was not medically necessary for the petitioner to receive psychosocial rehabilitation services because the services have not produced any significant or long term benefit.

DECISION

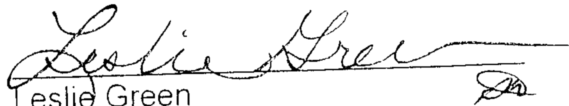
The appeal is denied. The agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 3rd day of December, 2008,

in Tallahassee, Florida.



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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-07456

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 November 25, 2008, at 10:44 a.m., in Tampa, Florida. The petitioner was present. The petitioner was represented by his mother [redacted] Present on behalf was the petitioner's father [redacted] and the account manger for [redacted] Observing were the petitioner's brother, [redacted] his grandfather, [redacted] and care provider for the petitioner's brother, [redacted] The respondent was represented by David Beaven, health care program specialist. Witness for the respondent was Carol Schultz, Medicaid health care program analyst with the Aged/Disabled Adult Program for the Aging Out Waiver.

ISSUE

The petitioner is appealing the respondent's policy that personal care services or companion services may not be used at the same time skilled nursing is being provided.

FINDINGS OF FACT

1. The petitioner is disabled and has been eligible for the Aging Out Waiver under the Aged/Disabled Adult Program since July 2007. The respondent approved twelve to sixteen hours per day for five to seven days a week of attendant care services/skilled nursing and ten hours a day for five to seven day a week of personal care services. The petitioner's service is provided by [redacted] .

2. [redacted] had received approval from the respondent for the petitioner for twelve to sixteen hours per day for five to seven days a week of attendant care services/skilled nursing and ten hours a day for five to seven day a week of personal care services. The services of attendant care/skilled nursing and personal care were provided to the petitioner. [redacted] provided both services to the petitioner at the same time. After the services were received [redacted] billed Medicaid for both services using the same code. [redacted] discovered that they had incorrectly coded the service for billing the respondent. [redacted] corrected the coding and billed Medicaid for services received.

3. When the respondent received billing from [redacted] for providing attendant care services/skilled nursing and personal care services at the same time, the respondent denied payment for the hours services billed of attendant

care and personal care services which were provided to the petitioner at the same time. The respondent determined that ______ continued to bill Medicaid for both services using the same code for at least three years. The respondent offered to increase the attendant care services/skilled nursing.

4. After the denial, ______ provided the services and staffing as authorized, twelve to sixteen hours per day for five to seven days a week of attendant care services/skilled nursing and ten hours a day for five to seven day a week of personal care services. However, both services were not provided at the same time.

5. The petitioner's mother is requesting services of both attendant care/skilled nursing and personal care assistant be provided at the same time 30 hours a week. She and her husband care for both of their children that are disabled and both require full care. She and her husband cannot be there all the time. She attested that it takes two people to care for the petitioner at a time and when the petitioner is driven to an appointment, two people are needed one to drive and one to care for the petitioner. She opined that two services at the same time are less costly than services offered by the respondent to increase skilled nursing up to 24 hours a day.

CONCLUSIONS OF LAW

At the beginning of the hearing, the hearing officer attributed the burden to the respondent as the issue was presented as a termination of services. The evidence demonstrated that the respondent did not terminate any of the approved hours of twelve to sixteen hours per day for five to seven days a week

of attendant care services/skilled nursing and ten hours a day for five to seven day a week of personal care services. The change occurred due to incorrect billing by the providers not a change, denial or termination by the respondent. As the petitioner is requesting the respondent to duplicate services, the petitioner has the burden of proof.

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

The Florida Administrative Code at 59G-13.030 "Aged and Disabled Adult Waiver Services" incorporates the Florida Medicaid Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook (March 2004, updated August 2005):

> (1) This rule applies to all aged and disabled adult waiver services providers enrolled in the Medicaid program.
> (2) All aged and disabled adult waiver services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook, March 2004, updated August 2005, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081 which is incorporated by reference in Rule 59G-13.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

Aged and Disabled Adult Waiver Services Coverage and Limitations Handbook sets forth the description and service limitations for attendant care services on page 2-17:

Attendant Care Services

> Description Attendant care services are both supportive and health-related hands-on care services specific to the needs of a medically stable, physically handicapped individual. Supportive services are substitutes for the absence, loss, diminution, or impairment of a physical or cognitive function. These services include skilled nursing care or personal care to the extent permitted by state law. Housekeeping activities incidental to the performance of care may also be furnished as part of this activity. This service can be authorized when the recipient's mental or physical condition requires assistance with medically related needs.
>
> Service Limitations
> The following service limitations apply to attendant care services:
>
> - Attendant care services are limited to the amount, duration and scope of services described in the recipient's plan of care as authorized by the case manager and must be provided in the recipient's residence.
> - The services can be authorized up to a maximum of ten hours per day.
> - The services may not be used at the same time as Personal Care or Companion.

The respondent approved twelve to sixteen hours per day for five to seven days a week of attendant care services/skilled nursing and ten hours a day for five to seven day a week of personal care services. The petitioner's mother is requesting services of both attendant care/skilled nursing and personal care assistant be provided at the same time 30 hours a week. Even though the petitioner's mother's request appears to be more cost effective than the hours approved by the respondent, the policy incorporated by rules sets forth that attendant care services may not be used at the same time as personal care services. The petitioner's request for attendant care/skilled nursing and personal care assistant to be provided at the same time 30 hours a week does not meet the service limitation criteria. An error on the part of the provider for years is not precedence to continue providing services that do not meet the limitation criteria.

The petitioner's request for attendant care/skilled nursing and personal care assistant to be provided at the same time 30 hours a week is denied.

DECISION

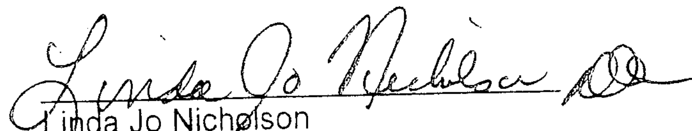
This appeal is denied.

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 23rd day of December, 2008,

in Tallahassee, Florida.



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DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-6518

PETITIONER,

Vs.

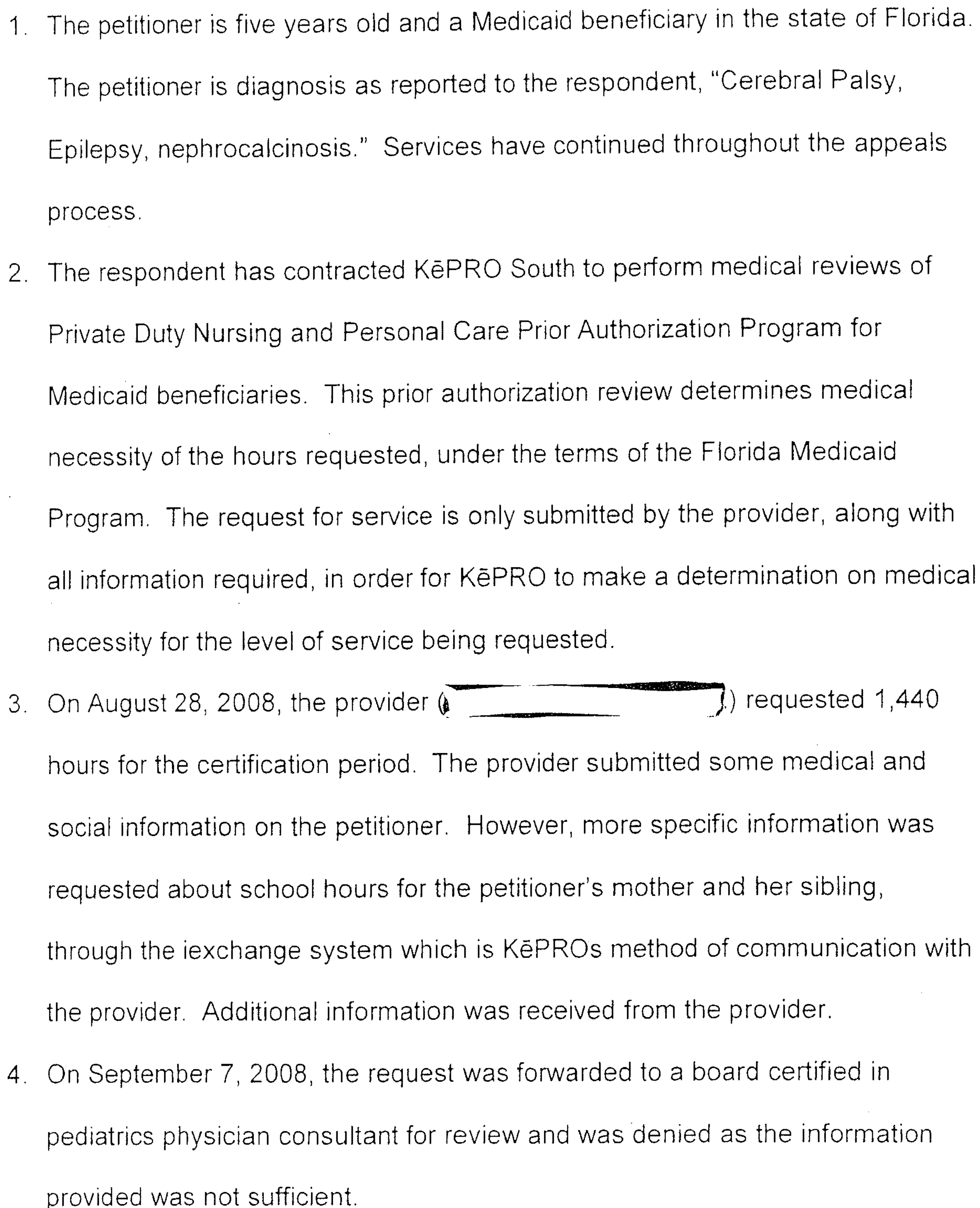
AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA
RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on November 6, 2008, at 8:15 a.m., in Miami, Florida. The petitioner was present along with her mother, ________ The respondent was represented by Monica Otoriola, program specialist with the Agency for Health Care Administration (AHCA). Telephonically present, as witnesses for the respondent was Dr. Robert A. Buzzeo, physician consultant and Edna Clifton, operations manager, both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez served as translator.

ISSUE

At issue is the respondent's action of September 8, 2008 and September 17, 2008, 258 hours of home health aide (HHA) and approving 1,182 hours of the 1,440 hours requested for the certification period of September 9, 2008 through March 7, 2009 (180 days). The respondent has the burden of proof.



FINDINGS OF FACT

1. The petitioner is five years old and a Medicaid beneficiary in the state of Florida. The petitioner is diagnosis as reported to the respondent, "Cerebral Palsy, Epilepsy, nephrocalcinosis." 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.

3. On August 28, 2008, the provider ( ) requested 1,440 hours for the certification period. The provider submitted some medical and social information on the petitioner. However, more specific information was requested about school hours for the petitioner's mother and her sibling, through the iexchange system which is KēPROs method of communication with the provider. Additional information was received from the provider.

4. On September 7, 2008, the request was forwarded to a board certified in pediatrics physician consultant for review and was denied as the information provided was not sufficient.

5. On September 9, 2008, a reconsideration was submitted by the provider with additional information and on September 16, 2008 a second physician consultant. The consultant documented that information provided shows the second child (sibling) as being tutored on weekdays until 10:00 pm and attending therapies on a daily basis. The request was approved, except for 258 hours (from 8pm-10pm) which continued to be questionable.

6. On September 17, 2008, a notice of denial was issued to the petitioner and provider informing them of the denial and approval of hours. The petitioner appealed the decision on October 1, 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 petitioner's mother explained that the second child has tutoring from 6:30 to 7:30 pm (M-W-F) and the same child has counseling from 6-7pm (T-Th) plus traveling time each day.

The physician consultant stated that if the new information was factual, he would rescind and grant the two hours daily from Monday through Friday that were denied.

As a de novo hearing is conducted by this hearing officer, new or additional evidence not previously considered by the respondent in making its decision is now considered. The agency's decision was correct at the time it was taken, given the information provided. However, the hearing officer agrees with the physician consultant's recommendation to "rescind and grant" the two hours denied and therefore, grants the

appeal. The petitioner will provide verification of said tutoring and therapies to the local agency for confirmation.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 23rd day of December, 2008, in Tallahassee, Florida.

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

APPEAL NO. 08N-00164

PETITIONER,

Vs.

CASE NO.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 10, 2008, at 11:22 a.m., in Tampa, Florida. The petitioner was present and represented herself. The facility was represented by [redacted], administrator. Present as witnesses for the facility were [redacted] business manager; and [redacted], director of social services.

ISSUE

At issue is the August 29, 2008 action by the facility proposing to discharge the petitioner due to her failure to pay her bill at the facility.

FINDINGS OF FACT

1. The petitioner resided at [redacted] nursing facility in August 2008. On August 29, 2008, the facility delivered a Nursing Home Transfer and Discharge Notice to the petitioner. The stated reason for the

discharge was her failure to pay her bill at the facility after reasonable and appropriate notice to pay. The nursing home proposed to discharge the petitioner to her home on August 31, 2008.

2. The facility presented a copy of the August 29, 2008 bill from the facility showing that the petitioner owed $1,835.42 to the facility. The amount owed was calculated from the date the petitioner entered the facility in August 2008 through her September 2008 stay. The petitioner receives benefits through the Institutional Care Program and Medicaid. Her monthly patient responsibility is $981 monthly.

3. The petitioner paid the facility $100 for August 2008 on October 1, 2008. She paid the facility $100 toward the October 2008 bill on October 9, 2008. The petitioner stipulated to the respondent's calculation setting the amount owed to the facility as $2,516.42 as of the date of the hearing.

4. The petitioner receives $1016 monthly from the Social Security Administration. She is allowed to keep $35 as a personal needs allowance. The remainder must be paid to the facility each month. However, the petitioner keeps an apartment in the community with a monthly rental cost of $420. In addition, she also pays the monthly utility costs.

5. The petitioner entered the facility on August 5, 2008. She entered the facility from the hospital. Before entering the hospital, she resided in another nursing facility. The petitioner suffers from obesity, depression,

pain, osteoarthritis, and has experienced staph infections. The petitioner needs knee surgery which cannot be done until she loses weight.

6. The petitioner does not intend to pay the facility her patient monthly responsibility. She needs to use this money to maintain her apartment in the community.

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

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.
>
> (5)(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

As of the billing received on August 29, 2008, the total amount due to the facility was $1835.42. The unpaid balance as of October 10, 2008 is not in dispute. It totals $2,516.42. The petitioner argues that she cannot pay the facility and maintain her home in the community.

The Notice of Discharge and Transfer had an effective date of August 31, 2008. This did not allow the petitioner the required 30 days before

transfer. The nursing facility argued that the federal laws do not require 30 days notice, when the petitioner has not been in the facility for 30 days.

It is true that the federal regulations specify that the proposed Notice of Discharge does not require 30 days when the resident has not been in the facility for 30 days. However, Florida chose to keep the 30 day notice requirement. It is outlined in the following Florida Statute:

> 400.022 Residents' rights.--
> (p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act. For nonpayment of a bill for care received, the resident shall be given 30 days' advance notice.

The evidence establishes that the petitioner is aware that there is a debt to the facility. The facility has given the petitioner and her family reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial arrangements have not resulted. While the notice to the petitioner did not give her the required 30 day notice, no harm occurred since the 30 days had elapsed as of the date of the hearing. The petitioner still did not intend to pay her monthly patient responsibility. Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is in accordance with federal regulations. The respondent may proceed with the discharge to an appropriate location as

determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

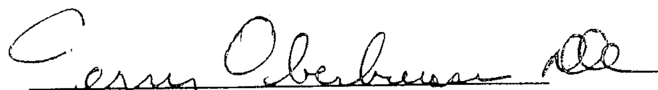
DECISION

This appeal is denied. The respondent's proposed action to discharge 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 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 1st day of December, 2008, in Tallahassee, Florida.



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DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-06181

PETITIONER,

Vs.

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

RESPONDENT.

_______________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on October 17, 2008, at 1:27 p.m., in New Port Richey, Florida. The infant petitioner was present but was represented by his mother, who also testified. Kathy Sizak-Freeman, registered nurse specialist with the Agency For Health Care Administration (AHCA), represented the respondent and testified.

Two persons with Kepro appeared as witnesses for the respondent by telephone: Mary Wheeler, review operations manager, and Dr. Robert A. Buzzeo, pediatrician and physician reviewer.

ISSUE

At issue is the respondent's decision of August 28, 2008 to terminate private duty nursing (PDN) hours paid by Medicaid. The respondent previously

paid for 12 hours daily, seven days weekly PDN. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is one of six children all born at 29 weeks gestation on September 1, 2007. A five year-old sister also lives in the home. The petitioner and all his siblings lives with and receives care from his mother. The petitioner's father also lives in the home.
2. The petitioner's father works from 3:30 a.m. until noon seven days weekly in a self-employment business. The petitioner's mother and caretaker do not work outside the home. However, the petitioner's mother assists with accounting in the self-employment business.
3. The petitioner originally received 24 hours daily PDN hours, seven days weekly. These PDN hours were later reduced to 12 hours daily seven days weekly. On August 28, 2008, the respondent sent notice to petitioner that all PDN hours for the petitioner had terminated, based on the respondent conclusion of no medical necessity. The termination action was upheld by the respondent upon request for reconsideration on September 15, 2008. The petitioner seeks to retain the prior 12 hour daily PDN services for the reviewing period of August 29, 2008 to February 24, 2009.
4. As of the date of hearing, one sextuplet in the home received 24 hours daily PDN hours, seven days weekly. The petitioner received PDN hours from 8:00 a.m. to 8:00 p.m. before the intended action to

terminate the PDN hours at issue. Two nurses are presently in the home to provide care for all the sextuplets from 8:00 a.m. to 8:00 p.m. One nurse is in the home from 8:00 p.m. to 8:00 a.m. to provide assigned care for another sextuplet.

5. The petitioner's pediatrician opines that it is very important to continue nursing care to maximize improvement of his current health issues. This pediatrician requests home nursing care because of diagnoses to include prematurity, reactive airway disease, chronic lung disease, abnormal head ultrasound with enlarged ventricles, sleep disorder, speech and swallowing disorders, and feeding difficulties.

6. The respondent contracts with Kepro physicians to make a medical necessity determination for the requested PDN hours at issue. The Kepro physicians make medical necessity determinations based on the clinical and social information supplied them by the nursing provider. Based on this information, the Kepro physician determined the petitioner no longer meets medical necessity criteria for PDN hours. The Kepro reviewing physician, Dr. Robert Buzzeo, testified at the hearing. Dr. Buzzeo retained the conclusion of no medical necessity for PDN hours after hearing testimony from the petitioner's mother on the petitioner's conditions. Dr. Buzzeo considered all of the factors listed by the treating physician and stated that all of these conditions were considered in determining medical necessity. Dr.

Buzzeo further noted that the petitioner has greatly improved and several of the initial treatments for the stated diagnosis have been discontinued as a result.

7. The petitioner is no longer on oxygen and tolerates feedings well. The petitioner has a diagnosis of gastric esophageal reflux disease and receives treatment as needed. The petitioner drinks from a bottle, but has texture aversion to certain foods, per testimony.
8. The petitioner remains at some risk for upper respiratory infection. The petitioner is no longer on oxygen and his apnea monitor was recently removed. The petitioner receives nebulizer treatment two or more times daily. The petitioner is not at a particularly high risk for upper respiratory infection given the discontinuance of the apnea monitor and lack of oxygen therapy, per Dr. Buzzeo's opinion. The petitioner's overall condition has improved and is stable.
9. The petitioner has a sleep disorder where he has interrupted sleep, or may sleep an excess time period. The petitioner receives speech therapy. The petitioner has been hospitalized three times, per petitioner testimony. There is no epilepsy diagnosis. There is no evidence that the petitioner's mother and caretaker is unable to provide for the petitioner's needs.

CONCLUSIONS OF LAW

The Florida Administrative Code Rule 59G-1.010 addresses relevant definitions within the Medicaid Program, which also apply to this Medicaid

decision on the private duty nursing services at issue. Subsection (166) of the Florida Administrative Code Rule defines "medically necessary" care, goods or services, as follows:

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

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the contracted Kepro reviewing physician recommends the termination of ongoing nursing services based on his evaluation of the petitioner's needs.

The petitioner's treating physician opines that it is very important to continue the petitioner's home nursing care to maximize improvement of current health issues. This opinion of the treating physician was given considerable and substantial weight to evaluate the medical necessity of PDN services. The treating opinion evidence shows that it would be certainly helpful to continue

nursing care hours if only to monitor the petitioner's continued health care progress. However, the "medical necessity" definition sets a higher standard of medically necessity to those services that are necessary to "protect life, significant illness or disability, or to alleviate severe pain."

The evidence shows that the petitioner's overall condition has recently improved. Since the written opinion of the treating physician is not dated, the exact time of such opinion is not known. While it is evident that some health risk factors continue, it must be concluded whether these risks rise to a level of requiring private duty nursing services to monitor these risks. The petitioner's current conditions do not suggest that such risks rise to the defined medical necessity for continued PDN services. Therefore, there is good cause to conclude that Dr. Buzzeo's testimony on the lack of defined medical necessity for continued PDN hours overcomes the customary weight given the treating physician's opinion on the importance of such PDN hours.

Further, there is no evidence that the petitioner's mother and caregiver is not able to provide needed care to the petitioner, even though she has many responsibilities in her home. The language of the cited "Home Health Services Coverage and Limitations Handbook," on page 2-15, shows that parents and caregivers must participate in care "to the fullest extent possible," as in the following excerpt:

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

In sum, it is concluded that the respondent decision to terminate ongoing nursing hours is correct, given the overcoming weight of the reviewing physician opinion on medical necessity, and the petitioner's mother's ability to provide such care. The respondent has agreed to review any episodic future need for care, if the petitioner later requests such. However, the available evidence does not show that the petitioner meets the defined medical necessity criteria for continued 12 hours daily of professional PDN care. Thus, the respondent has met its burden to justify the termination of PDN hours for the petitioner.

DECISION

This appeal is denied in that the respondent has met the burden to prove that ongoing PDN hours are not medically necessary.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 15th day of December, 2008,

in Tallahassee, Florida.

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

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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-06683

PETITIONER,

Vs.

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

RESPONDENT.

______________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on November 6, 2008, at 3:25 p.m., in New Port Richey, Florida. The petitioner was present but was represented by his mother, __________ who also testified. Kathy Sizak-Freeman, registered nurse specialist with the Agency For Health Care Administration (AHCA) represented the respondent and testified. Two individuals with NurseStat appeared as witnesses for the petitioner: __________ director of nursing and __________, licensed practical nurse.

Two persons with KePRO appeared as witnesses for the respondent by telephone: Edna Clifton, operations manager, and Dr. Robert Buzzeo, pediatrician and physician reviewer.

ISSUE

At issue is the respondent's decision of November 29, 2007 to reduce the amount of private duty nursing (PDN) hours paid by Medicaid from; 16 hours daily, 7 days weekly, to: 8 hours daily, 7 days weekly, with 12 hours daily provided on weekends. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is 15 years old. The petitioner lives with and receives care from his mother, [redacted] is a single parent. The petitioner's 14 year-old sister also lives in the home.
2. The petitioner's mother is not employed, but does volunteer work at a domestic center. The petitioner's mother has severe low back problems from a prior injury, as well as previous fractured ribs. The petitioner's mother is unable to lift and reposition the petitioner due to these conditions.
3. The petitioner was hit by a car when he was five years old. The petitioner has multiple medical conditions with diagnoses to include anoxic encephalopathy, and seizure disorder. He is incontinent of bowel and bladder, hearing impaired, non-ambulatory with spastic quadriplegia. He is totally dependent with all activities of daily living.
4. The petitioner receives gastrostomy-tube (G-tube) feedings with medications given through the G-tube. He also receives nebulizer

treatment and suctioning if needed. The petitioner requires periodic repositioning.

5. The respondent previously approved PDN services for 16 hours daily, seven days weekly. The petitioner's mother provided any needed care from 11:00 p.m. to 7:00 a.m., and PDN services were provided from 7:00 a.m. to 11:00 p.m. On September 24, 2008, the respondent sent notice that PDN hours were to be reduced for the certification period of September 10, 2008 to March 8, 2009. The petitioner requested appeal of this decision on October 7, 2008.

6. The respondent contracts with KePRO physicians to make a medical necessity determination for the requested PDN hours at issue. The KePRO physicians make medical necessity determinations based on the clinical and social information supplied them by the nursing provider. Based on this information, the KePRO physician determined the petitioner meets medical necessity criteria for reduced PDN hours. The KePRO reviewing physician, Dr. Robert Buzzeo, testified at the hearing. There was no rebuttal physician testimony on the number of PDN hours needed.

7. Dr. Buzzeo determined that the petitioner's mother can provide most needed care to the petitioner from 7:00 a.m. to 3:00 p.m., Monday through Friday. Dr. Buzzeo recognized that the petitioner's mother has a 14 year-old child in the home after 3:00 p.m., and also needs time for other household activities. Further, Dr. Buzzeo determined

the petitioner's mother needs time on weekends from 7:00 a.m. to 3:00 p.m. while her 14 year-old daughter is in the home. Therefore, Dr. Buzzeo determined that PDN hours are medically necessary from 3:00 p.m. to 11:00 p.m. Monday through Friday, with 12 hours daily PDN provided on weekends. The respondent proposes to reduce PDN hours from a total of 112 hours weekly to 64 hours weekly.

8. Since the petitioner's mother has back problems, KePRO proposes the petitioner to request replacement of the denied PDN hours with assistance from a home health aide (HHA). The HHA can provide assistance with activities of daily living to include repositioning, bathing and transfers. However, an HHA can not do g-tube feedings or medication administration. The petitioner has also been recently approved to receive services through the Medicaid Waiver Program. However, the amount and type of services to be possibly provided through the Medicaid Waiver Program is not known.

9. The petitioner's mother believes the petitioner is at high risk for aspiration, and that she would panic in the event of such aspiration. Dr. Buzzeo advises that there is a noted aspiration precaution in the medical records. The treating nursing provider believes the petitioner needs more assessment than what an HHA could provide, based on the petitioner's history of seizures and need for frequent suctioning.

Dr. Buzzeo retained his conclusion of the reduced need for opined medically necessary PDN hours after hearing testimony from the petitioner and the nursing provider.

CONCLUSIONS OF LAW

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

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

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the contracted KePRO reviewing physician

recommends the reduction of nursing services to 8 hours daily, 5 days weekly with 12 hours daily on weekends.

The evidence does *not* show that the petitioner's mother and caregiver is *totally* incapable to provide needed care to the petitioner, even though she has concerns on her response in the event of aspiration. A requested HHA can provide assistance with activities of daily living that the petitioner's mother can not physically perform. Further, additional services may be provided under the Medicaid Waiver Program, though such is not known presently. The language of the cited "Home Health Services Coverage and Limitations Handbook," on page 2-15, shows that parents and caregivers must participate in care "to the fullest extent possible," to provide care as in the following excerpt:

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

It is concluded that the respondent decision to reduce approved nursing hours to the amount listed is reasonable, given the petitioner's responsibility to provide care to the fullest extent possible. Continued PDN hours provided on weekday afternoons and during daytime hours on weekends should permit the petitioner reasonable opportunity for other household activities. The addition of requested HHA hours will assist the petitioner with activities of daily living. Thus, the respondent has met the burden to prove the defined medical necessity for the reduced PDN hours at issue. If the petitioner's and/or his caregiver's

circumstances change to warrant a request for an increase in PDN hours, the petitioner may request such hours.

DECISION

This appeal is denied in that the respondent has met the burden to prove defined medical necessity for a decrease in private duty nursing hours to the amount at issue.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 9th day of December, 2008,

in Tallahassee, Florida.

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

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DEC 23 2008
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-07283

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 November 20, 2008, at 8:35 a.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by her mother [redacted] The respondent was represented by Ken Hamlin, program operations administrator. Present on the telephone from Kepro was Dr. Robert Buzzeo, and Edna Clifton, review operations manager.

ISSUE

At issue is the Agency's October 29, 2008 action of approving the petitioner's skilled home nursing services for 3,106 hours, and denying 492 hours for October 15, 2008 to April 12, 2009. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, date of birth , , s 11 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 October 17, 2008, stating that zero hours of skilled home nursing services were approved, and 2,428 hours were denied for the petitioner for October 15, 2008 to April 12, 2009.

3. Included in the evidence is a copy of a Modification Denial Letter, dated October 29, 2008, stating that 107 hours of skilled home nursing services were approved, and 30 hours were denied for the petitioner for October 15, 2008 to April 12, 2009.

4. Included in the evidence is a copy of a Reconsideration Denial Overturned Letter, dated October 29, 2008. This notice informs the petitioner that upon reconsideration, 3,106 hours of skilled home nursing services were approved, and 492 hours were denied for the petitioner for October 15, 2008 to April 12, 2009.

5. The notices sent to the petitioner explained that it was determined by Kepro that the medical care of the private duty nursing services of 3,106 hours was determined to be medically necessary.

6. Included in the evidence is a copy of a Kepro Internal Focus Review Finding Report on the petitioner, dated October 13, 2008, stating that the petitioner's requested number of nursing hours are 24 hours per day on non school days, and 10 hours per day when she goes to school on early release days. It also states that the petitioner was diagnosed with infantile cerebral palsy, and there is a presence of a cerebrospinal fluid draining device.

7. Included in the evidence is a copy of a Kepro Synopsis Of Case Report, stating that the petitioner's mother works, and is home by 4:00 p.m. on Mondays, Saturdays, and Sundays. The reconsideration reviewer denied the hours of 4:00 p.m. to 10:00 p.m. on Mondays, Saturdays, and Sundays, and approved the rest of the nursing hours.

CONCLUSIONS OF LAW

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

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

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

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. Skilled home nursing services of 3,106 hours were approved, and 492 hours were denied for the petitioner for October 15, 2008 to April 12, 2009. This determination took into account the petitioner's condition, and her mother's work hours, as reported by the nursing service to Kepro. The physician that testified at the hearing agrees with this determination. After careful consideration, it is determined that the Agency's action to approve skilled home nursing services of 3,106 hours, and deny 492 hours for the petitioner for October 15, 2008 to April 12, 2009, is upheld.

DECISION

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

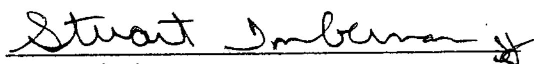
NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District

Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 23rd day of December, 2008,

in Tallahassee, Florida.



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

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DEC 15 2008
APPEAL HEARINGS

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

APPEAL NO. 08F-07498

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 December 3, 2008, at 11:05 a.m., at the West Dade Service Center, in Miami, Florida. The petitioner was present and represented herself. The respondent was represented by Margaret Warner, senior specialist, Agency For Health Care Administration (AHCA). Present as witnesses for the respondent, via the telephone, was Dr. Stuart Hesky, physician reviewer, from KePRO and Edna Clifton, operations manager at KePRO. Blanche Rodriguez interpreted for Ms. Aguinaga.

ISSUE

At issue is the respondent's action of October 23, 2008, to deny the petitioner Home Health Aide visits daily, for the period of September 12, 2008 through November 10, 2008, because documentation submitted by the provider

does not support the medical necessity for the visit frequency of the services requested. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who was fifty five years of age at the time of review, has been diagnosed with diabetes mellitus, osteomyelitis, hyperlipidemia, obesity and functional decline. The petitioner lives alone and requires assistance with personal care and activities of daily living (ADL).

2. On behalf of the petitioner, a home health care provider, requested authorization for daily Home Health Aide (HHA) and Skilled Nurse (SN) visits for the certification period of September 12, 2008 through November 10, 2008, seven days a week.

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

4. On October 10, 2008, a physician consultant reviewed the petitioner's request and approved the daily SN visits but denied the daily HHA visits.

5. On October 22, 2008, a reconsideration determination was completed. A different physician consultant reviewed the reconsideration request stating: "Reconsideration request for daily HHA visits denied as information submitted fails to show the medical necessity for this frequency of care. Rationale: this is a 55 y/o with an open wound of the foot and osteomyelitis. She lives alone, is alert and oriented, independent with medications, not incontinent, transfers and

ambulates with a walker. Daily baths are not medically necessary for this continent patient. Patient has relatives who assist when aid is not present. The above information indicates to me that patient and/or relatives should be able to participate in patient care. I will approve three times per week HHA visits to assist with bathing and other chores due to decreased ambulation, poor endurance and debility."

5. On October 23, 2008, the petitioner was notified of the above decision.

6. The petitioner disagreed with this decision and on November 6, 2008 requested a hearing.

7. At the hearing the petitioner explained that the person that was caring for her, her aunt, suffered a stroke and is no longer able to assist her. She explained that her neighbor sometimes helps her but she has diabetes and had open heart surgery. The petitioner noted that she is currently receiving daily HHA visits.

8. The respondent explained that the decision to deny daily HHA visits for the certification period of September 12, 2008 through November 10, 2008, was made based upon information they had available to them at that time. Any change in the frequency of the visits might have been based on new or additional information provided for a subsequent certification period. The respondent noted that they do not have any record that they approved or denied any services after November 10, 2008.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

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

The Home Health Services Coverage and Limitations Handbook (July 2007) explains service requirements for Home Health Aide Visit Service on page 2-15, stating in part:

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

The respondent, through KePRO, took action on October 23, 2008, to deny the petitioner Home Health Aide visits daily, for the period of September 12, 2008 through November 10, 2008. This decision was based on the petitioner's medical necessity for the frequency of care and on the information available at the time the services were provided, specifically that the petitioner is alert and oriented, independent with medication, not incontinent, transfers and ambulates with a walker and has relatives who participate in her care and assist her when HHA is not present.

The petitioner argues that she no longer has relatives who assist her when HHA is not present and that she needs HHA visits daily.

The respondent argues that the agency's decision was correct based on the petitioner's condition and the information as provided by the petitioner's service provider at the time of the initial request. The hearing officer agrees with the respondent's argument.

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

DECISION

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

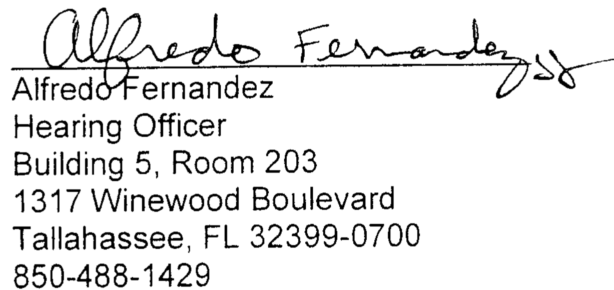
NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive,

Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 15th day of December, 2008,

in Tallahassee, Florida.



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

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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-04427

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 St. Johns
UNIT: AHCA

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 29, 2008, at 1:30 p.m. in Saint Augustine, Florida. The petitioner was represented by ________, consulting psychologist for the ________ appeared as a witness for the petitioner. The respondent was represented by Karen Dexter, assistant general counsel with the Agency for Health Care Administration (AHCA). Margaret Dorceus, medical health care program analyst with AHCA, appeared as a witness for the respondent. In addition Debra Nussbaum, director of clinical services with Magellan Health Care of Florida, Inc. (Magellan), Dr, Michael Bojkovic, consulting reviewing psychiatrist with Magellan and Dr. Alan Lipton, M. D. and medical director for Magellan of Florida appeared telephonically as witnesses for the respondent. Lee Ann Williams, utilization

manager with AHCA and Stephanie Dovsky, senior account executive with Magellan observed.

The record was held open for both parties to submit proposed orders. A proposed order was received from the respondent; one was not received from the petitioner.

ISSUE

The petitioner is appealing termination of psychosocial rehabilitation services under Medicaid. The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 37 year old female diagnosed with Mood Disorder not otherwise specified (NOS) and Mild Mental Retardation. The Mood Disorder is the principal diagnosis for which the petitioner has been receiving psychosocial rehabilitation services at the through the AHCA Prepaid Mental Health Program (PMHP) since at least January 2007. In addition to psychosocial rehabilitation, the petitioner also receives day treatment, individual therapy, group therapy and medication management services. The petitioner lives at the

2. Psychosocial rehabilitation services are intensive, short term, outpatient rehabilitative services. The petitioner attends psychosocial rehabilitation multiple times per week (approximately four to five days per week) for approximately five hours per day. The purpose of these services is to restore functioning skills lost due to mental illness. To qualify for coverage under the PMHP, the psychosocial rehabilitation services must be medically necessary. Medical necessity is determined by a prior

authorization review. Magellan is a specialized managed care organization contracted by AHCA to perform prior authorization reviews for psychosocial rehabilitation services.

3. In June 2008, the center submitted an authorization request for continued psychosocial rehabilitation services for the petitioner to Magellan. The request was reviewed by a Magellan clinician who concluded the medical necessity criteria were not met. The clinician consulted with psychiatrist Dr. Michael Bojkovic (only a psychiatrist can make a non-authorization decision); Dr. Bojokovic is a contracted consultant with Magellan. He concurred with the clinician's assessment and assumed responsibility for completing the petitioner's authorization review. After reviewing the medical records submitted by the and discussing the case with one of the center's clinician's, Dr. Bojokovic concluded psychosocial rehabilitation services were not medically necessary. On June 19, 2008, a non-authorization notice was sent to the petitioner. On June 30, 2008, a hearing was requested by the petitioner's representative; the psychosocial rehabilitation services were continued pending the outcome of the hearing.

4. In August 2008, a reconsideration review was completed by Magellan. Dr. Bojkovic again determined the medical necessity criteria required to receive psychosocial rehabilitation services was not met. On August 27, 2008, a reconsideration non-authorization notice was sent by Magellan to the petitioner.

5. Dr. Bojkovic appeared telephonically as a witness for the respondent. He is a board certified psychiatrist and an independent consulting reviewer for Magellan. Dr. Bojkovic completed the aforementioned initial and reconsideration

non-authorizations for the petitioner. In his medical opinion, the petitioner lacks the cognitive functioning skills (due to her mental retardation) necessary to benefit from psychosocial rehabilitation services. The doctor explained the ultimate goal of these services is for the recipient to be able to live independently in the community without daily support; to be able to maintain a job of some kind. The doctor further explained that the petitioner's level of cognitive functioning (due to her mental retardation) is that of a 5th or 6th grader (a pre-teen child, age 10 to 12) and someone functioning on that level is incapable of living independently. It is Dr. Bojkovic's opinion that anyone with a diagnosis of mental retardation (principal or secondary) is precluded from receiving psychosocial services. He believes the petitioner was determined to be eligible for these services in error. Margaret Dorceus, AHCA contract manager for the PMHP with Magellan, also appeared as a witness for the respondent. She explained that Medicaid does not pay for treatment of mental retardation. However, a patient with a principal diagnosis of mental illness may also have a secondary diagnosis of mental retardation and still qualify for psychosocial rehabilitation services to treat the mental illness. She went on to explain that a principal diagnosis of a mental illness is not the only criteria which must be met to qualify for continued psychosocial rehabilitation services; the services must also be effective. The clinical records must show that progress is being made, that the recipient is benefiting from the services.

6. Dr. Alan Lipton appeared telephonically as a witness for the respondent. He is a board certified psychiatrist and the medical director for Magellan of Florida. He reviews all non-authorization decisions which are appealed. Dr. Lipton concurs with the non-authorization decision reached by Dr. Bojkovic. Dr. Lipton reached his decision

after reviewing the clinical records provided by the [redacted] In his opinion, the petitioner's presenting symptoms (anger, depression, attention seeking behavior) are consistent with a diagnosis of Mild Mental Retardation. In Dr. Lipton's opinion, the petitioner's mental illness diagnosis is not supported by the clinical records. Dr. Lipton argued that in his opinion, the petitioner's mental illness misdiagnosis is evidenced by her lack of progress and unchanging behaviors after nearly two years of intensive psychosocial rehabilitation services. Dr. Lipton believes the petitioner's presenting symptoms would be more appropriately served in a program designed for the developmentally disabled.

7. [redacted] appeared as a witness for the petitioner. [redacted] is a consulting psychologist who works with the treating clinicians at the [redacted]. In her capacity as a consultant, she provides oversight services such as assisting clinicians with assessing the progress of patient treatment plans. In her position, [redacted] has the opportunity to observe the petitioner daily Monday through Friday during working hours. Based on her observations and review of the petitioner's clinical records, [redacted] believes the petitioner was correctly diagnosed with Mood Disorder NOS. In her opinion the petitioner's progress is evidenced by the progress notes in the clinical file, however, none of the notes were specifically highlighted as examples of progress. [redacted] admitted that she does not provide psychosocial rehabilitation therapy at the [redacted] and has never treated the petitioner for her mental illness. [redacted] disagrees with reviewing physicians' conclusion that the petitioner will never be able to live independently. [redacted] does not believe independence requires living without any support system; she believes all human

beings require some form of support regardless to their living environment. She believes independent living is accomplished by the individual living up to their maximum level of functioning.

8. The petitioner's treating psychiatrist at the

Dr. Michael Ameil, did not appear as a witness, however, the petitioner's representative offered into evidence a prescription reportedly written by Dr. Ameil on July 21, 2008 prescribing psychosocial rehabilitation for the petitioner. No additional evidence was offered from the treating psychiatrist in regards to the petitioner's continued need for psychosocial rehabilitation services.

9. The petitioner's psychosocial rehabilitation progress is charted by, among other things, Master Treatment Plans, Treatment Plan Reviews and Global Assessment of Functioning (GAF) scores. The Master Treatment Plan is comprised of major goals and goal objectives created annually by the petitioner and the petitioner's treating clinicians. The goals are categorized by functioning skills lost due to the participant's mental illness. Reviews are conducted quarterly to assess the progress made in meeting the main goals and goal objectives of the Master Treatment Plan. The GAF is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. The clinical records document that the petitioner has never met any of the goals of her Master Treatment Plan and her GAF score has ranged from 48 to 51 during her years of psychosocial rehabilitation. In Dr. Lipton's opinion, these results substantiate his belief that the petitioner is not benefiting from psychosocial rehabilitation and therefore the services are not medically necessary. In opinion, meeting objectives within major

goals and the GAF score increase from 48 to 51 (from August 2007 review to May 2008 new Master Treatment Plan) are both substantial evidence of the petitioner's progress. Both parties stipulate that psychosocial rehabilitation services are intended for short term utilization only. The respondent defines short term as a few months up to a year. The petitioner believes short term cannot be generally defined across the board and is determined on a case by case basis.

CONCLUSIONS OF LAW

Medical services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Florida Administrative Code Rule 59G-1.010(166)(a)(c) as follows:

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

The above authority defines medical necessity criteria relative to eligibility for Medicaid services.

The Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook, October 2004, is incorporated by reference in Fla. Admin. Code 59G-4.050. The service exclusions section of the handbook, page 2-1-4 states in relevant part:

> Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation.
>
> Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

The above cited legal authority makes it clear that Medicaid does not pay for the treatment of mental retardation.

Magellan Behavioral Health of Florida, Inc. 2007 Medical Necessity Criteria, Utilization Management Guidelines, IV Community Mental Health Services c. Psychosocial Rehabilitation Services – Adult and Child/Adolescent, states in part:

> Continued Stay Service Components (Must meet 1 and 2)
>
> 1. An assessment appropriate to the model of recovery indicates at least one of the following:
>
> a. As a result of the mental illness, there are or continue to be functional impairments and skill deficits which are effectively addressed in the psychiatric rehabilitation plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues.
>
> Or
>
> b. There is reasonable expectation that the withdrawal of services may result in the loss of rehabilitation gains or goals attained by the enrollee.
>
> Or

c. A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change.
2. The enrollee chooses to continue participation in the program.
Exclusion Criteria:
(Any of the following)
1. Enrollee's identified problem is primarily social, financial, and/or medical (non-psychotic) in the absence of a primary psychiatric diagnosis of one of the following ICD-9 codes: 290.0-290.43, 293.0-298.9, 300.00-301.9, 302.7, 306.51-312.4, 312.81-314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.
2. Substance abuse is the primary source of impairment in the absence of active symptoms.
3. Enrollee abandons the intent of or is incapable of moving toward independent living.
4. Enrollee is a passive participant and therefore unable to participate actively in the development and execution of a rehabilitative plan.

It is the opinion of the reviewing psychiatrist that the absence of mental retardation in the exclusion criteria code list shown above precludes anyone with mental retardation from receiving psychosocial rehabilitation services. The AHCA contract manager for the PMHP, whose job it is to interpret Medicaid policy, explained that individuals who have a sole diagnosis of mental retardation or a primary (principal) diagnosis of mental retardation are not eligible to receive psychosocial rehabilitation services. However, those who have a principal mental illness diagnosis and a secondary diagnosis of mental retardation may qualify to receive psychosocial rehabilitation services to treat the mental illness if the other eligibility criteria are also met. The undersigned hearing officer gave greater weight to the testimony of contract Manager as this is her area of expertise; however, this issue did not impact the ultimate decision of the hearing officer.

Fla. Admin. Code 65-2.056 (3) in parts states:

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.

It is the respondent's opinion that the undersigned hearing officer is limited to consideration of evidence available at the time of the adverse action under appeal. However, the legal authority cited above makes it clear that the hearing is a de novo proceeding; either party may present new or additional evidence not previously considered by the agency in making its decision. The undersigned hearing officer considered all the evidence and testimony presented by both parties.

Fla. Admin. Code 65-2.060 in parts states:

> 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 office

The agency terminated psychosocial rehabilitation services for the petitioner. The controlling legal authority cited above makes it clear that the burden of proof rests with the agency to prove the correctness of this action by a preponderance of the evidence. Evidence submitted by the respondent shows the petitioner has been receiving psychosocial rehabilitation services since January 2007 without successfully meeting any of the goals of her Master Treatment Plan and with only a small (3 point) improvement in her GAF score. The respondent argued that after nearly two years of intensive psychosocial rehabilitation, it cannot be reasonably expected that the petitioner will receive additional rehabilitative benefit from these services. It is the

opinion of the respondent's witness, medical director Dr. Lipton, that all of the petitioner's presenting symptoms are attributable to her mental retardation and that the mental illness diagnosis is not supported by the clinical record. The petitioner's witness, consulting psychologist, [redacted], admitted that the petitioner has not met any of her treatment plan goals, however, she argued the fact that the petitioner has accomplished some of the objectives within the goals and has increased her GAF score by three points is evidence that progress is being made. In her opinion, the petitioner should continue to receive psychosocial rehabilitation services. The petitioner's treating psychiatrist did not testify during the hearing. Comparatively significant weight was given to the expert testimony of the licensed psychiatrist.

After carefully reviewing the testimony, evidence, and controlling legal authorities, the hearing officer finds that the respondent met its burden of proof by presenting evidence which established that it is not medically necessary for the petitioner to receive psychosocial rehabilitation services, as the service was in excess of the petitioner's needs; the services have not produced any significant or sustained benefit in almost two years.

DECISION

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

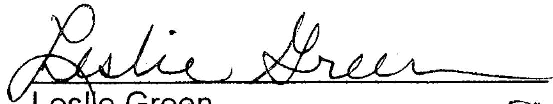
NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

be the petitioner's responsibility.

DONE and ORDERED this 16th day of December, 2008,

in Tallahassee, Florida.



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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-06682

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 December 3, 2008, at 9:50 a.m., in Miami, Florida. The petitioner was not present. He was represented by his mother, friend, was present on behalf of the petitioner. Monica Otalora, human service analyst, Agency for Health Care Administration (AHCA), represented the respondent. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Rakesh Mittel, M.D., consulting physician, and Edna Clifton, operations manager, KePRO. Carlos Rodriguez interpreted for the petitioner.

ISSUE

At issue is the respondent's action of September 24, 2008, to deny the petitioner 362 hours of private duty nursing (PDN) services of 4,120 requested

for the certification period September 18, 2008 to March 16, 2009. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner, [redacted] is a thirteen year old recipient of Medicaid benefits. He has diagnoses to include Krabbe's Disease, Static Encephalopathy, Microcephaly, severe Developmental Delay, Seizure Disorder, Nephrolithiasis, Urinary Retention and chronic respiratory failure. The petitioner requires gastrostomy (G tube) feedings, bladder catheterization, and mechanical ventilation. He has a tracheotomy and requires frequent suctioning. The petitioner is bedridden and needs constant assistance with all activities of daily living.

2. The petitioner lives with and receives care from his mother, [redacted] She is a single parent. There is a seven year old sibling at home who has some learning problems.

3. KePRO is the Peer Review Organization contracted by AHCA to perform medical review for the private nursing and personal care prior authorization program for Medicaid beneficiaries in the state of Florida.

4. Prior to review under challenge, the petitioner received 4,120 hours of PDN services. On September 23, 2008, Nationwide Healthcare Services, as the provider, submitted a request on behalf of the petitioner for 4,120 hours of private duty nursing for the period of September 18, 2008 to March 16, 2009.

5. The request was reviewed by a KePRO physician consultant Board-Certified in Pediatric who determined that there was no medical necessity supporting the above request for services. KePRO approved 3,758 hours of private duty nursing and denied 362 hours.

6. Reconsideration occurred on October 1, 2008, and the original decision was upheld. Denial Letters were issued to the petitioner.

7. The petitioner disagreed with this decision and a hearing was requested on October 7, 2008.

8. Dr. Mittel explained that according to the information submitted by the provider, the petitioner's mother works Monday through Saturday, from 8:00 a.m. to 5:00 p.m. and she is off on Sunday. Thus, KePRO determined that the petitioner's mother should be able to provide care to her son in the evening hours after she is home from work. Dr. Mittel noted that KePRO only denied two hours of coverage on Monday, Tuesday, Thursday, Friday and Saturday, in the evening from 8:00 p.m. to 10:00 p.m. In addition KePRO denied four hours on Sunday from 6:00 p.m. to 10:00 p.m.

9. The petitioner's representative explained that she takes her daughter to tutoring classes after she returns from work. The petitioner's representative also explained that she takes English classes on Mondays, Tuesdays, Thursdays and Fridays, from 6:00 p.m. to 10:00 p.m.

10. Dr. Mittel explained that this information was not provided to KePRO until now. Dr. Mittel stipulated that they could modify the denial and approve the

hours when the petitioner's representative attends the English classes on those four days, and only deny two hours on Saturday and four hours on Sunday.

11. The petitioner's representative expressed that she still disagrees with this determination because her son needs constant assistance and she has another child to care for.

12. Dr. Mittel explained that the PDN program is just to supplement care provided by parents and caregivers, and that they must participate in providing care as much as they can do.

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 new information provided by the petitioner's representative at the hearing, the respondent agreed to modify the denial and to approve two additional hours of PDN services on Mondays, Tuesdays, Thursdays and Fridays, from 8:00 p.m. to 10:00 p.m. for the period of March15, 2008 to September 10, 2009. The hearing officer agrees with this determination.

Therefore, the appeal is partially granted in accordance with above stipulation.

DECISION

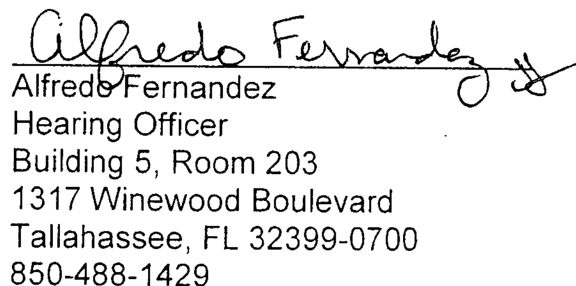
The appeal is partially granted as stated in the Conclusions of Law.

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 29th day of December, 2008,

in Tallahassee, Florida.



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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-04453

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 St. Johns
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 28, 2008, at 3:15 p.m. in Saint Augustine, Florida. The petitioner was represented by [redacted] consulting psychologist for the [redacted] appeared as a witness for the petitioner. The respondent was represented by Karen Dexter, assistant general counsel with the Agency for Health Care Administration (AHCA). Margaret Dorceus, medical health care program analyst with AHCA, appeared as a witness for the respondent. In addition, Debra Nussbaum, director of clinical services with Magellan Health Care of Florida, Inc. (Magellan); Dr, Michael Bojkovic, consulting reviewing psychiatrist with Magellan; and Dr. Alan Lipton, medical director for [redacted] of Florida appeared telephonically as witnesses for the respondent. Carrie English, long term behavioral

health care analyst with AHCA; Lee Ann Williams, utilization manager with AHCA and Stephanie Dovsky, senior account executive with Magellan, were present as observers.

The record was held open for both parties to submit proposed orders. A proposed order was received from the respondent; no proposed order from the petitioner.

ISSUE

The petitioner is appealing termination of psychosocial rehabilitation services under Medicaid. The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 23 year old female diagnosed with Mood Disorder not otherwise specified (NOS) and Mild to Moderate Mental Retardation. The Mood Disorder is the principal diagnosis for which the petitioner has been receiving psychosocial rehabilitation services at the [illegible] through the AHCA Prepaid Mental Health Program (PMHP) since at least January 2007. In addition to psychosocial rehabilitation, the petitioner also receives day treatment, individual therapy, group therapy and medication management services to treat her mental illness. The petitioner lives in a group home in [illegible] Florida.

2. Psychosocial rehabilitation services are intensive, short term, outpatient rehabilitative services. The petitioner attends psychosocial rehabilitation multiple times per week, multiple hours per day (approximately four days per week, five hours per day). The purpose of these services is to restore functioning skills lost due to mental illness. To qualify for coverage under the PMHP, the psychosocial rehabilitation services must be medically necessary. Medical necessity is determined by a prior

authorization review :s a specialized managed care organization contracted by AHCA to perform prior authorization reviews for psychosocial rehabilitation services.

3. In June 2008, the Center submitted an authorization request for continued psychosocial rehabilitation services for the petitioner to The request was reviewed by a clinician who concluded the medical necessity criteria were not met. The clinician consulted with psychiatrist (only a psychiatrist can make a non-authorization decision); is a contracted consultant with . He concurred with the clinician's assessment and assumed responsibility for completing the petitioner's authorization review. After reviewing the medical records submitted by the and discussing the case with one of the center's clinician's, Dr. Bojokovic concluded psychosocial rehabilitation services were not medically necessary. On June 19, 2008, a non-authorization notice was sent to the petitioner. On June 30, 2008, a hearing was requested by the petitioner's representative; the psychosocial rehabilitation services were continued pending the outcome of the hearing.

4. In August 2008, a reconsideration review was completed by Dr. Bojkovic again determined the medical necessity criteria required to receive psychosocial rehabilitation services was not met. On August 27, 2008, a reconsideration non-authorization notice was sent by to the petitioner.

5. Dr. Bojkovic appeared telephonically as a witness for the respondent. He is a board certified psychiatrist and an independent consulting reviewer for Dr. Bojkovic completed the aforementioned initial and reconsideration

non-authorizations for the petitioner. In his medical opinion, the petitioner lacks the cognitive functioning skills (due to her mental retardation) necessary to benefit from psychosocial rehabilitation services. The doctor explained that the ultimate goal of these services is for the recipient to be able to live independently in the community without daily support and to be able to maintain a job of some kind. The doctor further explained that the petitioner's level of cognitive functioning is that of a 2nd to 6th grader (a pre-teen child, age 8 to 12) and someone functioning on that level is incapable of living independently. It is Dr. Bojkovic's opinion that anyone with a diagnosis of mental retardation (principal or secondary) is precluded from receiving psychosocial rehabilitation services. He believes the petitioner was determined to be eligible for these services in error. [redacted], [redacted] director of clinical services, also appeared as a witness for the respondent. She explained that Medicaid does not pay for treatment of mental retardation. However, a patient with a principal diagnosis of mental illness may also have a secondary diagnosis of mental retardation and still qualify for psychosocial rehabilitation services to treat the mental illness. She went on to explain that a principal diagnosis of a mental illness is not the only criteria which must be met to qualify for continued psychosocial rehabilitation services; the recipient must also receive benefit from the services. Ms. Nussbaum explained that the clinical information submitted quarterly by [redacted] with the reauthorization requests showed no change in the petitioner's goals, behaviors, medications or assessments for approximately a year. [redacted] concluded that the petitioner had received maximum benefit from psychosocial rehabilitation and therefore, the services were no longer medically necessary. Ms. Nussbaum asserted that the services are intensive for the

purpose of expediting the rehabilitative process. The services should not exceed a few months, a year at most. Ms. Nussbaum noted the cancellation of psychosocial rehabilitation services will not impact the other services the petitioner receives at the [redacted] She will continue to receive group therapy, individual therapy, medication management and other behavioral services to treat her mental illness.

6. Dr. Alan Lipton appeared telephonically as a witness for the respondent. He is a board certified psychiatrist and the medical director for [redacted] of Florida. He reviews all non-authorization decisions which are appealed. Dr. Lipton concurs with the non-authorization decision reached by Dr. Bojkovic. Dr. Lipton reached his decision after reviewing the clinical records provided by the [redacted] In his opinion, the petitioner lacks the cognitive functioning skills necessary to benefit from psychosocial rehabilitation due to her diagnosis of mild to moderate mental retardation. Dr. Lipton argued that the petitioner's unsuitability for these services is evidenced by her lack of sustained progress after nearly two years of intensive psychosocial rehabilitation. In his opinion, the petitioner has received maximum benefit from these services and continuation of services that do not help the petitioner may actually be harmful. Dr. Lipton believes the petitioner's condition would be more appropriately treated in a program designed for the developmentally disabled.

7. [redacted] appeared as a witness for the petitioner. [redacted] is a consulting psychologist who works with the treating clinicians at the [redacted] Center. In her capacity as a consultant, she provides oversight services such as assisting clinicians with assessing the progress of patient treatment plans. In her position, [redacted] has the opportunity to observe the petitioner daily Monday through

Friday during working hours. Based on her observations and review of the petitioner's clinical records [redacted] believes the petitioner was correctly diagnosed with Mood Disorder NOS. In her opinion the petitioner's progress is evidenced by the progress notes in the clinical file. [redacted] admitted that she does not provide psychosocial rehabilitation at the [redacted] and has never treated the petitioner for her mental illness. [redacted] disagrees with the reviewing physicians' conclusion that the petitioner will never be able to live independently. [redacted] does not believe independence requires living without any support system; she believes all human beings require some form of support regardless to their living environment. She believes independent living is accomplished by the individual living up to their maximum level of functioning. [redacted] admitted that the petitioner has not yet reached her maximum level of functioning, but feels this can be accomplished with continued psychosocial rehabilitation.

8. The petitioner's treating psychiatrist at the [redacted] did not appear as a witness at the hearing. The petitioner's representative offered into evidence a prescription reportedly written by [redacted] on July 21, 2008 prescribing psychosocial rehabilitation for the petitioner as proof that the treating psychiatrist believes the petitioner continues to need psychosocial rehabilitation services.

9. The petitioner's psychosocial rehabilitation progress is charted by, among other things, Master Treatment Plans, Treatment Plan Reviews and Global Assessment of Functioning (GAF) scores. The Master Treatment Plan is comprised of major goals and goal objectives created annually by the petitioner and the petitioner's treating

clinicians. The goals are categorized by functioning skills lost due to the participant's mental illness. Reviews are conducted quarterly to assess the progress made in meeting the main goals and goal objectives of the Master Treatment Plan. The GAF is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. The clinical records document that the petitioner has never met any of the goals of her Master Treatment Plan and has had a consistent GAF score of 40 (this score is within the range of Moderate Mental Retardation). The Respondent argued that these results prove that the petitioner is not benefiting from psychosocial rehabilitation and therefore the services are not medically necessary. The petitioner's representative argued that meeting objectives within major goals of the treatment plan is substantial evidence of the petitioner's progress. Both parties stipulate that psychosocial rehabilitation services are intended for short term utilization only. The respondent defines short term as a few months up to a year. The opposing party believes short term cannot be defined in general terms and should be determined on a case by case basis.

CONCLUSIONS OF LAW

Medical services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Florida Administrative Code Rule 59G-1.010(166)(a)(c) as follows:

> 'Medically necessary' or 'medical necessity' means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) 'Medically necessary' or 'medical necessity' for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The above authority defines medical necessity criteria relative to eligibility for Medicaid services.

The Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook, October 2004, is incorporated by reference in Fla. Admin. Code 59G-4.050. The service exclusions section of the handbook, page 2-1-4 states in relevant part:

> Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation.
>
> Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

The above cited legal authority makes it clear that Medicaid does not pay for the treatment of mental retardation.

Magellan Behavioral Health of Florida, Inc. 2007 Medical Necessity Criteria, Utilization Management Guidelines, IV Community Mental Health Services c. Psychosocial Rehabilitation Services – Adult and Child/Adolescent, states in part:

Continued Stay Service Components (Must meet 1 and 2)

1. An assessment appropriate to the model of recovery indicates at least one of the following:

a. As a result of the mental illness, there are or continue to be functional impairments and skill deficits which are effectively addressed in the psychiatric rehabilitation plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues.

Or

b. There is reasonable expectation that the withdrawal of services may result in the loss of rehabilitation gains or goals attained by the enrollee.

Or

c. A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change.

2. The enrollee chooses to continue participation in the program.

Exclusion Criteria:

(Any of the following)

1. Enrollee's identified problem is primarily social, financial, and/or medical (non-psychotic) in the absence of a primary psychiatric diagnosis of one of the following ICD-9 codes: 290.0-290.43, 293.0-298.9, 300.00-301.9, 302.7, 306.51-312.4, 312.81-314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.
2. Substance abuse is the primary source of impairment in the absence of active symptoms.
3. Enrollee abandons the intent of or is incapable of moving toward independent living.
4. Enrollee is a passive participant and therefore unable to participate actively in the development and execution of a rehabilitative plan.

It is the opinion of the reviewing psychiatrist that the absence of mental retardation in the exclusion criteria code list shown above precludes anyone with mental retardation from receiving psychosocial rehabilitation services. [redacted] director of clinical services, whose job it is to ensure Magellan compliance with Medicaid policy,

believes that it is the principal diagnosis and effectiveness of services which determines continued eligibility. In her opinion, individuals with a primary (or principal) diagnosis of mental illness and a secondary diagnosis of mental retardation may qualify to receive psychosocial rehabilitation services to treat the mental illness, if the other eligibility criteria are also met. Individuals with a primary (or principal) diagnosis of mental retardation or only a diagnosis of mental retardation cannot receive psychosocial rehabilitation services. In considering which of the above interpretations was correct, the undersigned hearing officer gave greater weight to the testimony of the director of clinical services as it is her responsibility to ensure [redacted] has correctly interpreted Medicaid policy. The undersigned hearing officer gave greater weight to the testimony of contract Manager as this is her area of expertise; however, this issue did not impact the ultimate decision of the hearing officer.

Fla. Admin. Code 65-2.056 (3) in parts states:

> 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.

It is the respondent's opinion that the undersigned hearing officer is limited to consideration of evidence available at the time of the adverse action under appeal. However, the legal authority cited above makes it clear that the hearing is a de novo proceeding; either party may present new or additional evidence not previously considered by the agency in making its decision. The undersigned hearing officer considered all the evidence and testimony presented by both parties.

Fla. Admin. Code 65-2.060 in parts states:

> 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 office

The agency terminated psychosocial rehabilitation services for the petitioner. The controlling legal authority cited above makes it clear that the burden of proof rests with the agency to prove the correctness of this action by a preponderance of the evidence. Evidence submitted by the respondent proves the petitioner has been receiving psychosocial rehabilitation services since January 2007 without successfully meeting any of the goals of her Master Treatment Plan. In the months prior to the non-authorization decision, the petitioner's mental health deteriorated; the petitioner had been receiving psychosocial rehabilitation for over a year at that time. The respondent argued that after nearly two years of intensive psychosocial rehabilitation, it cannot be reasonably expected that the petitioner will receive additional rehabilitative benefit from these services. Termination of psychosocial rehabilitation will not end all treatment of the petitioner's mental illness. The petitioner will continue to receive individual therapy, group therapy, medication management and various behavioral services to treat her mental illness. The petitioner's witness, consulting psychologist [redacted] admitted the petitioner has failed to meet the goals of her treatment plan and that the petitioner's mental health deteriorated in recent months, however, she believes the overall clinical picture shows the petitioner has benefited from psychosocial rehabilitation and therefore

the services should be continued. The petitioner's treating psychiatrist did not testify during the hearing. Comparatively significant weight was given to the testimony of the reviewing psychiatrists.

After carefully reviewing the testimony, evidence, and controlling legal authorities, the hearing officer concludes that the respondent met its burden of proof by presenting evidence which established that it is not medically necessary for the petitioner to receive psychosocial rehabilitation services as the service is in excess of the petitioner's needs; the services have not produced any significant or sustained benefit in almost two years.

DECISION

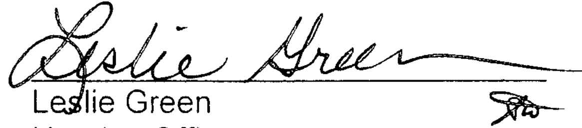
The appeal is denied. The agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of December, 2008,

in Tallahassee, Florida.



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

APPEAL NO. 08F-06587

PETITIONER,

Vs.

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on November 14, 2008, at 10:55 a.m., in Palatka, Florida. The petitioner was not present. He was represented by his mother and father, [redacted] and [redacted]. The respondent was represented by Alice Reshard, program administrator with the Agency for Health Care Administration (AHCA). Edna Clifton, operations manger with KePRO and Dr. Rakesh Mietal, consultant physician reviewer for KePRO appeared telephonically as witnesses for the respondent.

The record was held open for the petitioner's mother to provide additional evidence which was received and entered as Petitioner's Composite Exhibits 1 and 2.

ISSUE

At issue is the respondent's decision of August 13, 2008 to deny 816 hours of private duty nursing services paid by Medicaid for the petitioner. The agency bears the

burden of proof.

FINDINGS OF FACT

1. The petitioner is a 18 year old male diagnosed with a history of cerebral palsy, seizure disorder, legally blind, Global delays, non verbal, non ambulatory, incontinent, chronic respiratory disease, wheel chair bound, fragile bones. The petitioner cannot communicate his needs and is totally dependant in all care. He is fed pureed food by bottle and receives medications by a gastronomy tube (g tube).

2. The petitioner lives with his mother, father (age 59), brother (age 23) and grandmother (age 76). His mother works in the home as a telephone translator Monday through Wednesday 9:00 a.m. through 5:30 p.m. The mother suffers from diabetes but is otherwise healthy. The petitioner's father does not work. He has a history of partial paralysis, lumbar spinal steno sis, hypertension, and hyperlipidemia. He is unable to assist with the petitioner's care. The petitioner's brother suffers from downs syndrome and lacks the cognitive functioning skills to assist with the petitioner's care. The petitioner's grandmother is also unable to assist with the petitioner's care; she is elderly and has a history of vertigo and colon cancer. The petitioner's mother is the only family member capable of taking care of the petitioner's needs. She is the only member of the household who is physically able to drive; she is responsible for taking all the family members to medical appoints, picking up their prescriptions, and all the other transportation needs of the average family. The petitioner's father attends medical appointments three times per week for approximately four hours per day. His grandmother attends medical appointments on average once a month.

3. The family was living in south Florida until June 2008. While living in south Florida, the petitioner was been receiving private duty nursing (PDN) under Medicaid Monday – Sunday (seven days a week), 9:00 a.m. to 5:00 p.m.; total 1440 PDN hours. The service certification period in south Florida was April 3, 2008 through September 29, 2008. The household relocated to north Florida in June 2008; the PDN services were terminated until a prior authorization review was completed based on the new family circumstances. On August 11, 2008, the petitioner's new provider of private duty nursing benefits, Maxim Healthcare Services, submitted an authorization request for 1440 hours of PDN, for the period of August 11, 2008 through February 6, 2009.

4. To qualify for payment by Medicaid, PDN hours must be medically necessary. Medical necessity is determined by a prior authorization review. KePRO is the Peer Review Organization (PRO) contracted by AHCA to perform medical reviews for PDN. In August 2008, a KePRO clinician reviewed the petitioner's request for 1440 hours of PDN; 624 hours were approved, the remaining 816 hours requested were denied. In September 2008, a reconsideration review was completed by a different clinician who reached the same conclusion; 624 hours were approved, 816 hours were denied. The reconsideration notes state in part: "It seems that mother has sufficient help from family in providing lift and position changes for recipient. I would agree with the first physician..."

5. Dr. Rakesh Mietal appeared telephonically as a witness from the respondent. He is a licensed physician and independent consulting reviewer for KePRO. He completed a third review of the petitioner's PDN request and reached the same conclusion as the two previous reviewers. Dr. Mietal explained that he took into consideration the

petitioner's medical condition, the medical conditions of the other family members and the petitioner's social environment. He concluded that PDN hours are needed for the hours the petitioner's mother works which are Monday through Wednesday 9:00 a.m. through 5:30 p.m. In his opinion, the family is capable of taking care of the petitioner during the hours the mother is not working (after 5:30 p.m. Monday through Wednesday and all day Thursday through Sunday).

6. The petitioner's mother disagrees with KePRO's decision. She believes KePRO does not fully understand the household circumstances. She explained that she is the only member of her household with both the physical and cognitive skills required to take care of the petitioner; she has no other assistance. When not working or taking care of the petitioner, she must take care of the medical transportation needs of her husband and mother. A minimum of 12 hours a week are spent taking just the husband to physical therapy (three times per week, four hours per trip including travel time). The petitioner admitted this therapy is temporary, but argued her husband's paralysis has only marginally improved; additional surgery is required which will necessitate more medical appointments and more therapy. In addition, her mother has medical appointments on average once a month.

7. After hearing this testimony, Dr. Mietal offered an additional four hours of PDN on Fridays and Saturdays (eight additional PDN hours per week) for the petitioner's mother to transport the other family members to medical appointments, pick up prescriptions and other medically necessary transportation. The petitioner's mother would like the full 1440 requested PDN hours. She believes the petitioner's health is at risk because she must also attend to the needs of the other family members. The petitioner has to be

repositioned constantly. His mother explained that he is developing a skin condition because she cannot turn him as often as needed because she is also taking care of the other family members.

8. The petitioner's mother provided medical records for her husband dated August 2007 which state in part "Assessment: cervical myelopathy with incomplete tetraplegia status post c5-6 anterior discectomy and fusion, neurogenic bowel, neurogenic bladder, hypertension, hyperlipidemia, hypocalcemia, leukocytes, Plan: the patient will be admitted for comprehensive inpatient rehabilitation, occupational therapy to upgrade his activities of daily living and self-care activities, working on upper extremity strength as well as fine motor skills of both hands, physical therapy to increase his overall limb strength, balance, transfer and wheelchair training." The petitioner's mother argued that her husband's condition has improved to the extent that he now uses a walker instead of a wheelchair and he can take care of most of his own personal care. However, he is unable to help care for the petitioner.

9. The petitioner's mother provided December 2007 medical records for the petitioner regarding his recurrent seizures and March 1991 neurologic consultation notes which document the petitioner has suffered from seizures and developmental disabilities since birth.

CONCLUSIONS OF LAW

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

Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

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

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

It is concluded that the agency needed to review need for nursing service.

Florida Statute 409.913 addresses Oversight of the integrity of the Medicaid program, with (1)(d) describing "medical necessity or medically necessary" standards and says in relevant part: "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity..."

Code 59.G-1.010, Definitions, states for medical necessity:

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) 'Medically necessary' or 'medical necessity' for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The above authority defines medical necessity criteria relative to eligibility for Medicaid Services.

The Home Health Services Coverage and Limitations Handbook defines private duty nursing (at page 2-15):

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

Fla. Admin. Code 65-2.056 Basis of Hearings states in part:

> 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...
>
> (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.

The agency denied PDN services based on information submitted by the provider in a prior authorization request for services. The reviewer's decision was based in part on the belief that the petitioner's mother had sufficient help from family in providing for the petitioner's care. At the hearing, the petitoner's mother introduced medical conditions, and other pertinent information which proves the other family members are not able to help her with the petitioner's care. The petitioner's father has lifting restrictions due to his partial paralsysis; the petitioner's grandmother is not stable on her feet; she suffers from vertigo and colon cancer. The petitioner's 23 year old borther has downs syndrone and is unable to assist with the petitioner's care. As the reviewer's determination was not based on the petitioner's actual situation, it can only be given limited weight. Based on the above cited rule concerning de novo hearings, relevant new evidence can be considered.

According to the above authorities, the assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep and care for other family dependents. After carefully reviewing the testimony, evidence and controlling legal authorities, the hearing officer finds that the respondent has not met its burden of proof and that the respondent's action to reduce Private Duty Nursing is not supported by the record. In addition, the findings show that there are no able-bodied household members to assist the mother with the petitioner's care. Therefore, the undersigned cannot affirm the respondent's denial of PDN hours.

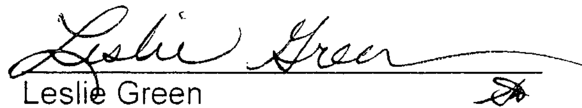
DECISION

The appeal is granted. The respondent's action to deny 816 hours of PDN is hereby reversed.

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 23rd day of December, 2008, in Tallahassee, Florida.



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

APPEAL NO. 08F-06944

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 November 13, 2008, at 11:00 a.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by his mother, [redacted]. Also present was [redacted], director of clinical services from [redacted]. The respondent was represented by Ken Hamlin, program operations administrator. Present on the telephone from Kepro was Dr. Rakesh Mittal, and Theresa Ashy, review operations supervisor.

ISSUE

At issue is the Agency's October 6, 2008 action of approving the petitioner's skilled home nursing services for 3,032 hours, and denying 1,032 hours for October 7, 2008 to April 4, 2009. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, date of birth (;, is 15 years old. He is a Medicaid benefits recipient in Broward County, Florida.

2. Included in the evidence is a copy of a Recipient Denial Letter, dated October 6, 2008, stating that 3,032 hours of skilled home nursing services were approved, and 1,032 hours were denied for the petitioner for October 7, 2008 to April 4, 2009.

3. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld notice, dated October 14, 2008. This notice informs the petitioner that upon reconsideration, the approval of 3,032 hours of skilled home nursing services, and the denial of 1,032 hours from October 7, 2008 to April 4, 2009, was upheld.

4. Included in the evidence is a copy of a Kepro Internal Focus Review Findings Report, dated September 30, 2008, stating that the petitioner's requested number of nursing hours are Mondays through Fridays 22 hours per day, and on Saturdays and Sundays 24 hours per day. It also states that the petitioner was diagnosed with anoxic brain damage, quadriplegia, hypertension, incontinent, and he also has gastrostomy and jejunostomy tubes.

5. Included in the evidence is a copy of a Kepro Synopsis Of Case Report stating that the household consists of only the petitioner and his mother. It states that his mother works three days per week on Mondays and Tuesdays from 2:00 p.m. to 11:00 p.m., and Saturdays from 8:00 a.m. to 8:00 p.m.

6. The petitioner's mother's work hours were considered in determining the denial of requested nursing hours. It was determined that the petitioner's mother can take care of him when she does not work on Sundays, Wednesdays, Thursdays, and Fridays from

12 noon to 10:00 p.m., therefore skilled home nursing care was denied for the petitioner for these times.

7. The petitioner's mother is a nurse who works at [redacted] This is the nursing service that takes care of her son, and her employer was present at the hearing.

8. According to the petitioner's mother, as of October 2008, her work hours have changed to six days per week with Sundays off. According to the Synopsis Of Case, the requested nursing care was for flexible hours that his mother needs, and it was stated that Kepro is not authorized to approve flexible 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 3,032 hours, and denied 1,032 hours for October 7, 2008 to April 4, 2009.

The petitioner's requested number of nursing hours are Mondays through Fridays 22 hours per day, and on Saturdays and Sundays 24 hours per day. The petitioner's mother's work hours, as reported on the Synopsis Of Case, were considered in determining the denial of requested nursing hours. According to the petitioner's mother, as of October 2008, her work hours have changed to six days per week with Sundays off.

An Agency determination was made based on the petitioner's mother's work schedule, and at the hearing it was found that her work scheduled has changed. In accordance with judicial precedence, the hearing officer is required to consider information at the hearing in making the final decision. After careful consideration, it is determined that the Agency's action of denying 1,032 hours of skilled home nursing care is not upheld, and the petitioner's request for nursing hours for Mondays through Fridays 22 hours per day, and on Saturdays and Sundays 24 hours per day, is granted.

DECISION

The appeal is granted, as explained in the Conclusions Of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9th day of December, 2008,

in Tallahassee, Florida.

Stuart Imberman

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

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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-04425

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 St. Johns
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 28, 2008, at 10:15 a.m. in Saint Augustine, Florida. The petitioner was represented by [redacted]. [redacted] consulting psychologist for [redacted] appeared as a witness for the petitioner. The respondent was represented by Karen Dexter, assistant general counsel with the Agency for Health Care Administration (AHCA). Margaret Dorceus, medical health care program analyst with AHCA appeared as a witness for the respondent. Debra Nussbaum, director of clinical services with Magellan Health Care of Florida, Inc. (Magellan), Dr. Michael Bojkovic, consulting reviewing psychiatrist with Magellan and Dr. Alan Lipton, M. D., medical director for Magellan of Florida appeared telephonically as witnesses for the respondent. Lee Ann Williams, utilization manager with AHCA and Stephanie Dovsky, senior account executive with Magellan observed.

The record was held open for both parties to submit proposed orders. A proposed order was received from the respondent only.

ISSUE

The petitioner is appealing termination of psychosocial rehabilitation services under Medicaid. The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 30 year old male diagnosed with Psychotic Disorder not otherwise specified (NOS) and Mild to Moderate Mental Retardation. The Psychotic Disorder is the principal diagnosis for which the petitioner has been receiving psychosocial rehabilitation services at the [redacted] through the Medicaid Prepaid Mental Health Program (PMHP) since at least January 2007. In addition to psychosocial rehabilitation, the petitioner also receives day treatment, individual therapy, group therapy and medication management services. The petitioner lives at the [redacted] Florida.

2. Psychosocial rehabilitation services are intensive, short term, outpatient rehabilitative services. The petitioner attends psychosocial rehabilitation approximately four days per week, approximately five hours per day. The purpose of these services is to restore functioning skills lost due to mental illness. To qualify for coverage under the PMHP, the psychosocial rehabilitation services must be medically necessary. Medical necessity is determined by a prior authorization review. Magellan is a specialized managed care organization contracted by AHCA to perform prior authorization reviews for psychosocial rehabilitation services.

3. In June 2008, the [redacted] submitted an authorization request for continued psychosocial rehabilitation services for the petitioner to Magellan. The request was reviewed by a Magellan clinician who concluded the medical necessity criteria were not met. The clinician consulted with psychiatrist Dr. Michael Bojkovic (only a psychiatrist can make a non-authorization decision); Dr. Bojokovic is a contracted consultant with Magellan. He concurred with the clinician's assessment and assumed responsibility for completing the petitioner's authorization review. After reviewing the medical records submitted by the [redacted] and discussing the case with one of the center's clinician's, Dr. Bojokovic concluded psychosocial rehabilitation services were no longer medically necessary because the petitioner's psychiatric condition was stable. Dr. Bojokovic determined the petitioner would not benefit from further treatment. On June 18, 2008, a non-authorization (termination) notice was sent to the petitioner terminating psychosocial rehabilitation services under Medicaid effective June 30, 2008. On June 30, 2008, a hearing was requested by the petitioner's representative; the psychosocial rehabilitation services have been continued pending the outcome of the hearing.

4. In August 2008, a reconsideration review was completed by Magellan. The reviewing physician again determined the petitioner's psychiatric condition was stable and therefore the medical necessity criteria required to receive psychosocial rehabilitation services was not met. On August 27, 2008, a reconsideration non-authorization notice was sent by Magellan to the petitioner.

5. Dr. Bojkovic appeared telephonically as a witness for the respondent. He is a board certified psychiatrist and an independent consulting reviewer for Magellan. Dr. Bojkovic completed the aforementioned initial and reconsideration non-authorizations for the petitioner. In his medical opinion, the petitioner lacks the cognitive functioning skills (due to his mental retardation) necessary to benefit from psychosocial rehabilitation services. The doctor explained that the ultimate goal of these services is for the recipient to be able to live independently in the community without daily support and to be able to maintain a job of some kind. The doctor further explained that the petitioner's level of cognitive functioning is that of a 2nd to 6th grader (a pre-teen child, age 8 to 12) and someone functioning on that level is incapable of living independently. Dr. Bojkovic believes the petitioner's presenting systems (talking to himself, withdrawn, blunt affect, presents as confused, responds to internal stimuli- possibly experiencing auditory hallucinations) can be attributed to his mental retardation. It is Dr. Bojkovic's opinion that anyone with a diagnosis of mental retardation is precluded from receiving psychosocial services. He believes the petitioner was determined to be eligible for these services in error.

6. Dr. Alan Lipton appeared telephonically as a witness for the respondent. He is a board certified psychiatrist and the medical director for Magellan of Florida. He reviews all non-authorization decisions which are appealed. Dr. Lipton concurs with the non-authorization decision reached by the reviewing physician. Dr. Lipton reached his decision after reviewing the clinical records provided by the [redacted] In his opinion, the petitioner's presenting symptoms (detailed in the paragraph above) are consistent with a diagnosis of Mild to Moderate Mental Retardation. In Dr. Lipton's

opinion, the petitioner's mental illness diagnosis is not supported by the clinical records. Dr. Lipton believes the petitioner's unsuitability for psychosocial rehabilitation is evidenced by the length of time the petitioner has been receiving services (22 months as of the date of the hearing) designed for short term utilization only. Dr. Lipton believes the petitioner's presenting symptoms would be more appropriately served in a program designed for the developmentally disabled.

7. [redacted] appeared as a witness for the petitioner. [redacted] is a consulting psychologist who works with the treating clinicians at the [redacted] In her capacity as a consultant, she provides oversight services such as assisting clinicians with assessing the progress of patient treatment plans. In her position, [redacted] has the opportunity to observe the petitioner daily Monday through Friday during working hours. Based on her observations and review of the petitioner's clinical records, [redacted] believes the petitioner was correctly diagnosed with Psychotic Disorder NOS. She admits the petitioner is also mentally retarded, but in her professional opinion the Psychotic Disorder NOS in the principal diagnosis. [redacted] believes the petitioner is benefiting from psychosocial rehabilitation. In her opinion the petitioner's progress is evidenced in part by him moving recently from a restricted group home to a group home with much less supervision. [redacted] admitted that she does not provide psychosocial rehabilitation services at the [redacted]r and has never treated the petitioner for his mental illness, however, she disagrees with Dr. Lipton's and Dr. Bojkovic's opinions that the petitioner's diagnosis of mental illness was misappropriate. [redacted] also disagrees with their assertions that the petitioner will never be able to live independently. [redacted] does not believe independence

requires living without any support system; she believes all human beings require some form of support regardless to their living environment. She believes independent living is accomplished by the individual living up to his maximum level of functioning.

8. The petitioner's treating psychiatrist at the [redacted] did not appear as a witness at the hearing. His most recent notes, dated April 14, 2008, in the petitioner's clinical file read in part: "Behavioral graphs note that [redacted] has had a decrease in his verbal outbursts and his non-reality based statements...Overall his behavior has been stable."

9. The petitioner's psychosocial rehabilitation progress is charted by, among other things, Master Treatment Plans, Treatment Plan Reviews and Global Assessment of Functioning (GAF) scores. The Master Treatment Plan is comprised of major goals and goal objectives created annually by the petitioner and the petitioner's treating clinicians. The goals are categorized by functioning skills lost due to the participant's mental illness. Quarterly reviews are conducted to assess the petitioner's progress in meeting the main goals and goal objectives of the Master Treatment Plan. The GAF is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. The clinical records document that the petitioner has never met any of the goals of his Master Treatment Plan, however his GAF score has increased from 35 to 45 during his years of psychosocial rehabilitation. Both scores fall within the range of moderate retardation (moderate retardation range 35-40 to 50-55).

CONCLUSIONS OF LAW

Medical services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Florida Administrative Code Rule 59G-1.010(166)(a)(c) as follows:

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

The above authority defines medical necessity criteria relative to eligibility for Medicaid services.

The Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook, October 2004, is incorporated by reference in Fla. Admin. Code 59G-4.050. The service exclusions section of the handbook, page 2-1-4 states in relevant part:

Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation.

Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

The above cited legal authority makes it clear that Medicaid does not pay for the treatment of mental retardation.

Magellan Behavioral Health of Florida, Inc. 2007 Medical Necessity Criteria, Utilization Management Guidelines, IV Community Mental Health Services c. Psychosocial Rehabilitation Services – Adult and Child/Adolescent, states in part:

1. An assessment appropriate to the model of recovery indicates at least one of the following:

a. As a result of the mental illness, there are or continue to be functional impairments and skill deficits which are effectively addressed in the psychiatric rehabilitation plan. In the event that earlier efforts have not achieved the intended objectives, the revised plan indicates service modifications to address these issues.

Or

b. There is reasonable expectation that the withdrawal of services may result in the loss of rehabilitation gains or goals attained by the enrollee.

Or

c. A change in program or level of service is indicated and a transition plan is in place reflecting the proposed change.

Exclusion Criteria:

(Any of the following)

1. Enrollee's identified problem is primarily social, financial, and/or medical (non-psychotic) in the absence of a primary psychiatric diagnosis of one of the following ICD-9 codes: 290.0-290.43, 293.0-298.9, 300.00-301.9, 302.7, 306.51-312.4, 312.81-314.9, 315.3, 315.31, 315.5, 315.8, and 315.9.

2. Substance abuse is the primary source of impairment in the absence of active symptoms.

3. Enrollee abandons the intent of or is incapable of moving toward independent living.

4. Enrollee is a passive participant and therefore unable to participate actively in the development and execution of a rehabilitative plan.

It is the opinion of the reviewing psychiatrist that the absence of mental retardation in the exclusion criteria code list shown above precludes anyone with mental retardation from receiving psychosocial rehabilitation services. The undersigned hearing officer found no legal authority to substantiate this assertion and therefore concluded that a diagnosis of mental retardation does not preclude the petitioner from receiving psychosocial rehabilitation. This issue was given consideration, but did not impact the ultimate decision of the hearing officer.

Fla. Admin. Code 65-2.056 (3) in parts states:

> 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.

It is the respondent's opinion that the undersigned hearing officer is limited to consideration of evidence available at the time of the adverse action under appeal. However, the legal authority cited above makes it clear that the hearing is a de novo proceeding; either party may present new or additional evidence not previously considered by the agency in making its decision. The undersigned hearing officer considered all the evidence and testimony presented by both parties.

Fla. Admin. Code 65-2.060 in parts states:

> 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 office

The agency terminated psychosocial rehabilitation services for the petitioner. The controlling legal authority cited above makes it clear that the burden of proof rests with the agency to prove the correctness of this action by a preponderance of the evidence. Evidence submitted by the respondent shows the petitioner has been receiving psychosocial rehabilitation services since January 2007 without successfully meeting the goals of his Master Treatment Plan. The petitioner's cognitive functioning has improved as evidenced by the 10 point increase (35 to 45) in his GAF score; however, both scores are included in the range of moderate retardation. The respondent believes that after nearly two years of intensive psychosocial rehabilitation it cannot be reasonably expected that petitioner will receive additional rehabilitative benefit from these services. It is the opinion of the respondent's expert witnesses Dr. Lipton and Dr. Bojkovic that all of the petitioner's presenting symptoms are attributable to his mental retardation and that the mental illness diagnosis is not supported by the clinical record. The petitioner's witness, [redacted] admitted that the petitioner has not met the goals of his treatment plan; however, she believes the petitioner's progress is evidenced by his improved GAF score and his move to a less restrictive group home. [redacted] believes the petitioner should continue to receive

psychosocial rehabilitation services. The petitioner's treating psychiatrist did not testify during the hearing. The most recent clinical notes written by the treating psychiatrist describe the petitioner as stable. As the only psychiatrists to testify at the hearing, Dr. Lipton's and Dr. Bojkovic's expert medical opinions were given comparatively significant weight in the overall conclusions.

After carefully reviewing the testimony, evidence, and controlling legal authorities, the hearing officer finds that the respondent met its burden by presenting evidence which establishes that it is not medically necessary for the petitioner to receive psychosocial rehabilitation services because the petitioner has received maximum benefit from these services and they are in excess of the petitioner's needs.

DECISION

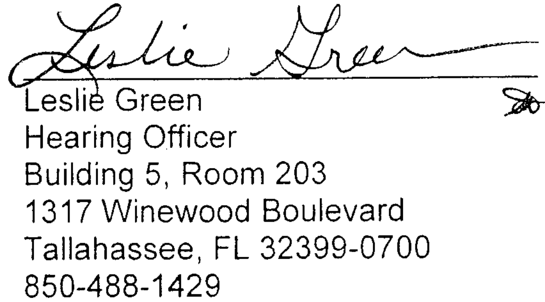
The appeal is denied. The agency's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18th day of December, 2008,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 203
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OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-04429

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 St. Johns
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened telephonically before the undersigned hearing officer on November 19, 2008, at 11:06 a.m. The petitioner was represented by [redacted] [redacted], consulting psychologist for [redacted] appeared as a witness for the petitioner. The respondent was represented by Karen Dexter, assistant general counsel with the Agency for Health Care Administration (AHCA). Margaret Dorceus, medical health care program analyst with AHCA, Debra Nussbaum, director of clinical services with Magellan Health Care of Florida, Inc. (Magellan), and Dr. Alan Lipton, M. D. and medical director for Magellan of Florida appeared as witnesses for the respondent. Stephanie Dovsky, senior account executive with Magellan observed.

The record was held open for both parties to submit proposed orders. A proposed order was received from the respondent; not from the petitioner.

ISSUE

The petitioner is appealing termination of psychosocial rehabilitation services under Medicaid. The respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 34 year old male diagnosed with Impulse Control Disorder and Profound Mental Retardation. The Impulse Control Disorder is the principal diagnosis for which the petitioner has been receiving psychosocial rehabilitation services at the [redacted] through the Medicaid Prepaid Mental Health Program (PMHP) since at least January 2007. In addition to psychosocial rehabilitation, the petitioner also receives day treatment, individual therapy, group therapy and medication management services. The petitioner lives at the [redacted] in Saint Augustine, Florida. The group home is located on the same grounds as the [redacted]

2. Psychosocial rehabilitation services are intensive, short term, outpatient rehabilitative services. The purpose of these services is to restore functioning skills lost due to mental illness. To qualify for coverage under the PMHP, the psychosocial rehabilitation services must be medically necessary. Medical necessity is determined by a prior authorization review. Magellan is a specialized managed care organization contracted by AHCA to perform prior authorization reviews for psychosocial rehabilitation services.

3. In June 2008, the [redacted] submitted an authorization request for continued psychosocial rehabilitation services for the petitioner to Magellan. The request was reviewed by a Magellan clinician who concluded the medical necessity

criteria were not met. The clinician consulted with psychiatrist Dr. Michael Bojkovic (only a psychiatrist can make a non-authorization decision); Dr. Bojokovic is a contracted consultant with Magellan. He concurred with the clinician's assessment and assumed responsibility for completing the petitioner's authorization review. After reviewing the medical records submitted by the [redacted] and discussing the case with one of the center's clinician's, Dr. Bojokovic concluded psychosocial rehabilitation services were no longer medically necessary because the petitioner's psychiatric condition was stable. Dr. Bojokovic determined the petitioner would not benefit from further treatment. On June 19, 2008, a non-authorization (termination) notice was sent to the petitioner terminating psychosocial rehabilitation services under Medicaid effective June 30, 2008. On June 30, 2008, a hearing was requested by the petitioner's representative; the psychosocial rehabilitation services have been continued pending the outcome of the hearing.

4. In August 2008, a reconsideration review was completed by Magellan. The reviewing physician again determined the petitioner's psychiatric condition was stable and therefore the medical necessity criteria required to receive psychosocial rehabilitation services was not met. On August 27, 2008, a reconsideration non-authorization notice was sent by Magellan to the petitioner.

5. Dr. Alan Lipton appeared telephonically as a witness for the respondent. He is a board certified psychiatrist and the medical director for Magellan of Florida. He reviews all non-authorization decisions which are appealed. Dr. Lipton concurs with the non-authorization decision reached by the reviewing physician. Dr. Lipton reached his decision after reviewing the clinical records provided by the [redacted] In his

opinion, the petitioner's presenting symptoms (inappropriate touching and grabbing of people and objects) are consistent with a diagnosis of Profound Mental Retardation. In Dr. Lipton's opinion, the petitioner's mental illness diagnosis is not supported by the clinical records. He explained that people with the petitioner's level of retardation have obvious problems with verbal communication, an inability to relate to others, difficulty with the activities of daily living and are severely and universally disabled. Profound retardation is the worst type of retardation in terms of severity; people with this level of retardation lack the cognitive functioning skills necessary to live independently. They will always require a supportive or assisted environment in which to live. Dr. Lipton argued that in his opinion, the petitioner's mental illness misdiagnosis is evidenced by his lack of progress and unchanging behaviors after nearly two years of intensive psychosocial rehabilitation services. Dr. Lipton believes the petitioner's presenting symptoms would be more appropriately served in a program designed for the developmentally disabled.

6. [ ] appeared telephonically as a witness for the petitioner. [ ] is a consulting psychologist who works with the treating clinicians at the [ ]. In her capacity as a consultant, she provides oversight services such as assisting clinicians with assessing the progress of patient treatment plans. In her position, [ ] has the opportunity to observe the petitioner daily Monday through Friday during working hours. Based on her observations and review of the petitioner's clinical records, [ ] believes the petitioner was correctly diagnosed with Impulse Control Disorder. She admits the petitioner is also profoundly mentally retarded, but in her professional opinion, the Impulse Disorder in the principal diagnosis.

[redacted] believes the petitioner is benefiting from psychosocial rehabilitation. In her opinion the petitioner's progress is evidenced by substantial improvement in his non-verbal communication skills. The petitioner has difficulty expressing himself verbally. [redacted] admitted that she does not provide psychosocial rehabilitation therapy at the [redacted] and has never treated the petitioner for his mental illness, however, she disagrees with Dr. Lipton's opinion that the petitioner's diagnosis of mental illness was misappropriate. [redacted] also disagrees with Dr. Lipton's assertions that the petitioner will never be able to live independently. [redacted] does not believe independence requires living without any support system; she believes all human beings require some form of support regardless to their living environment. She believes independent living is accomplished by the individual living up to his maximum level of functioning.

7. The petitioner's treating psychiatrist at the [redacted] [redacted], did not appear as a witness, however, the respondent's representative offered into evidence a prescription reportedly written by [redacted] on October 30, 2008 prescribing psychosocial rehabilitation for the petitioner. No additional evidence was offered from the treating psychiatrist in regards to the petitioner's continued need for psychosocial rehabilitation services.

8. The petitioner's psychosocial rehabilitation progress is charted by, among other things, Master Treatment Plans , Treatment Plan Reviews and Global Assessment of Functioning (GAF) scores. The Master Treatment Plan is comprised of major goals and goal objectives created annually by the petitioner and the petitioner's treating clinicians. The goals are categorized by functioning skills lost due to the

participant's mental illness. Treatment Plan Reviews are conducted quarterly to assess the progress made in meeting the main goals and goal objectives of the Master Treatment Plan. The GAF is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. The clinical records document that the petitioner has never met any of the goals of his Master Treatment Plan and his GAF score has decreased from 35 to 32 during his years of psychosocial rehabilitation. In Dr. Lipton's opinion, these results substantiate his belief that the petitioner is not benefiting from psychosocial rehabilitation and therefore the services are not medically necessary. In opinion, meeting objectives within major goals is progress and small GAF score differences are expected and do not conclusively prove lack of development.

CONCLUSIONS OF LAW

Medical services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Florida Administrative Code Rule 59G-1.010(166)(a)(c) as follows:

> '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

It is the respondent's opinion that the undersigned hearing officer is limited to consideration of evidence available at the time of the adverse action under appeal. However, the legal authority cited above makes it clear that the hearing is a de novo proceeding; either party may present new or additional evidence not previously considered by the agency in making its decision. The undersigned hearing officer considered all the evidence and testimony presented by both parties.

Fla. Admin. Code 65-2.060 in parts states:

> 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 office

The agency terminated psychosocial rehabilitation services for the petitioner. The controlling legal authority cited above makes it clear that the burden of proof rests with the agency to prove the correctness of this action by a preponderance of the evidence. Evidence submitted by the respondent shows the petitioner has been receiving psychosocial rehabilitation services since January 2007 without successfully meeting any of the goals of his Master Treatment Plan or improving his GAF score. The respondent argued that after nearly two years of intensive psychosocial rehabilitation, it cannot be reasonably expected that the petitioner will receive additional rehabilitative benefit from these services. It is the opinion of the respondent's expert witness, medical director, Dr. Lipton, that all of the petitioner's presenting symptoms are attributable to his mental retardation and that the mental illness diagnosis is not supported by the

clinical record. The petitioner's witness, [redacted] admitted that the petitioner has not met any of his treatment goals, however, she argued the fact that the petitioner has accomplished some of the objectives within the goals such as improving his nonverbal communication skills is proof progress is being made and that the petitioner should continue to receive psychosocial rehabilitation services. The petitioner's treating psychiatrist did not testify during the hearing. As the only licensed psychiatrist to testify at the hearing was Dr Lipton, his medical opinion was given comparatively significant weight in the overall conclusions.

After carefully reviewing the testimony, evidence, and controlling legal authorities, the hearing officer finds that the respondent met its burden by presenting evidence that established that it was not medically necessary for the petitioner to receive psychosocial rehabilitation services because the services have not produced any significant or long term benefit.

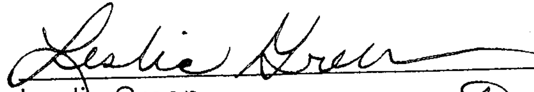
DECISION

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

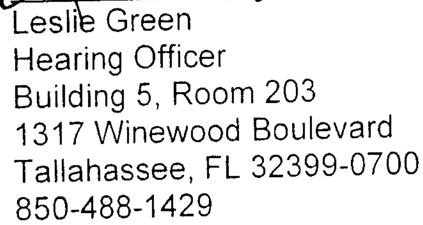
NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 8th day of December, 2008,



in Tallahassee, Florida.



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DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08N-00174

PETITIONER,

Vs.

RESPONDENT.

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 16, 2008, at 2:20 p.m., in Melbourne, Florida. The petitioner was not present. He was represented via telephone by his son and power of attorney, [redacted]. The petitioner's ex-wife, [redacted], was present and offered testimony. [redacted] and [redacted] Ombudsman, were present. [redacted] attorney, represented the respondent. [redacted] nursing home administrator, [redacted] LPN, unit manager, [redacted] business office manager, and [redacted] social services director, were present as witnesses for the respondent.

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 his "bill for services at the facility has not been paid after reasonable and appropriate notice to pay". 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 entered the nursing facility on October 5, 2007. He had been discharged to the hospital and has been a constant resident in the facility since December 7, 2007. He has health insurance but no custodial care insurance. He owns his own business. He does not have Medicaid or Medicare, so he is considered private pay. An application for Medicaid was submitted on the petitioner's behalf, but was subsequently denied for failure to return information and excess assets. He was also denied Veteran's benefits. He is currently residing in the facility pending the outcome of this hearing.

2. On September 11, 2008, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner with an effective transfer date of October 12, 2008. The Notice indicated the reason for transfer as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay" (Respondent's Exhibit 3).

3. By the end of December 2007, the petitioner had incurred a bill in excess of $40,000 for services rendered for his care. The respondent explains that at the time of the discharge notice, the petitioner owed in excess of $90,000 (Respondent's Exhibit 5).

The monthly billing accrues at a minimum of $8,000 a month. There is no payment plan in place, and the facility does not want to bear the expense of providing care to the petitioner any longer. In August 2008, the pharmacy that supplies the petitioner's medications was going to stop providing them because of an outstanding bill for medication. The nursing facility intervened and he is receiving his medicine.

4. Monthly statements are mailed return receipt to the petitioner's ex-wife and son. The mail was returned unclaimed from the son, but the petitioner's ex-wife accepts the mailed statements. The need to settle the bill had been discussed by telephone and in person, in addition to the statements. The petitioner had been consulted concerning his bill. On April 18, 2008, a Payment Agreement was mailed to the petitioner's ex-wife when the balance was $34,678.74. Payments of $6,000 had not been posted to reduce the balance as of that date. The agreement asked for seven payments of $4,000 each to be made biweekly to bring down the balance. It was not signed and returned. The petitioner's ex-wife explained that the payments were too much. A payment of $2,000 was made in May 2008. It was the last payment made on the account.

5. On June 2, 2008, a meeting was held to discuss the balance and to make a payment plan. On June 10, 2008, the petitioner and his ex-wife signed a Promissory Note stating that the full balance of the account would be made "at the conclusion of the sale of the auction". The sale date was pending and not filled in on the note (Respondent's Exhibit 3). They thought the auction/sale would take place in two to three weeks.

6. The petitioner's son thought the nursing facility would honor the Promissory Note and not attempt to remove his father from the facility until the sale of the equipment took

place. He does not dispute the amount of the bill or the fact that it has not been paid. He believed that the facility would work with him, and believes that the practical answer is to leave the petitioner in the facility to await the sale of the machinery.

7. The discharge location on the notice is the residence of the petition's ex-wife. Discharge planning was initiated, and the respondent found that [redacted] had beds available for private pay residents. The facility believed that an alternate choice would be to send the petitioner home with a home health nurse and aide. They believed he would flourish at home.

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;...

Pursuant to federal guidelines, the nursing facility issued a Nursing Home Transfer and Discharge Notice to the petitioner on September 11, 2008. The nursing home administrator signed the notice.

The Notice, as required, indicated the reason for transfer or discharge, as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The effective date of the transfer or discharge was given as October 12, 2008.

The Findings of Fact show that the petitioner has an undisputed balance owed to the facility for the cost of his care. The facility has notified the petitioner and his family of the balance due for the cost of his care. The petitioner's son argues that the respondent should wait until the auction or sale to take place to liquidate the petitioner's business assets. He wants his father to remain at the facility although he has not made any payments since May 2008 to pay the bill; he offered to settle the bill expediently once the auction took place.

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. The undersigned 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 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 respondent 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 16th day of December 2008,

in Tallahassee, Florida.

Margaret Poplin

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

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APPEAL HEARINGS

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

APPEAL NO. 08N-00180

PETITIONER,

Vs.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 24, 2008, at 1:39 p.m., at the in Ft. Lauderdale, Florida. The petitioner was present and represented herself at the hearing. Also present on behalf of the petitioner was the petitioner's sister, The respondent was represented at the hearing by administrator,

ISSUE

The respondent notified the petitioner that she was to be discharged from the facility. The respondent will have the burden of proof to establish by clear and convincing evidence that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and Fla. Stat. ch. 400.0255.

FINDINGS OF FACT

1. The facility notified the petitioner on or about October 2, 2008 that she was to be discharged by November 2, 2008. The discharge notice states: "The facility is granting your request to be discharged home. We will assist you in doing so. You also have the option of remaining in the facility or going to one of your choice." Currently the petitioner resides at

2. The petitioner had recently applied for Home and Community Based Waiver services with the intent on going home. The "service" was supposed to supply her home with needed medical type equipment and other related services in order for her to be able to be at home, as she meets all requirement to receive nursing care. She was apparently approved for the service. For whatever reason, (as she, or the facility; do not know) she was disenrolled from this Program.

The facility provided the petitioner with the discharge notice. The facility representative stated that the facility is not discharging the petitioner from the facility at this time.

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.

As shown in the Findings of Fact, the facility notified the petitioner on or about October 2, 2008 that she was to be discharged from the facility. The discharge notice provided the petitioner with a choice of staying or being discharged. The facility representative testified that the facility was not discharging the petitioner.

The petitioner had a concern that the facility was going to discharge her to her home at this time where she could not take care of herself without equipment or service care as provided by the Home and Community Based Waiver service.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that as the facility is not discharging the petitioner from the facility; the issue under appeal is moot. This appeal is thus denied accordingly.

DECISION

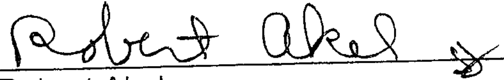
This appeal is denied.

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 15th day of December, 2008,

in Tallahassee, Florida.



Robert Akel
Hearing Officer
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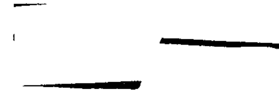

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

PETITIONER,
Vs.
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
DISTRICT: 12 Volusia
UNIT: 88209
RESPONDENT.
_______________________________/

APPEAL NO. 08F-06793

CASE NO. 1282939807

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 1:25 p.m. on November 14, 2008, in Daytona Beach, Florida. The petitioner was not present but was duly represented by her daughter, The respondent was represented by Ernestine Bethune, ACCESS senior specialist, with Parrey Hardwick, ACCESS specialist.

ISSUE

At issue was whether or not Medicaid Institutional Care Program (ICP) denial was correct due to excess assets for months between April and August 2008. As an applicant, the petitioner had the burden of proof.

FINDINGS OF FACT

1. An initial application for medical assistance, including ICP benefits, was filed on April 16, 2008 (Respondent's Exhibit 4). On June 26, 2008, Medically

Needy Share of Cost Program was approved. When Medically Needy assistance was authorized, notice of ICP denial was not generated or issued.

2. The respondent denied ICP because the respondent determined there were excess assets from a life insurance policy (Respondent's Exhibit 3). Cash value of the policy was $5928.94.

3. The June 2008 ICP ineligibility calculations showed subtraction of a $2500 burial exclusion (Respondent's Exhibit 8). Countable assets decreased, but the remaining amount exceeded policy limit of $2000. The petitioner was not informed of the reason for ICP denial at that time.

4. On August 28, 2008, aware that ICP approval had not occurred, but unaware of reason, the representative filed another ICP application (Respondent's Exhibit 2). Effective September 2008 that application was approved (Respondent's Exhibit 7).

5. ICP approval occurred after the new eligibility specialist informed the petitioner's representative of more asset standards and policies related to the existing problem. When the representative learned of the asset standards and the opportunity to establish a burial fund, she promptly liquidated the insurance asset. In September 2008, she established a burial fund. Countable assets decreased below the $2000 limit during September 2008.

6. The petitioner's gross income exceeds $1000 per month.

7. The representative called the DCF office and left thirty-one telephone messages while pursuing her mother's eligibility. Until she filed the August 2008

application, her questions were not answered. Once the August application was filed, her concerns were addressed. She was advised of the eligibility problem and asset options. The respondent's representative noted the telephone response problem would be explored further and would be addressed internally.

CONCLUSIONS OF LAW

Addressing these problems, federal regulation at 20 C.F.R. § 416.1201 (a) defines resources:

> For purposes of this Subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

Additionally, 20 C.F.R. § 416.1205 establishes the maximum asset limitation for the ICP category as $2,000 for an individual with income at the level of the petitioner's (greater than $763 per month in accord with regulation and Florida Integrated Public Policy Manual 165-22, Appendix A-9). Florida Administrative Code 65A-1.712 and 65A-1.716 address SSI-Related Medicaid Resource and Financial Eligibility Criteria:

> **65A-1.712**
> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C....
>
> **65A-1.716**
> ...
> (5) SSI-Related Program Standards.
> (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:
> 1. $2000 per individual.

In accord with state and federal regulations, the Department's guidelines at **Florida Integrated Public Policy Manual 165-22,** inform as follows:

> **1640.0514 Burial Exclusion Policy (MSSI, SFP)**
> An individual and the individual's spouse may set aside funds of up to $2,500 each for burial expenses. These funds are excluded as assets as long as the individual shows that they are clearly designated as being set aside for burial. This is true even if the case has been closed as long as the funds continue to be designated for burial. The funds must be separately identifiable (not commingled with other funds) unless the asset cannot be separated or it is unreasonable to require it. The individual (or deemed individual) must provide a written statement defining:
> 1. the amount of funds set aside,
> 2. for whose burial the funds are set aside, and
> 3. the form in which the funds are held.
>
> The individual and the individual's spouse must be given the opportunity to designate funds for burial at the time of application and at review if the maximum amount is not already designated. These funds may be excluded regardless of whether the exclusion is needed to allow eligibility.
> The $2,500 limit is not reduced by the value of excluded life insurance policies or irrevocable burial contracts.

On behalf of the petitioner, her representative noted that she had not been properly informed of her options and she had received insufficient response to her repeated queries. She could have fixed the problem much sooner if she had been informed. The respondent's representative concurred to some extent, but noted that the assets had been reduced by the $2500 burial exclusion during the June 2008 eligibility review, and even after subtracting that amount, the asset limit was exceeded. The respondent's representative was unaware of a further potential remedy.

The situation has been thoroughly explored and the arguments and regulations have been carefully considered. Despite the unfortunate

circumstance and apparent administrative concerns, the assets between April and August 2008 simply exceeded the $2000 limit even after the $2500 exclusion is recognized. Regulations do not provide a remedy for this problem before September 2008. If assets are exceeded, eligibility cannot be authorized.

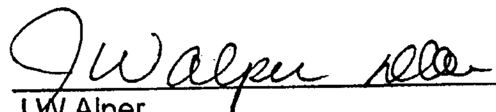
DECISION

The appeal is denied.

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 23rd day of December, 2008, in Tallahassee, Florida.



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Hearing Officer
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850-488-1429

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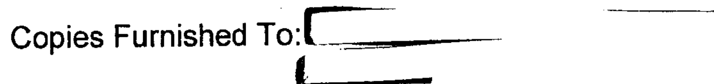

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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-06365

PETITIONER,

Vs.

CASE NO. 1062061420

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Pinellas
UNIT: 88521

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 24, 2008, at 10:09 a.m., in St. Petersburg, Florida. The petitioner was present. He was represented by [redacted] social worker for the facility in which the petitioner's resides. Witnesses for the petitioner from the facility were [redacted] administrator, and [redacted] unit manager. The respondent was represented by Theresa McComber, senior worker.

The record was left open for twenty days for both parties to provide additional clarification documentation as to discrepant information regarding the petitioner's status with Social Security. Both parties were to submit documentation no later than November 14, 2008. On November 13, 2008, the hearing officer received a facsimile from the respondent which was entered into

record. As of November 20, 2008, no additional evidence was received from the respondent. The record was closed on November 20, 2008.

ISSUE

The petitioner is appealing the notice by the respondent dated September 18, 2008 for the action to deny him Institutional Care Program and Medicaid benefits. As this was a change, the respondent has the burden of proof.

FINDINGS OF FACT

The petitioner received a Notice of Case Action on September 19, 2008. The notice informed the petitioner his Institutional Care Program and Medicaid Program benefits were cancelled. The reason stated were: "No one in your household is eligible for this program" and "Individual does not meet disability requirement".

1. In August 2007, the petitioner was determined disabled by the District Medical Review Team. A diary date of one year was set. The petitioner was approved for Institutional Care Program and Medicaid Program benefits.

2. The petitioner completed an Interim Contact Review for reapplication on August 5, 2008. The respondent reviewed the petitioner reapplication. The case was sent to the District Medicaid Review Team for a disability determination. The District Medicaid Review Team determined that the petitioner was no longer disabled.

The respondent inquired with the Division of Disability Determination for a State disability determination. The Division of Disability Determination

responded that the petitioner applied for Social Security Administration benefits on February 12, 2008 and that application was denied on July 17, 2008. Social Security determined that the petitioner was not disabled. The respondent adopted the decision of Social Security that the petitioner was not disabled. The respondent cancelled the petitioner Institutional Care Program benefits and Medicaid. A Notice of Case Action was sent on September 18, 2008.

3. The petitioner's representative attested that the petitioner was receiving Supplemental Security Income from Social Security. The petitioner's impairments are neuropathy, spinal problems, problems with walking, ambulates with a wheelchair, numbness and pain. The unit manager attested that the petitioner's condition has worsened. The petitioner did not allege a new disabling condition. The petitioner has not appealed any Social Security decision.

4. As there was conflicting testimony as to the petitioner's Social Security disability status, the hearing officer left the record open for additional evidence. The additional evidence was submitted by the respondent from Social Security. The information stated that the petitioner applied for Social Security on February 12, 2008. Social Security denied that application for Social Security disability and Supplemental Security Income on July 17, 2008. Social Security determined that the petitioner was not disabled. No evidence was submitted that the petitioner appealed that decision.

CONCLUSIONS OF LAW

The Florida Administrative Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less

Than the Federal Poverty Level. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulations state, in part:

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

The Code of Federal Regulations at 42 C.F.R. § 435.000 sets forth the definition and determination of disability and states in relevant part:

> § 435.540 Definition of disability.
> (a) Definition. The agency must use the same definition of disability as used under SSI...
>
> § 435.541 Determinations of disability.
> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
> (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

A Social Security Administration disability determination is binding, on an agency, until the determination is changed by Social Security Administration. Based on the regulations, the respondent cannot make a decision independent of

the Social Security Administration. The evidence, as submitted, indicated that on July 17, 2008 Social Security determined that the petitioner was not disabled. The respondent's action to adopt the decision of the Social Security Administration was with in the regulations of the Program. Therefore, the respondent's denial of the petitioner's Medicaid application was 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 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 1st day of December, 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:

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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-07199

PETITIONER,

Vs.

CASE NO. 1018656693

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 07 Orange
UNIT: 66292

RESPONDENT.

________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 8:55 a.m. on December 8, 2008, in Orlando, Florida. His son, represented the petitioner. Reginald Schofield, ACCESS supervisor, represented the respondent.

ISSUE

At issue was whether or not Institutional Care Program (ICP) ineligibility under Medicaid was correct due to excess assets.

FINDINGS OF FACT

1. The petitioner did not receive ICP coverage between January 2006 and February 2007. Before and after that time, he did receive coverage.

2. Notices of case actions, case notes, and computerized records of the situation were unavailable from the respondent. The petitioner's representative

had some notices, but it was not possible to complete an adequate review of the ICP eligibility circumstances and hearing process timeframes with the limited information he had. Based upon available data, it was not possible to determine if proper notices had been sent to proper parties and at proper timeframes.

3. The petitioner's representative and the respondent's representative agreed that financial eligibility factors should be reevaluated for the entire period between January 2006 and February 2007.

4. After reevaluation of that period, results would be sent to the petitioner's representative (i.e., his son). Such written notice(s) would be appealable in customary business practice of the Department. If any determination(s) of excess assets occurs for any of the months in that period, such would be appealable and could be addressed at a future hearing.

CONCLUSIONS OF LAW

The agreement stipulated by the petitioner's representative and the respondent's representative is fair and reasonable under the circumstances and it shall be implemented as described. The available information did not permit full and proper development of either financial merits or burden of proof factors.

Regarding burden of proof, Florida Administrative Code **65-2.060 Evidence** (1), informs:

> 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.

Regarding assets, federal regulation at 20 C.F.R. § 416.1201 (a) defines resources:

> For purposes of this Subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

Additionally, 20 C.F.R. § 416.1205 establishes the maximum asset limitation for the ICP category as $2,000 for an individual with monthly income above $719 - $743 during time in question (in accord with regulation and Florida Integrated Public Policy Manual 165-22, Appendix A-9). Florida Administrative Code 65A-1.712 and 65A-1.716 address SSI-Related Medicaid financial criteria, saying:

> **65A-1.712**
> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C....
>
> **65A-1.716**
> ...
> (3) The resource limits for the Medically Needy program are as follows:
> ...
> Family Size...1...
> Asset Level $5,000
> ...
> (5) SSI-Related Program Standards.
> (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:
> 1. $2000 per individual.

For people with lower income, the asset level is higher. For individuals with higher income, the asset level is lower, as described in regulations.

Additionally relevant, and in accord with state and federal regulations, the Department's guidelines at **Florida Integrated Public Policy Manual 165-22,** inform as follows:

> **1640.0514 Burial Exclusion Policy (MSSI, SFP)**
> An individual and the individual's spouse may set aside funds of up to $2,500 each for burial expenses. These funds are excluded as assets as long as the individual shows that they are clearly designated as being set aside for burial. This is true even if the case has been closed as long as the funds continue to be designated for burial. The funds must be separately identifiable (not commingled with other funds) unless the asset cannot be separated or it is unreasonable to require it.

This exclusion option may be useful for asset review purposes.

It is also important to note that the Department has processing standards and eligibility review requirements. This includes need to notify proper parties for information requests and eligibility determinations. The respondent shall comply with its administrative processing standards.

Eligibility review for the period January 2006 – February 2007 shall proceed, as agreed. The undersigned does not guarantee that eligibility will be found, but proper review shall occur. This will include notification to the son as to results. The Notice(s) of Case Action to be issued by the respondent shall be appealable as usual.

DECISION

The appeal is granted as described.

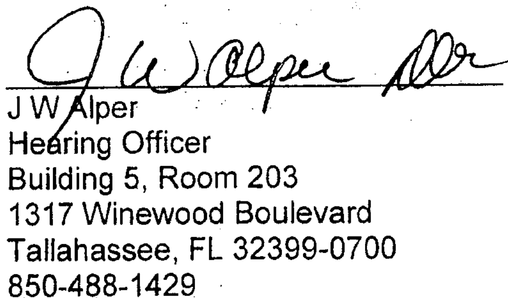
NOTICE OF RIGHT TO APPEAL

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 31st day of December, 2008, in

Tallahassee, Florida.



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