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

APPEAL NO. 07F-06846

PETITIONER,

Vs.

CASE NO. 1268358185

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 13 Lake
UNIT: 88006

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on January 23, 2008, at 1:48 p.m., in Tavares, Florida. The petitioner was not present but was represented by her daughter , who also testified. Sandra Maxwell, supervisor of Adult Payments in Wildwood, represented the respondent by telephone and testified. Edward Brooks, eligibility worker I, also appeared by phone as a respondent witness. Ralph Coleman, senior eligibility worker, physically appeared as a witness for the respondent.

ISSUE

At issue is the respondent's action of November 29, 2007, to deny the petitioner's application for Institutional Care Program and Medicaid benefits (ICP), for August and September 2007 due to excess assets. The respondent

believes the cash, or cash value of a life insurance policy caused the petitioner to be ineligible in these months. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner applied for ICP benefits on August 15, 2007. The petitioner has lived in a nursing facility since July 2007.
2. The petitioner owned a life insurance policy with a cash value of $6,864.93 as of August 6, 2007. The policy is listed in her name. On September 17, 2007, the life insurance company issued the petitioner a check for $6,878.04 for this cash value. The petitioner's representative received this check on September 30, 2007. The funds were deposited into the bank in October 2007.
3. The respondent subtracted a $2,500 burial exclusion amount from the value of the life insurance policy in August 2007. The respondent subtracted this $2,500 exclusion from the cash amount, $6,878.04, in September 2007. The respondent determined the remainders, $4,364.93 or greater, to be a countable asset for ICP. The respondent determines this $4,364.93 counted amount to exceed the ICP asset limit for August and September 2007. The respondent denied ICP benefits for August and September 2007, per notice.
4. The petitioner established an irrevocable trust in October 2007. The respondent determined the petitioner eligible for ICP benefits beginning October 2007.

5. The petitioner does not have funds to pay the nursing home bill for August and September 2007. The petitioner believes the process took time to establish and that she should be eligible for these months.

CONCLUSIONS OF LAW

Florida Administrative Code Rule 65A-1.716(5)(a)1. sets forth a $2,000 countable asset limit in the ICP Program. If the cash, or cash value of the life insurance policy correctly exceeds this asset limit, then the petitioner is ineligible for ICP benefits in August and September 2007.

The respondent's interpretive FLORIDA on-line manual at section 1640.0514 allows a $2,500 burial exclusion policy from countable assets. Findings establish that the respondent correctly subtracted this $2,500 amount from the cash or cash value of the life insurance policy.

The respondent interpretive manual at section 1640.0554 shows that the cash value of a life insurance is considered a countable asset. This manual section states that the cash value of a life insurance is considered available to the petitioner if in the name of the petitioner. Since the cash value of the life insurance policy minus the $2,500 burial exclusion exceeded the $2,000 limit, the petitioner was ineligible for ICP due to excess assets in August 2007.

Likewise, section 1640.0518 shows that cash itself is also included as a countable asset. Since the countable value of this cash exceeded the maximum $2,000 asset limit in September 2007, the respondent is also correct to deny ICP benefits due to excess assets in September 2007.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the 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 26th day of February, 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

District 13 ACCESS: Micheal Holder

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

APPEAL NO. 07F-06543

PETITIONER,

Vs.

CASE NO. 1009140728

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 14 Hardee
UNIT: 88581

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 12, 2007, at 10:00 a.m., in Wauchula, Florida. The petitioner was not present. She was represented by her treating physician, Dr The respondent was represented by Gail Crews, economic self-sufficiency supervisor.

The respondent was allowed 10 days to return further evidence. No further evidence was received. The record was closed.

ISSUE

At issue is the October 26, 2007 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program and Medicaid on the basis that she did not meet the disability criteria. The burden of proof falls with the petitioner as the applicant for benefits.

FINDINGS OF FACT

1. On September 9, 2007, the petitioner filed a Request for Assistance to apply for Institutional Care Program benefits and Medicaid. Since she was 59 years old, she did not meet the aged criteria and a disability determination was required. On October 19, 2007, the respondent forwarded a request for a disability determination to the District Medical Review Team (DMRT).
2. On October 24, 2007, DMRT determined that the petitioner did not meet the disability criteria. They determined that her medical condition would not prevent her from performing substantial gainful employment for a period of 12 months. On October 26, 2007, the respondent notified the petitioner that her application for benefits through the Institutional Care Program and Medicaid was denied.
3. The petitioner has arthritis, joint pain, fatigue, shortness of breath, and a leaky right heart valve. She fell in September 2007. She developed a large hematoma (hemangioma) that became infected. It is the size of a grapefruit on her right inner thigh. They are trying to drain the hemangioma but there is the risk that she could hemorrhage and lose her leg or life.
4. The petitioner weighs over 300 pounds. She suffers from depression, diabetes, circulatory problems, chronic dermatitis, cellulites, pulmonary hypertension, and has problems regulating her medications. She is

ambulatory with assistance. She needs assistance with all activities of daily living with the exception of eating.

5. The petitioner was initially hospitalized with the fall in September 2007 and was discharged to the nursing facility. She remains in the nursing facility as of the date of the hearing. Dr. t is her treating physician. The prognosis for any improvement is not good. Dr. the opinion that the prospects for medical improvement in the next 12 months are very slim. The medical evidence contains hospital records, medical tests, and nursing home records beginning in September 2007.
6. The petitioner graduated from the 9th grade with no further training. She has not worked in 25 years. Her past work consisted of selling Avon products and waitressing. She is not eligible for benefits through the Social Security Administration due to her spouses' income and her lack of wage credits.

CONCLUSIONS OF LAW

The Florida Administrative Code, Section 65A-1.710 et seq., set 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 hearing officer evaluated Ms. C claim of disability using the sequential evaluation as set forth in 20 C.F.R. §416.920. The first step is to determine whether or not the individual is working. Ms. is not working and therefore, meets the first step.

The second step is to determine whether or not an individual has a severe impairment. Since the petitioner's impairment affected work-related functioning and was medically determinable, it was considered severe.

The third step is to determine whether or not the individual's impairment(s) meets or equals a listed impairment in Appendix 1 of the Social Security Act. A review of the listings at 1.00, "Musculoskeletal System, 3.00, "Respiratory System", 4.00, "Cardiovascular System", 9.00, "Endocrine System", and 11.00, "Neurological", 12.00, "Mental Disorders" does not indicate that the petitioner meets a required listing. When the impairments are considered individually or in combination, the evidence does support the meeting of a listed level of an impairment that is medically equivalent to a listing.

The fourth step is to determine whether or not the individual's impairment(s) prevents her from doing past relevant work. The petitioner has not had any past relevant work for 25 years. Therefore, she cannot be evaluated for return to work.

The fifth step is to determine whether or not the individual's impairment prevents her from performing other work. The petitioner has no past relevant work history, she is of advanced age, and a limited education. She does not have the residual functional capacity to perform sedentary work. The vocational grids that apply to the petitioner are at part 404 sub-part P, Appendix 2 of 20 C.F.R., and include the non-exertional considerations. Rule 201.01 calls for a finding of disabled for an individual of advanced age, with a limited education, unskilled or no work experience, and capable of performing sedentary work. Since the petitioner is not capable of even sedentary work, this supports a finding of disabled.

DECISION

This appeal is granted. The respondent should reconsider the petitioner's eligibility for Institutional Care Program benefits and Medicaid accepting that she meets the factor of disability beginning in September 2007.

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 22nd day of February 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

14 DPOES: Karen Shank

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

APPEAL NO. 07F-06832

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 February 13, 2008, at 1:45 p.m., in Opa Locka, Florida. The petitioner was not present. , petitioner's father, represented the petitioner. Michelle Knuckle, clinical supervisor, Maxim Healthcare Services, was present on behalf of the petitioner. Sandy Moss, program administrator, Agency for Health Care Administration, represented the agency. Maria Hernandez, operation and management consultant, Agency for Health Care Administration, was present on behalf of the agency. Also present as witnesses for the agency, via the telephone, from Keystone Peer Review Organization (KePRO), were Dr. Robert A. Buzzeo, physician reviewer and Theresa Ashey, RN reviewer. This hearing was originally scheduled for January 9, 2008, but was continued at the request of both parties.

ISSUE

At issue is the agency's action of November 27, 2007, to deny 112 hours of Private Duty Nursing services (PDN) for the period of November 13, 2007 through January 11, 2008, because the medical care as described to them is not medically necessary. Since this was an increase in hours from the previous certification period, the petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, , two years of age, has severe and numerous medical problems related to preterm infancy that require medical services as provided through the Agency for Health Care Administration (AHCA) Medicaid State Plan. AHCA will be further addressed as the agency.

2. On November 8, 2007, Maxim Healthcare Services, as the provider, submitted a request on behalf of the petitioners for 1,128 hours of PDN, 20 hours a day, Monday through Friday, and 24 hours on weekends and days PPEC is closed, for the period of November 13, 2007 through January 11, 2008. This total 1,112 hours. (The provider miscalculated the hours.)

3. The agency has contracted KePRO to determine the number of service hours for PDN. This service is reviewed every 60 days.

4. On November 10, 2007, a board certified pediatric specialty physician consultant reviewed the request. Based on the information provided, the physician consultant determined that the petitioner's father, who works from 5:30 p.m. to 5:30 a.m., Monday through Saturday, can provide coverage on Sunday from 2:00 p.m. to 11:00 p.m.

5. A notice was sent to the petitioner on November 12, 2007. The notice denied 112 hours and approved 1,016 of Private Duty Nursing for the period of November 13, 2007 through January 11, 2008.

6. On December 25, 2007, the request was reviewed by a second board certified pediatric specialty physician consultant who had not issued the initial denial. This physician consultant modified the original denial, approving 16 hours and denying eight hours of PDN services on Sunday, considering that the father has to wake up early on Monday to begin work.

7. The petitioner expressed that he agrees with this determination.

CONCLUSIONS OF LAW

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

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

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

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

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render.

The agency, through KePRO, took action on November 12, 2007 to deny 112 hours of Private Duty Nursing services for the period of November 13, 2007 through January 11, 2008. The rational for this denial is that the petitioner's father is able to assist

in the care of the petitioner on Sunday, from 2:00 p.m. to 11:00 p.m. This denial was modified during the reconsideration process and only 80 hours were denied. The petitioner stipulated that he agrees with this decision.

After considering the evidence, the Florida Administrative Code Rules and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action.

DECISION

The 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 20th day of February 2008,

in Tallahassee, Florida.

Alfredo Fernandez

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

Copies Furnished To:

Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

APPEAL NO. 07F-06485

PETITIONER,

Vs.

CASE NO. 1270433067

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 03 Alachua
UNIT: 88324

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on December 12, 2007, at 3:45 p.m., in Gainesville, Florida. The petitioner was not present, but was represented by Jonathan Gallington with Hospital Inpatient Services H.I.S. Mr. Gallington also testified. Debra Morgan also with H.I.S., appeared as a witness. The respondent was represented by Louella Teague, supervisor.

ISSUE

1. The first and primary issue is the respondent decision of October 31, 2007 to deny Medicaid coverage under the Emergency Medicaid for Aliens (EMA) program for the months of August 2007 through October 2007. The respondent denied this coverage

based on the assertion that the respondent could not determine eligibility.

2. The second issue is the respondent's decision of the same date to deny Institutional Care Program and Medicaid (ICP) eligibility on the same date. The respondent denied coverage under the Medicaid category based on no eligible members. The petitioner has the burden of proof in both issues.

FINDINGS OF FACT

1. The petitioner is 75 years old with a birth date of May
   The petitioner was admitted to Shands Hospital in Gainesville on August 22, 2007 after being found unconscious behind a dumpster. The petitioner was homeless.
2. The petitioner was hospitalized at Shands Hospital from August 22, 2007 to October 30, 2007. The petitioner had diagnoses of encephalopathy and dehydration during this hospitalization. The hospitalization utilization review determined the petitioner to have an emergency health condition during this total period of hospitalization.
3. On September 13, 2007, H.I.S. submitted an application for EMA and ICP benefits in the petitioner's behalf. The respondent denied ICP benefits because the petitioner was not living in a nursing facility at the time of the decision at issue. H.I.S. seeks ICP eligibility for the petitioner for future placement concerns. The

respondent denied EMA benefits because Medicaid under this category cannot be determined. The parties stipulated to the receipt of notice dated October 31, 2007.

4. The petitioner's medical condition impairs his ability to provide information. The petitioner is a prior citizen of Great Britain. After arrival in the United States (U.S.), the petitioner obtained a Social Security number in 1991 when he then had a valid VISA. It is not known what type of VISA or when the VISA expired. The alien registration number is not known. Both the respondent and H.I.S. have been unable to obtain any other information from the petitioner's relatives.
5. The respondent denied the petitioner's application based on the assertion that eligibility for either EMA or possible regular Medicaid can not be determined. The respondent believes that the petitioner's statement or other proof that the VISA had expired would permit an eligibility determination for EMA. However, there is no testimony or other evidence of the VISA type or status. The respondent also believes that proof of identity is necessary. The H.I.S. representative asserts there is no policy that requires proof that a VISA has expired before EMA eligibility can be determined.

CONCLUSIONS OF LAW

H.I.S. is primarily seeking EMA benefits in the petitioner's behalf for the period of hospitalization for the months of August through October 2007.

However, H.I.S. also seeks ICP for the petitioner for possible future placement concerns. An individual must be a current resident of a nursing facility to be eligible for ICP benefits, per Florida Administrative Code (F.A.C.) Rule 65A-1.711(2)(a) as follows:

> **65A-1.711 SSI-Related Medicaid Non-Financial Eligibility Criteria.**
>
> To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F, with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate:
>
> (2) For ICP benefits, an individual must be:
>
> (a) Living in a licensed nursing facility, or confined to a hospital swing bed or to a hospital-based skilled nursing facility bed, or in an ICF/DD facility that is certified as a Medicaid provider and provides the level of care that the client needs as determined by the department; or living in a Florida state mental hospital and be age 65 or over;...

Since the petitioner was not living in a nursing facility at the time of the denial decision at issue on October 31, 2007, the respondent is correct to deny ICP benefits. In regard to EMA benefits, F.A.C. Rule 65A-1.715 sets forth the following:

> **65A-1.715 Emergency Medical Services for Aliens.**
>
> (1) Aliens who would be eligible for Medicaid but for their immigration status are eligible only for emergency medical services. Section 409.901(9), F.S., defines emergency medical conditions.
> (2) The Utilization Review Committee (URC) or medical provider will determine if the medical condition warrants emergency medical services and, if so, the projected duration of the emergency medical condition. The projected duration of the emergency medical condition will be the eligibility period provided that all other criteria

are continuously satisfied.

(3) Emergency services are limited to 30 consecutive days without prior approval. For continued coverage beginning with the 31st day prior authorization must be obtained from the Agency for Health Care Administration (Medicaid Program Office).

The petitioner had previous admission to the United States from Great Britain, and had a VISA in 1991. However, it is not known the type of VISA or whether or not the VISA is expired. The F.A.C. Rule above allows for potential EMA eligibility for aliens who would be eligible for Medicaid "but for their immigration status." However, the respondent's interpretive FLORIDA on-line manual at section 1440.0109 gives a list of non-citizens who are excluded for EMA eligibility, in part as follows:

1. Foreign government representatives on official business and their families and servants
2. Visitors for business or pleasure, including exchange visitors,
3. Crewmen on shore leave,
4. Non-citizens in travel status while traveling directly through the U.S.
5. Treaty traders and investors and their families

In the absence of knowledge on the type and expiration of the petitioner's VISA, it cannot be entirely ruled out that the petitioner may still be admitted to the U.S. under one of the above types of non-expired VISA documents. Therefore, the respondent is correct to deny EMA eligibility based on an inability to determine eligibility. Further, if the petitioner were to have a permanent type of registered alien status, he may qualify for other, non-temporary, coverage groups of SSI-Related Medicaid eligibility listed in F.A.C. Rule 65A-1.710. Since the petitioner's

actual alien status is not known, the respondent is correct to determine that the appropriate Medicaid eligibility coverage group can not be determined.

DECISION

The appeal is denied on both issues.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE AND ORDERED this 4th day of February, 2008, in Tallahassee, Florida.

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

Copies Furnished To:
3 DPOES: Theola Henderson

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

APPEAL NO. 07F-07167

PETITIONER,

Vs.

CASE NO. 1179770315

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 15 St. Lucie
UNIT: ICP

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on January 9, 2008, at 11:35 a.m., in Fort Pierce, Florida. The petitioner was not present. His daughte s, represented him. Erika Delgado, ACCESS supervisor, represented the respondent.

ISSUE

At issue is whether the respondent correctly determined that the petitioner is not eligible for Institutional Care Program and Medicaid benefits prior to November 2007 based on excessive income. The petitioner holds the burden.

FINDINGS OF FACT

1. On July 24, 2007, an application for Institutional Care Program (ICP) and Medicaid was submitted to the Department on the petitioner's behalf. ICP was

requested back to May 2007, when the petitioner began residing at the facility. In March 2007, prior to his placement in a nursing facility, his daughter began the eligibility process with the Department.

2. On March 30, 2007, the Department sent a Request for Information requesting additional information in order to determine the petitioner's eligibility. The Respondent's Exhibit 2 highlights the information needed. It shows that the nursing home income limit is $1869. The petitioner's income exceeded that amount, so instructions about executing an irrevocable income trust and funding it with at least $500 was also contained in the request. The information was due on April 12, 2007. Before the information was due, the petitioner's power of attorney, his daughter, requested an extension to the time given to submit verification of his pension and the income trust.

3. On April 17, 2007, the Department sent another Verification List requesting verification of his nursing care level, proof of a qualified trust, and proof of his pension (Respondent's Exhibit 4). The information was due April 27, 2007.

4. On May 17, 2007, the Department sent another Request for Information asking for among other things, proof that the qualified income trust had been executed with an attorney and funded with at least $500, and information concerning a lot in South Carolina (Respondent's Exhibit 5). An Over Income Notice for ICP/HCBS Assistance was attached to the request for information. The information was due May 29, 2007.

5. On July 30, 2007, the Department sent another Verification List asking for the same information concerning the level of care, the pension, the property, and the qualified trust. The information was due August 9, 2007.

6. On August 17, 2007, another Verification List was generated asking for verification of the nursing care level, proof of the qualified trust, proof that the property is for sale, and bank statements showing the funding of the trust from May to August (Respondent's Exhibit 7).

7. The petitioner's income is from Social Security and a pension from United Technologies. In 2007, he received $1315 in Social Security and $778.99 from his pension (Respondent's Exhibit 8). His total income is $2093.99. The ICP income limit is $1869. The amount that needed to be deposited in the trust each month that coverage was requested was $224. This amount was derived by subtracting $1869 from $2093. An income trust was established in May 2007. An opening deposit of $100 was made into the trust account on July 17, 2007. Another $100 deposit was made in August 2007. A deposit of $94 was made on October 4, 2007, and on November 5, 2007, a deposit of $768 was made into the account (Respondent's Exhibit 11).

8. The Department determined that the November 2007 was the first month the petitioner was eligible for ICP because that is the first month the trust account was properly funded thereby bringing the petitioner's income within the Program limits. ICP was denied from May 2007 through October 2007 (Respondent's Exhibit 1).

9. The petitioner's daughter made deposits to the trust account based on information she received from the facility. She had forgotten about the letter the Department sent telling her to deposit $500 a month. Her father accumulated a bill in excess of $23,000 while staying at the facility. The facility expected Medicaid to pick up his balance when he was approved for ICP, but when that did not happen he was

transferred to a different facility. His daughter is already paying $100 a month on a promissory note for another bill.

CONCLUSIONS OF LAW

Fla. Admin Code 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria, states in part:

> 1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.
> (f) For hospice services, income cannot exceed 300 percent of the SSI federal benefit rate or income must meet Medically Needy eligibility criteria, including the share of cost requirement. Effective October 1, 1998, institutionalized individuals with income over this limit may qualify for institutional hospice services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(14)(a), F.A.C.

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

> (15) Trusts. (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

The Department's Fla. Integrated Pub. Policy Manual, 165-22, Appendix A-9, April 2006, set forth the ICP income limit at $1869 for an individual for the time period at issue.

The Department's Fla. Integrated Pub. Policy Manual, passage1840.0110 Income Trusts (MSSI) states:

> The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and

Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.

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

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

2. it is irrevocable;

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

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

The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.

The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.**

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

> Once the District Legal Counsel returns the income trust transmittal through the District Program Office, the Economic Self-Sufficiency Specialist must promptly process the Medicaid application, making sure proper notification of eligibility and patient responsibility is given.

The Department informed the petitioner's representative of the need to establish and fund a qualified income trust, as the petitioner's income exceeded the ICP Program eligibility limits. The above authorities set forth that a sufficient amount of income must be placed in the trust for each month that eligibility is to be determined, in the month that the income is received, to reduce the countable income. The amount of monthly income not placed in the qualified income trust must be compared to ICP income limit.

The findings show that the petitioner had monthly income of $2093.99. The ICP income limit was $1869 for an individual. The findings show that for May 2007 through October 2007, the petitioner had income outside of the Program limits.

The hearing officer finds that since insufficient deposits were made to the trust account in May through October, the Department correctly denied ICP eligibility for those months, and that ICP eligibility began in November 2007.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 22nd day of February, 2008,

in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To:
15 DPOES, Eva Stokes

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

APPEAL NO. 07F-06701

PETITIONER,

Vs.

CASE NO. 1267271621

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on January 16, 2008, at 10:05 a.m., in Cocoa, Florida. The petitioner was not present. William Johnson, Esq. represented her. His legal assistant, Linda McConnell, attended. Present on the petitioner's behalf were her daughter and son-in-law, Elsie Hanaway, court reporter from King reporting, was present. Stacy Robinson, district 7 legal counsel, represented the Department. Bobbie VanCott, economic supervisor, and Kane Lamberty, senior human services program specialist, central region program office, were present as witnesses for the respondent.

ISSUE

At issue is whether the Department delayed in determining the petitioner's eligibility for Institutional Care Program Medicaid benefits. This was an application for benefits; the petitioner holds the burden in this matter.

FINDINGS OF FACT

1. On July 30, 2007, an application for Institutional Care Program (ICP) benefits was submitted to the Department on the petitioner's behalf.

2. On August 8, 2007, the Department sent the petitioner a pending letter requesting additional information to complete the eligibility determination process for ICP benefits. When information was received, the Department sought guidance from its program office in determining how to apply its policy towards a land trust. The district program office verbally discussed the issue with central office prior to submitting the clearance, and requested an opinion from district legal counsel to include with the clearance. On September 17, 2007, after researching the topic of land trusts, the district program office submitted a policy clearance request to central office to help clarify if the particular asset was income producing or personal property.

3. On September 27, 2007, the local office found that central office was still reviewing the clearance question, and it was going to seek guidance from the federal government.

4. A hearing was requested by the petitioner on the on November 16, 2007, as there had been no eligibility decision rendered by that date.

5. On December 3, 2007, central office had written the response to the clearance question, but it was still being reviewed. The district was asked not to approve or deny ICP benefits until the clearance was issued.

6. On January 2, 2008, the Department requested additional information from the petitioner.

7. The petitioner's application for ICP benefits was denied in January 2008.

8. The Department admits there is agency delay in processing the petitioner's application for ICP benefits, but asserts that it was not inexplicable or inexcusable delay. The Department believes that it was dually diligent before getting a decision from central office, and that the delay was reasonable. If the petitioner had been determined eligible for ICP benefits, the ICP benefits would have been effective from July 2007, the application month.

9. The petitioner is seeking ICP benefits from July through November 2007 as a remedy for the Department's delay. That period covers the application date through the hearing request date. The petitioner's position is that the Department's manual covers the topic of land trusts and cannot believe that it took over five months to get a decision, when the time standard for processing Medicaid application is 45 days (Petitioner's Exhibit 2).

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.205 Eligibility Determination Process, states:

> (1)(c) Time standards for processing applications vary by public assistance program. The time standard begins with the date on which the department or an outpost site receives a signed and dated application and ends with the date on which benefits are made available or a determination of ineligibility is made. For the Medicaid program, the time

> standard ends on the date an eligibility notice is mailed. Applications must be processed and determinations of eligibility made within the following time frames: ...
> For all other Medical Assistance and State Funded Programs 45 days.

The Findings of Fact show that the ICP Medicaid application was not dispositioned until five months after the application was made. This exceeds the Department's time standard of 45 days. However, the hearing officer cannot find inexplicable and inexcusable delay by the Department as efforts were ongoing to obtain a policy interpretation on the case and ultimately had to go to the federal level for policy direction.

The petitioner's legal counsel argues that the petitioner should be awarded ICP benefits based on case law presented as the Petitioner's Exhibit 3. This decision was based on 42 C.F.R. §431.246 which requires the agency to make corrective payments retroactive to the date the incorrect action was taken. In this case, the Department determined ineligibility for ICP Medicaid, which will be heard in a separate proceeding. Based on the facts in this hearing alone, the hearing officer finds that the case law is not applicable in this appeal. However, if the subsequent appeal should result in reversing the Department's denial action, the hearing officer would determine at that time the proper corrective action.

The above-cited rule does not assign a penalty for exceeding time standards. The only corrective action when a delay occurs where it has not been substantiated that the petitioner is eligible for the ICP Program, is to order the Department to stop delaying. In this case the Department completed the application in January of 2008 and

is no longer delaying. The hearing officer cannot award benefits based on the delay of the Department in this appeal.

DECISION

The appeal is denied a moot as the Department took action in January to deny the pending application. However, there is no corrective action to be ordered as the Department has now dispositioned the application.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 15th day of February, 2008, in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To:
District 7 ACCESS Cassandra Johnson
Stacy Robinson
WILLIAM JOHNSON

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

APPEAL NO. 07F-06266

PETITIONER,

Vs.

CASE NO. 1267870087

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was scheduled for December 4, 2007. The petitioner was granted a 30-day continuance. The hearing was convened before the undersigned hearing officer on January 8, 2008, at 2:23 p.m., in Largo, Florida. The petitioner was not present. Andrew Gracy, Esq. represented the petitioner. Present on behalf of the petitioner was Maureen Rulison, president of Guiding Light. The respondent was represented by David Selby, Esq. Witness for the respondent was Suzi Jackson, supervisor.

ISSUE

The petitioner is appealing the notice of December 17, 2007 for the respondent's action to deny Institutional Care Program (ICP) benefits. As this is an application, the petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner received a Notice of Application Disposition on December 17, 2007. The notice informed the petitioner that he had been denied ICP benefits. The reason for the denial was stated as: "...You have been found to have improperly transferred an asset...".

1. The petitioner is residing in a nursing home. The petitioner purchased a reversionary annuity on July 16, 2007 in the amount of $70,750. The compensation to the petitioner for the purchase of the reversionary annuity was zero dollars. The reversionary annuity is totally and permanently irrevocable. The policy pays to four named beneficiaries, the petitioner's four children, and the named beneficiaries cannot be changed.

2. On August 7, 2007, the petitioner applied for ICP benefits. The respondent reviewed the application. The asset limit for ICP is $5,000. The respondent determined that the reversionary annuity purchase on July 16, 2007 in the amount of $70,750 was a transfer without compensation. The respondent denied the application for ICP in October 2007.

3. The petitioner requested opportunity for rebuttal of the respondent's denial on October 3, 2007. The respondent reviewed the rebuttal. The respondent determined that the documentation presented demonstrated that the

transfer of the asset was made to make the petitioner Medicaid eligible. The respondent sent the petitioner a revised notice on December 17, 2007. The respondent determined the penalty period of fourteen months would be from July 2007 through August 2008.

CONCLUSIONS OF LAW

The petitioner argued that the petitioner received a policy and the reversionary annuity met the definition of "valuable consideration". The valuable consideration was the completion of the petitioner estate plan to provide for his heir, which has a very high intrinsic value. The petitioner opined that the transfer rules do not apply and the reversionary annuity is an excluded asset.

The respondent argued that the standard transfer of assets provisions apply for the reversionary annuity that was purchased one month before the petitioner applied for ICP. The respondent argued that the purchase was a transfer of an asset without fair compensation to the petitioner within the look-back period.

The Florida Administrative Code at 65A-1.303,"Assets", states in part:

> (1) Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.
> (2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.
> (3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the

representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

The Florida Administrative Code at 65A-1.702, "Special Provisions", states in part:

(1) Rules 65A-1.701 through 65A-1.716, F.A.C., implement Medicaid coverage provisions and options available to states under Titles XVI and XIX of the Social Security Act.
(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately proceeding the month of application (called the retroactive period). Eligibility for Medicaid begins the first day of a month if an individual was eligible any time during the month....

The Florida Administrative Code at 65A-1.712, "SSI-Related Medicaid Resource Eligibility Criteria", states in part:

(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....
(2) Exclusions. The department follows SSI policy prescribed in 20 C.F.R. Part 416 in determining what is counted as a resource with the following exceptions, as mandated by federal Medicaid policies, or additional exclusions, as adopted by the department under section 42 U.S.C. § 1396a(r)(2).
(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is $2,500 or less.
(3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing facility care services or HCBS waiver services. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the

date of application. These transfer policies apply to actual transfers made by applicants for institutional Hospice services that occur on or after October 1, 1998.
(a) The department follows the policy for transfer of assets mandated by 42 U.S.C. §§ 1396p and 1396r. For transfers prior to October 1, 1993, transfer policies apply only to transfers of resources. For transfers on or after October 1, 1993, transfer policies apply to the transfer of income and resources.
(b) When funds are transferred to a retirement fund, including annuities, within the transfer look back period the department must determine if the individual will receive fair market compensation in their lifetime from the fund. If fair compensation will be received in their lifetime there has been no transfer without fair compensation. If not, the establishment of the fund must be regarded as a transfer without fair compensation. Fair compensation shall be calculated based on life expectancy tables published by the Office of the Actuary of the Social Security Administration. See Rule 65A-1.716, F.A.C.
(c) No penalty or period of ineligibility shall be imposed against an individual for transfers described in 42 U.S.C. § 1396p(c)(2).

The United State Code at 42 U.S.C. § 1396p(c)(2) states in pertinent part:

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that -
(A) the assets transferred were a home
(B) the assets
(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,
(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,
(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or
(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);
(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual;...

The respondent denied the petitioner's application as they believe the petitioner transferred assets without receiving fair compensation. The critical questions are how to define the financial instrument in question, the reversionary annuity, and whether the respondent correctly viewed the purchase as an asset transfer. The petitioner has the burden of proof to show that the petitioner received fair compensation.

The hearing officer compared the reversionary annuity to the typical annuity found in retirement contracts. The retirement contract provides that an individual will be considered as receiving fair compensation if the dollar amount of the payments anticipated to be received based the on life expectancy tables equals the amount of the transfer. In the typical annuity, the individual will receive fair compensation in their lifetime from the purchase.

Because reversionary annuity is life insurance with no cash value and not a retirement fund, is irrevocable, and non-assignable, it is, solely as a financial instrument, its value is excluded as an asset. The reversionary annuity policy has no value that would be considered available as an asset to the petitioner under the Program rules. Although the asset value of a reversionary annuity policy is excluded in determining the petitioner's eligibility, the petitioner's action to transfer funds to a financial instrument that could have been used to meet his nursing needs and making those funds unavailable should be considered.

As to whether there was a transfer of an asset, the hearing officer relies on 65A-1.712(3)(c) which in turn refers to U.S.C. § 1396p(c)(2). The United

States Code allows exclusions for the transfer of a home. If the individual transferred the assets to a spouse or to benefit the spouse, the asset would meet the exclusion allowance. The beneficiaries were the petitioner's four children. There is no exclusion listed in the transfer rules that provides that the transfer to a reversionary annuity meets the provision for an allowable exclusion. The hearing officer concludes that the reversionary annuity does not meet the criteria as an allowable exclusion from transfer rules.

Next to be considered is to whether or not the reversionary annuity was transferred without fair market value. There was no evidence or testimony presented which demonstrated that the petitioner received fair compensation equal to a fair market value. There is no provision in any of the above cited authorities that define the "intrinsic value" or "valuable consideration" as the value of the petitioner's good feeling in providing for his heirs. There are no provision in any of the authorities which indicate that providing for the completion of an individual's estate planning supersedes the intention stated by Congress in the legislative history of 42 U.S.C. §1396a(a)(25): "Medicaid is intended to be the payor of last resort, that is, other available resources must be used before Medicaid pays....". The petitioner will not receive any fair compensation.

The hearing officer concludes that the reversionary annuity was transferred without fair market value and the petitioner will not receive fair compensation in his lifetime from the purchase of the reversionary annuity. The rule sets forth that if an individual disposes of resources for less than fair market value on or after the look back date, the Department must presume that the

disposal of resources or income was to become Medicaid eligible. Based on the above cited authorities, the hearing officer concludes that the respondent's action to deny ICP benefits and apply the applicable transfer penalty was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 19th day of February 2007,

in Tallahassee, Florida.

Linda Jo Nicholson
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
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Copies Furnished To:

Roseann Liriano, Suncoast Region
MAUREEN RULISON, Medicaid representative for petitioner
David Selby, Esq., counsel for the respondent
G. Andrew Gracy, Esq., counsel for the petitioner

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

APPEAL NO. 07F-06628

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 07 Brevard
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on December 13, 2007, at 10:55 a.m., in Cocoa, Florida. The petitioner was not present. His mother, a, represented him. Lizette Knott, human services program specialist, Area 7 Medicaid, represented the respondent at the hearing. Appearing by telephone was Dr. Mittal, pediatric reviewer, and Teresa Ashey, nurse reviewer, KePRO.

ISSUE

At issue is the respondent's decision of October 26, 2007 to deny 136 hours of private duty nursing services paid by Medicaid for the petitioner. The agency holds the burden on this matter.

FINDINGS OF FACT

1. The petitioner is ten years old. He is a medically complex child whose conditions include leukodystrophy, cerebral palsy, optic nerve atrophy, abnormal involuntary movements, developmental delays, and subluxation unilateral hips (congenital). He is legally blind. In August, he weighed 48 pounds. He is fed by jejunostomy (j tube), and receives medications by a gastronomy tube (g tube).

2. The petitioner has been receiving private duty nursing (PDN) under Medicaid. On October 12, 2007, the petitioner's provider of private duty nursing benefits, Pediatric Services of America, submitted an authorization request for 396 hours of PDN, for the period of October 10, 2007 through December 8, 2007.

3. The petitioner lives with his mother and father. He goes to school Monday through Friday. His mother does not work. She has had three lumbar surgeries. Her doctor has placed restrictions on her lifting no more than 20 pounds, and no extended period of standing, sitting, walking, bending, twisting, or squatting. She has limitations on reaching. Her treating doctor, , opines that she needs increased nursing help because she is unable to transfer the petitioner because he weighs over 40 pounds (Petitioner's Exhibit 1). His father works Monday through Friday, from 8:00 a.m. to 5:00 p.m. He sometimes has to work on Saturdays. PDN was requested Monday through Friday from 2:30 p.m.-8:30 p.m., and from 9:00 a.m. - 5:00 p.m. on Saturday and Sunday.

4. Requests for PDN are reviewed with a contract provider who completes a prior authorization review for the requested services. The contracted provider is KePRO. The request for services is submitted by the home health agency. All communication is

sent between the provider and KePRO. KePRO reviews the written request for services to determine if the number of hours requested are medically necessary. If additional information is needed, KePRO contacts the provider. In this case, additional information was requested and received.

5. The Respondent's Composite Exhibit 10 contains all of the information KePRO used in making a determination of medical necessity. On October 12, 2007, KePRO received a request for 396 hours of PDN. At first, it appeared that the provider requested 354 hours, but it was later clarified as 396. PSA left blank the "Description of medically necessary skilled services to be provided by private duty nurse (PDN) or personal care/home health aide (PC/HHA)", on the PDN questionnaire. His medications are listed as Nasonex, Ferrous sulfate, Gabitril, Miralax powder, Diastat Pediatric, Topamax, Phisohex, Saline Solution, Zanaflex, Valium, Previcid, Scopolamine Methylbromide powder, vitamin B6, Albuterol Sulfate, Pulmicort, Ambrotase Powder, O2, and Keppra. His functional limitations listed are endurance, ambulation, speech, and legal blindness. The report showed he requires oxygen, he has had no recent hospitalizations, no pain, and that his parents are able to assist with his care. On October 25, 2007, the physician reviewer recommended approval of 260 hours of PDN and the denial of 136 hours. The requested hours for the weekends were denied because the petitioner's father does not work weekends.

6. On October 30, 2007, KePRO received a Reconsideration review request submitted by PSA, and reviewed by a second physician consultant. The provider noted that weekend hours are necessary because sometimes the petitioner's father is mandated to work Saturday and Sunday if a job is not completed by Friday afternoon. It

is never known until Friday afternoon if the weekend work is required, but it appears to happen at least twice a month. The respondent explains that flex hours can be requested as needed, but they are not preapproved.

7. The petitioner's mother believes that KePRO made the correct assumptions concerning her son's need for PDN services based on the information or lack of information provided by PSA. However, she explains that the information is not accurate. She sleeps in his room at night to tend to his medical issues. Her son has a high aspiration risk. He has uncontrolled seizures, sometimes 12 in an hour. He has contractures. He has unexplained temperature spikes. He has GI issues that involve coughing, gagging, and retching, which in turn cause increased secretions. He has no head or trunk control. He has to be repositioned constantly. He uses a vest to help keep his lungs clear. He would not benefit from home health aides because they cannot provide the skilled medical care he needs. They need to be proactive protecting his airway.

8. The petitioner's mother explains that her husband is in the home but he does not provide any medical care for their son. He is not comfortable proving his care. He had a fracture of the coccyx in the summer, and now has a ruptured disc above that area. He needs surgical repair. She provided a note from his doctor that states he has a "45 lb wt limit on continual basis" (Petitioner's Exhibit 2). The respondent did not have any knowledge of his health information or limitation prior to the hearing as it was not provided by PSA.

9. The petitioner's mother believes that parents should see the information the provider submitted to KePRO prior to the hearing so that they could get a better

understanding of why they were denied and have an opportunity to provide complete information for consideration. She believes that not all parents are able to care for a disabled child, and it should not be assumed that just because they are in the home. The parents try to do a two-man lift when they have to reposition the petitioner, as he is afraid of the Hoyer lift. They have tried many different ways to move him in it, but have not been successful, as it still requires movement that is restricted.

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..." Consistent with statute, Fla. Admin. Code 59.G-1.010, **Definitions**, states for medical necessity:

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

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

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

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

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

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

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

Florida Admin. Code 65-2.056 Basis of Hearings.

> 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 or reduced PDN services based on information submitted by the provider in a prior authorization request for services. At the hearing, the petitoner's mother introduced medical conditions, and other pertinent information not known to the contracted agency when determining medical necessity. As that determination was not based on the petitioner's actual situation, it can only be given limited weight. The petitioner's husband has weight lifting restrictions placed on him by his medical doctor.

Based on the above cited rule concerning de novo hearings, relevant new evidence can be considered.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth above, the hearing officer finds that the Agency has not met its burden of proof and that the Agency's action to reduce Private Duty Nursing is not supported by the record. In addition, medical documentation showing that the petitioner's father has medical limitations leads the undersigned to conclude that the 136 hours of PDN that were denied are medically necessary. The hearing officer cannot affirm the agency's action in this matter.

DECISION

The appeal is granted. The agency's action to deny 136 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 4th day of February, 2008,

in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To: [illegible]
Judy Jacobs, Area 7 Medicaid Adm.
Pediatric Services America

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

APPEAL NO. 07F-6830

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 January 15, 2008, at 8:20 a.m., in Miami, Florida. The petitioner, , was not present however she was represented by her mother, . Present, on behalf of the respondent was Monica Otoriola, program specialist with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the agency was Dr. Robert A. Buzzeo, physician reviewer and Mary Wheeler, nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez, specialist with AHCA was present as an observer.

ISSUE

At issue is the agency's action on November 18, 2007 in denying 68 hours of private duty nursing (PDN) and approving 652 hours from the requested 720 hours of PDN. The certification period is for October 31, 2007 through December 29, 2007. The agency has the burden of proof.

FINDINGS OF FACT

1. The petitioner is fifteen years old and a Medicaid beneficiary in the state of Florida. The petitioner's medical condition as reported to the agency was: "Conditions due to anomaly of unspecified chromosome, Infantile cerebral palsy, unspecified, Sleep apnea, Unspecified Mental retardation."

2. On November 2, 2007, the provider (Nationwide Healthcare Services) requested 720 (12 hours daily, 7 days a week, 7pm-7am) of skilled nursing hours, for the petitioner for the certification period of October 31, 2007 through December 29, 2007.

3. The agency has contracted KēPRO South which is a Peer Review Organization (PRO) to perform medical reviews for the 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 submitted by the provider in order for KēPRO to make a determination on medical necessity.

4. On November 2, 2007, the initial screening of the request was performed by a registered nurse reviewer. Additional information was requested and was received. The request was referred to a board-certified pediatrician for review of medical necessity for the level of service requested.

5. A KēPRO physician consultant reviewed the request, considered all medical and social information and approved the 12 hours daily (7 pm through 7 am) Monday through Fridays (week days) and partially denied the hours for Saturdays and Sundays (weekend) from 7 pm to 11 pm, the days that the petitioner's mother was available. The

physician consultant determined that the mother was able to provide care for the petitioner during that time. The weekend hours were approved for 8 hours (11 pm through 7 am) each day. The provider was informed of the PDN hours that had been approved (652 hours) and denied (68 hours).

6. On November 12, 2007, a request for reconsideration was received with additional information.

7. A second board certified in pediatrics physician consultant reviewed the initial denial of 68 hours. The physician consultant considered all information (medical and social) and agreed with the initial physician reviewer.

8. On November 18, 2007, a PDN/PC Recipient Reconsideration-Denial Upheld letter was issued to the petitioner and the provider.

9. Considered in the agency's approval of the 652 hours and denial of 68 hours were: The petitioner's mother works weekdays from 8:30-5:30 pm and Saturdays from 9-2 pm; the petitioner's mother has physical limitations; there is a 4 year old sibling; the petitioner's medical condition; the petitioner's attendance at Prescribed Pediatric Extended Care (PPEC) which is a medical daycare from 8 am to 3 pm, Monday through Friday; the services of a personal care attendant (PCA) provided by the Medicaid Waiver Program from 3 pm to 7 pm, Monday through Friday and 2 pm to 7 pm on Saturday and Sunday.

10. The petitioner requested a hearing on the issue on November 28, 2007 and benefits have continued at its prior level, pending the outcome of the hearing.

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.

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

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

(a) Meet the following conditions:

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

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

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

goods or services medically necessary or a medical necessity or a covered service.

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 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. ...

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. Training can be offered to parents and caregivers to enable them to provide care they can safely render. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.

The petitioner's mother states that the petitioner is sleeping 10 hours and needs constant care and supervision. She states that due to her own physical limitations, her daughter needs the 12 hours daily, 7 days a week of PDN. She states that the PCA that cares for her daughter 3 pm to 7 pm only "watches her" as she provides no medical care. She states that her mother helps the PCA and even though her mother is not licensed to administer medication, but is authorized by her to do so in an effort to help out.

The physician consultant responded by saying that the denial of the 68 hours on the weekends (4 hours on Saturdays and Sundays) was reasonable. The hearing officer agrees.

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The opinion of the physician reviewer was that the petitioner's mother was capable of providing care for the petitioner for 4 hours on Saturday and Sunday.

The Findings of Fact shows that the agency approved PDN hours for 12 hours daily and 8 hours on the weekends. Ultimately, it is the parent's responsibility to provide the care for the child and the agency's responsibility to supplement that care and the agency has done so by approving 12 hours daily on week days and 8 hours daily on the weekend.

Based on the above cited authorities, the respondent's action to deny 68 PDN hours and approve 652 hours for the period of October 31, 2007 through December 29, 2007, was within the rules of the Program and is affirmed.

DECISION

The 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 1st day of February 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

APPEAL NO. 07F-6625

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER OF DISMISSAL

A hearing request was received on November 5, 2007, on behalf of Courtney Morrison (minor). This hearing request was made by , for private duty nursing services received through Medicaid for Courtney.

Pursuant to notice, an administrative hearing was convened on January 9, 2008, in Miami, Florida. Upon introduction of the parties present, it was learned that Ms. is the foster mother of the petitioner. The hearing was previously scheduled for December 27, 2007, but was continued at the request of the petitioner's foster mother. The agency did not object.

Fla. Admin. Code 65-2.045 Hearings Request, states in part:

> (3) A Request for Hearing may be made by the applicant/recipient or someone in his/her behalf. However, if the appeal is filed by someone other than the applicant/recipient, attorney, legal guardian, spouse, next of kin, the grantee relative in cash assistance, or a person allowed by the Department as an authorized representative to participate in the eligibility determination, the person making the appeal must have written authorization of the applicant/recipient. Such written authorization must accompany the Hearing

> Request. Should the request be filed without the written authorization, the authorization must be provided in response to a request from the Department or hearing officer, prior to the appeal going forward. Without prior proper written authorization, the Department will treat a request for hearing as being made by someone not authorized to do so. Therefore, the appeal will be dismissed.

The hearing officer informed that proper representation was required in order to go forward with the hearing, as she was not the legal guardian. The hearing officer granted fourteen (until January 23, 2008) days to in order to obtain proper representation for from the courts. The agency did not object. The petitioner does not have the ability to appoint a representative and the foster mother does not fall with the individuals who may request a hearing on the child's behalf.

On January 22, 2008, Motion for additional time to obtain proper representation through the courts was submitted. The hearing officer granted an additional fourteen (until February 6, 2008) days to . The agency did not object.

As of the day of this order, Ms. has not contacted the hearing officer nor has she provided proper written representation to the hearing officer in order to allow the hearing to go proceed. In accordance with the above-mention rule, the appeal is dismissed.

NOTICE OF RIGHT TO APPEAL

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

funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

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

in Tallahassee, Florida.

A. G. Littman

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

Copies Furnished To:

Mary Wheeler
Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-06747

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 January 4, 2007, at 9:55 a.m., in Tampa, Florida. The petitioner was present. The respondent was represented by David Beaven, health care program specialist. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Maureen Levy, M.D., physician reviewer, and Theresa Ashey, R.N., nurse reviewer.

The record was left open until January 18, 2007 for the petitioner to submit additional evidence. On January 14, 2008, the hearing officer received a cover letter and an operative report. These documents were entered as Petitioner Exhibit 3 and 4. The record was closed on January 18, 2007.

ISSUE

The petitioner is appealing the notice of September 26, 2007 for the respondent's action to deny prior authorization of a revision of total right knee arthroplasty surgery.

FINDINGS OF FACT

1. The petitioner had total right knee replacement on November 23, 2005. On September 21, 2007, the petitioner's physician, , submitted information for prior authorization for a revision of total right knee arthroplasty. The procedure was to be preformed on October 29, 2007 with subsequent hospitalization through November 3, 2007.

2. Prior authorization for is required for payment of surgery by Medicaid. The respondent authorizes any Medicaid payment. KePRO is the contract provider for the respondent for the prior authorization decisions. The request for prior authorization is reviewed by a nurse reviewer and a physician consultant.

3. KePRO received the request for prior authorization for a revision of total right knee arthroplasty on September 21, 2007. The nurse reviewer used InterQual criteria to determine the medical necessity for the request. InterQual is a planning criteria and procedures criteria. InterQual sets forth the indications required to meet the criteria for prior authorization. InterQual criteria under Adult Procedures "Removal and Replacement, Total Joint Replacement (TJR) Knee" criteria was reviewed. From the information provided by the petitioner's physician, the request did not meet the criteria. The case was referred to a physician consultant.

4. The physician, board certified in surgery, reviewed the request. The physician consultant denied the request. The reason for the denial was "Deny – not enough pre-operative data provided to describe why the surgery is to be performed. On September 21, 2007, notices of denial were issued.

5. On September 26, 2007, the petitioner's physician requested a Reconsideration. He submitted additional documentation of Office Notes. The petitioner's physician stated: "...We really need to do this surgery...". The Office Notes included the following in relevant part. From January 6, 2006 notes: "...home PT was stopped secondary to his lapse of his insurance...he went for about three visits of outpatient PT and that was subsequently stopped as well...". From January 24, 2007 notes: ' comes in today status post arthroscopy, manipulation under anesthesia two weeks ago in which he had full range of motion under anesthesia. He still comes in today with continuous pain unable to fully extend his knee with physical therapy...Impression patient with painful hardware status...".

6. A second physician reviewer completed the reconsideration review and reviewed the information provided with the reconsideration. The physician reviewer denied the reconsideration. The physician reviewer stated: "...the patient has had lapses in insurance and therefore PT. But is the pain coming from an infection? Has a septic w/u (workup) been done to rule this out prior to surgery? Or is the issue of possible overstuffing the knee originally and/or poor patient compliance? If it is the latter, what is going to prevent the same thing from happening after the next surgery?

7. The petitioner attested that his knee is very painful. He is unable to straighten the leg full and it is always in a bent position. He stopped going to therapy as the therapy was very painful and resulted in bruises the size of eggs around his knee. He did home exercises, but the leg would not fully extend. The petitioner opined that the "piece" in his knee is too thick.

8. The office notes of December 12, 2007 for the petitioner by Dr. I stated: "...He is still having pain. He is still having flexion deformity with 10 degrees of extension lag. I am going to need to I&D his knee and need to re-cut his tibia, put his tibia into more flexion, put spacer, so that he can get full extension, probably a smaller spacer like a 9 after I re-cut his tibia so that there is a gap in extension, so that I can get his full motion back...X-rays taken in the office today show total knee in good alignment in AP and lateral views...".

9. The respondent noted the petitioner was not compliant with therapy after the first surgery. The respondent stated that no report of the arthroscopy was submitted. The respondent was questioning the medical necessity of the second knee replacement as the petitioner had full range of motion under anesthesia. There was no bone scan or work up to eliminate infection as the cause of the pain. The respondent was unable to authorize the surgery as there was no explanation for the cause of the pain, if the second knee replacement would take care of the problem or if the petitioner would be compliant with therapy.

10. The Operative Report January 8, 2007 was submitted by the petitioner on January 14, 2008. The Operative Report stated in part:

"...Manipulation was attempted first, but we could not get the leg straight, and we could not get it to 140...We shaved out adhesions medially, laterally and in the patellofemoral joint. We shaved out adhesions anteriorly to the tibia and in the intercondylar notch...We then manipulated it, and we were able to get from 0 - 140...We then...used the shaver to get rid of more of the adhesions..." This report indicates that after the shaving the physician manipulated the leg under anesthesia and a range of motion from zero to 140 degrees was achieved.

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 Hospital Services Coverage and Limitations Handbook (June 2005) page 2-25 sets forth for prior authorization:

> Authorization for Inpatient Admissions
> Effective March 1, 2002, Medicaid recipient admissions in Florida for medical, surgical, and rehabilitative services must be authorized by a peer review organization (PRO). The purpose of authorizing inpatient admissions is to ensure that inpatient services are medically necessary...

Florida Administrative Code 59.G-1.010, "Definitions", sets forth the definition of 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 hearing officer reviewed the rule for the determination as to whether the requested service met all the criteria of medical necessity. The petitioner has disability and pain and would meet the first condition. The second condition would require a confirmed diagnosis of the illness or injury under treatment. The respondent denied pre-authorization for the revision for the reason that there was not enough pre-operative data provided by the treating physician to describe why the surgery is to be performed. The petitioner's treating physician described what he was going to do in the surgery. The petitioner's treating physician indicated that the petitioner was having pain. The arthroscopy was submitted which indicating after scraping a range of motion of zero to 140 was achieved. There was no bone scan or work up to eliminate infection as the cause of the

pain. There was no medical documentation to explain the cause of the pain or if the second knee replacement would take care of the problem. The report by the treating physician of an x-ray on December 12, 2007 indicated that the total knee was in good alignment. The petitioner opined that the "piece" in his knee is too thick. The physician stated that he "probably" would put in a smaller spacer. However, there was no statement by the treating physician with supporting medical imagery to support that the first total knee replacement was all or in part too large. As set forth in rule, 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 evidence as submitted does not support that the criteria for medical necessity was met. Based upon the above cited authorities, the respondent's action to deny prior authorization of a revision of total right knee arthroplasty surgery 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 agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 21st day of February 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:

Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting

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

APPEAL NO. 07F-06746

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 January 4, 2008, at 12:34 p.m., in Tampa, Florida. The petitioner was not present. She was represented by her mother, [illegible]

The respondent was represented by David Beaven, health care program analyst. Witnesses for the petitioner were [illegible] administrator for Nurse Stat, [illegible]je, RN for NurseStat. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Rakesh Mittal, M.D., physician reviewer, and Teresa Ashey, R.N., nurse reviewer.

ISSUE

The petitioner is appealing the notice of October 25, 2007 for the respondent's action to deny 204 hours of private duty nursing for the period of October 17, 2007 through December 15, 2007. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Denial Letter on October 25, 2007. The notice informed the petitioner that for the requested 720 hours of private duty nursing for the period of October 17, 2007 through December 15, 2007, 204 hours were denied.

1. The petitioner care is medically complex. She was receiving private duty nursing private duty nursing twelve hours a day. The petitioner resides with her mother, father, and 13-year-old brother. Both parents work.

2. The nursing agency requested 720 hours of private duty nursing for the petitioner for the period of October 17, 2007 through December 15, 2007. The request was on the basis that both parents work at the family store and sometime need to work on weekends. This request would be twelve hours a day of private duty nursing.

3. Prior authorization for private duty nursing is reviewed every 60 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.

4. The initial nurse reviewer 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 consultant.

5. The initial physician consultant determined was based on the information received from the nursing agency. The initial physician consultant determined that based the parents were able to provide more hours on weekends, as the mother's work schedule on weekends was a flexible schedule. A PDN/PC Recipient Denial Letter was sent to the petitioner on October 15, 2007. The notice informed the petitioner that for the requested 720 hours of private duty nursing for the period of October 17, 2007 through December 15, 2007, 516 hours was approved and 204 hours were denied.

6. The nursing agency requested a reconsideration. The reconsideration was reviewed by a second physician consultant. The reconsideration was denied. The physician reviewer noted: "Information submitted indicates parents work some weekends dependent on "games" and store staff availability. These are "flex hours" in that the PDN hours are "in case" the parents must work. Per AHCA, KePRO cannot approve flex hours. If parents find that they must work on a specific upcoming weekend, then the Provider may request those hours as a Modification". A PDN/PC Recipient Reconsideration - Denial Upheld notice was sent to the petitioner on October 25, 2007.

7. The petitioner's mother attested that she had not fully informed the nursing agency of her and her husband's work hours, the number of businesses the owned and worked at or other family issues. The parents have four businesses. The mother works seven days a week. She works ten hours out of

the home on Saturday and Sunday. She work eight hours a day Monday through Friday, four to five hours out of the home and the rest at home. The father works ten to twelve hours Saturday and Sunday. He works eleven hours a day Monday through Friday. The petitioner's home situation changed. The mother now has custody of her grandson. The mother needed additional time to attend to her son who broke his leg on November 5, 2007.

8. The respondent attested that the information of the parents working on weekends was not available to them at the time of the decision to deny 204 hours of private duty nursing.

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

The Home Health Services Coverage and 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 handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The respondent's decision was based on the information provided by the nursing agency. The information was that the parent only worked on weekends during "games", not every weekend. The amount of private duty nursing the respondent authorized in order that the parent's participation in providing care for the petitioner to the fullest extent possible was twelve hours a day Monday through Friday and a denial of all weekend hours. Therefore, the respondent's decision at the time was correct. However, the respondent was not fully informed that the parents were working

every Saturday and Sunday and the work schedule was not a flexible schedule. As the denial of 204 hours of private duty nursing was based on the parent availability on weekends and the respondent received bad information, the decision of the respondent would be different had this information been available to the respondent. Based on the inaccurate information provided to the respondent, the respondent's action to deny 204 hours of private duty nursing for the period of October 17, 2007 through December 15, 2007 is reversed.

DECISION

This appeal is granted for the period of October 17, 2007 through December 15, 2007.

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 4th day of February, 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: k

Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting

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

APPEAL NO. 07f-06554

PETITIONER,

Vs.

CASE NO. 1267568852

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 29, 2008, at 10:45 a.m., in Lake Worth, Florida. The petitioner is deceased. Representing the petitioner was [redacted], Medicaid planner, Terrace of Lake Worth. Representing the respondent was Terry Verduin, attorney, Circuit 15 Legal. Appearing as a witness was Martha Stollberg, specialist supervisor.

ISSUE

At issue is whether the respondent was correct in denying Institutional Care Program (ICP) Medicaid for the retroactive month of July 2007 due to the improper transfer of assets. The petitioner has the burden of proof.

FINDINGS OF FACT

Prior to the commencement of the hearing, the respondent reviewed the case record and determined that there should not have been a denial of benefits. The respondent has stipulated that the petitioner was eligible for the Program for the retroactive month of July 2007.

The representative has agreed to the stipulation.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.204 **Rights and Responsibilities** states in part:

> (1) Any person has the right to apply for assistance, have his/her eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing all necessary facts and documentation to establish eligibility, advise the Department of any changes in his/her circumstances which might affect eligibility and/or the amount of the public assistance benefit, and to provide the department with any channel of information concerning his/her affairs that may be determined necessary. If the information or documentation is difficult for the person to obtain, the department must provide assistance in obtaining the information or documentation when requested or when it appears necessary.

As noted, both sides have agreed to the stipulation that the petitioner was eligible for July 2007.

DECISION

The appeal is granted. The respondent will make July 2007 an eligible month for the ICP.

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 February 2008,

in Tallahassee, Florida.

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

Copies Furnished To: E [illegible]
9 DPOES Martha Prock
Colleen Farnsworth, Esq.

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

APPEAL NO. 07F-07273

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 07 Orange
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned-hearing officer convened an administrative hearing in the above-referenced matter on January 22, 2008, at 9:54 a.m., in Orlando, Florida. The petitioner appeared and represented himself. , petitioner's legal guardian, appeared as a witness. Lisa Sanchez, senior human services program specialist, appeared and represented the respondent, the Agency for Health Care Administration.

ISSUE

At issue is the agency's action of August 29, 2007, denying the petitioner's request for direct reimbursement for payment of Medicaid-covered services. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

1. The petitioner, a terminally ill patient, applied for Medicaid with the Department of Children and Families (DCF) on December 4, 2006. On February 26, 2007, DCF issued a Notice of Case Action approving the petitioner's application for disability-related Medicaid. The approval was retroactive beginning December 1, 2006.
2. The petitioner received a gold colored Medicaid card in the mail. He experienced difficulty in using the card with different providers including pharmacies. He was told his card was "no good" and was denied coverage but was given nothing in writing to verify this. After several telephone calls, he discovered that DCF had some third party insurance information listed in his computer file that was keeping his Medicaid from properly working. The petitioner told his case specialist at DCF that he no longer had insurance but that in 1998 he had coverage under Principle Healthcare from his former employer. The specialist at DCF told him he needed to provide proof he no longer had this third party insurance. The petitioner tried to contact Principle Healthcare to obtain proof that he was no longer covered under its plan but found the company was obsolete. He did inform DCF of this information. Finally, after several attempts to remove the information regarding Principle Healthcare, DCF removed the information in April 2007.
3. The petitioner was placed under coverage with a Medicaid Health Maintenance Organization (HMO) in April 2007. From April 2007 on, the

petitioner experienced less difficulty in using his gold Medicaid card, although at the hearing he indicated that his Medicaid never "fully worked" until July 2007. He incurred Medicaid-covered expenses that he paid out-of-pocket from December 2006 through July 2007 for which he sought reimbursement. He contacted the Agency in August 2007 requesting direct reimbursement of these expenses.

4. The Agency reviewed his request and found that because DCF did not issue the petitioner a notice of Medicaid denial that was erroneous, he was not eligible for direct reimbursement of services during the time period requested. The Agency issued a notice, dated August 29, 2007, to the petitioner informing of this decision.
5. At the hearing, the petitioner stated that the Agency ultimately denied him because it kept old information in the computer system regarding his former health insurance which kept his Medicaid card from "going through." This caused him hardship because he had to pay for his medications and other medical services. Even though DCF sent him an approval letter, he was essentially denied because he had to pay out of pocket for medications and because he did not get this letter until February 26, 2007.
6. The Agency stated that it checked the provider eligibility system and found no record of any provider attempting to run the Medicaid card through until March 13, 2007. Yet the pharmacy evidence submitted by the petitioner indicates that some form of insurance was used because "savings" was

indicated on the receipt portion by the pharmacy's notation "Your Insurance Saved You..." which left a co-payment for the petitioner to pay. This evidence shows dates during December 2006 through July 2007. This was not addressed on the record and the hearing officer concludes that the pharmacy did accept the petitioner's Medicaid card even though a verbal denial was given in some instances.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-5.110 states in relevant part:

> (1)(a)...Direct payment may be made to a recipient who paid for medically necessary, Medicaid-covered services received from the beginning date of eligibility and a successful appeal or an agency determination in a recipient's favor. The services must have been covered by Medicaid at the time they were provided. Medicaid will send payment directly to the recipient upon submission of valid receipts to the Agency for Health Care Administration. All payments shall be made at the Medicaid established payment rate in effect at the time the services were rendered. Any goods or services the recipient paid before receiving an erroneous determination or services for which reimbursement from a third party is available are not eligible for reimbursement to the recipient.

AHCA's Direct Reimbursement/Payment to Recipients Policy Guidelines (March 2001) states:

> Federal regulations allow the states to directly reimburse an applicant and/or recipient who has paid for medical services after receiving an erroneous denial of Medicaid eligibility which is subsequently reversed upon appeal.

The above authorities state that in order to receive direct reimbursement for Medicaid covered services an individual must show that he received an erroneous denial of Medicaid. The evidence submitted shows the opposite in

that the petitioner received an approval letter from DCF granting approval of his application for Medicaid. While it is noted that the petitioner did experience difficulty in using his Medicaid card due to the old insurance information in the computer system, his initial complaint should have been placed with DCF in early 2007 rather than AHCA. No hearing was filed against DCF in this matter. The Agency presented testimony which shows the petitioner's Medicaid eligibility was valid on the system from December 2006 through July 2007. There is no doubt that the petitioner dealt with obstacles during this process but the technical requirement for receiving direct reimbursement from the Agency has not been met and as a result the Agency's action must be upheld.

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 5th day of February 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

Judy Jacobs, Area 7 Medicaid Adm.

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

[redacted]

APPEAL NO. 07f-06961

PETITIONER,

Vs.

CASE NO. 1197276271

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 31, 2008, at 10:30 a.m., in Lake Worth, Florida. The petitioner is deceased. Representing the petitioner was [redacted], director of social services, Heartland of Boynton Beach. Appearing as a witness was Marta Strong, VIP Care Management. Representing the respondent was Martha Stollberg, specialist supervisor. Present as an observer was Barbara Gonzalez, specialist I.

ISSUE

At issue is whether the respondent correctly denied Institutional Care Program (ICP) Medicaid benefits for the retroactive months of October 2006 through April 2007 due to there not being an eligible application for the period. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who was residing in a nursing facility, had ICP Medicaid benefit eligibility through September 2006. In August 2006 the respondent had issued an interim Notice that eligibility had to be re-certified. When there was no response, the respondent terminated the ICP September 30, 2006.
2. The respondent next received an application August 23, 2007. Because the petitioner's assets were never verified, this application was denied October 2007.
3. On October 30, 2007, a new application was submitted and approved. The respondent authorized ICP benefits effective May 2007 and ongoing until the petitioner passed away.
4. The representative presents that in 2006 the petitioner had a power of attorney (POA) and trustee of his income trust who passed away March 12, 2006. A new POA and trustee was assigned to the petitioner but she also passed away April 24, 2006.
5. It was not until July 2006 that the nursing facility became aware of both deaths and that a new POA had to be assigned. The nursing facility did not submit an application at this time. Eventually in May 2007 a grandson became POA and trustee.
6. Because there was no one who was responsible for the re-certification, the eligibility lapsed. The nursing facility is seeking a hardship consideration to

allow eligibility for the period in question in order that outstanding bills can be paid.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.204 **Rights and Responsibilities** states in part:

(1) Any person has the right to apply for assistance, have his/her eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing all necessary facts and documentation to establish eligibility, advise the Department of any changes in his/her circumstances which might affect eligibility and/or the amount of the public assistance benefit, and to provide the department with any channel of information concerning his/her affairs that may be determined necessary.

65A-1.205 **Eligibility Determination Process** states in part:

(1) The individual receives a Request for Assistance and completes it to the best of the individual's ability.

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

(f)(2)(b) A partial eligibility review entails review of one or more, but not all factors of eligibility. Partial reviews are scheduled based on known facts or anticipated changes or when an unanticipated change occurs. A face-to-face interview is not usually required, unless the necessary information cannot be obtained without this exchange.

(4) An applicant or recipient who fails to keep an appointment without arranging another time with the eligibility specialist, fails or refuses to sign and date the application form(s) described in subsection (1); fails or refuses to submit a periodic report; or fails or refuses to submit required documentation or verification will be denied benefits as eligibility cannot be established.

(5) Information provided by the applicant/recipient must be substantiated, verified or documented as part of each determination of eligibility.

According to the Fla. Admin. Code, the respondent had correctly sent Notice that a partial review was required. Without a response, the respondent correctly terminated the ICP.

It is the petitioner's responsibility to inform the respondent when any change occurs that would affect the ongoing case. The fact that the POAs and trustees passed away and left the petitioner without representation is not the responsibility of the respondent.

It was not until over a year had passed that a new POA and trustee was established. It was not until a year and a half until a new application was submitted and approved.

DECISION

The appeal is denied. The respondent's action is affirmed. The respondent cannot offer eligibility without an existing application.

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 5th day of February 2008,

in Tallahassee, Florida.

Melvyn Littman

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

Copies Furnished To:
9 DPOES Martha Prock

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

PETITIONER,

Vs. APPEAL NO. 07N-00199

Administrator Lynn Smith

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on January 18, 2008, at 10:10 a.m., at the Health Care Center, Jacksonville, Florida. The petitioner was present and represented himself. The respondent was represented by , director of nursing. Present as witnesses for the respondent were ey, director of social services and minimum data set coordinator. Present observing was Leslie Green with the Office of Appeal Hearings.

ISSUE

At issue is whether or not the action by r Health Care Center to discharge the petitioner from the facility, on the basis that his needs cannot be met by the facility, is correct.

Care Center has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. §483.12.

FINDINGS OF FACT

1. The petitioner is a resident of Care Center. The petitioner is a quadriplegic and also has been diagnosed with scoliosis, asthma, constipation, hyperlipidemia, reflux esophagitis and acute pain.

2. On August 6, 2007, the respondent gave the petitioner a Nursing Home Transfer and Discharge Notice. The notice notified the petitioner that he was being discharged from the facility because his needs could no longer be met by the facility. The notice listed , a nursing facility, as the location to which the petitioner was to be discharged. In support of the action to discharge the petitioner, the notice stated that the petitioner was not compliant with his plan of care.

3. On December 6, 2007, the respondent issued a revised Nursing Home Transfer and Discharge Notice, as the August 6, 2007 notice listed the discharge effective date as August 6, 2007, which was not correct. The revised notice listed the discharge effective date as January 4, 2008 and stated that the petitioner was being discharged because his needs could not be met by the facility. Additionally, in support of the action to discharge the petitioner, the notice stated that the petitioner was a risk to himself and others. The petitioner's physician signed both of the discharge notices.

4. On August 5, 2007, the petitioner was hospitalized as he could not stop shaking. At the time of the hospitalization, the petitioner had a "fanny pack" which the respondent took for safe keeping. Risk management opened the "fanny pack" to inventory the

contents and found a plastic bag with marijuana in it. The respondent called the police and the petitioner was charged with a misdemeanor for having possession of marijuana. According to the petitioner, the charges have been adjudicated and there are no outstanding charges against him.

5. The petitioner is employed by and also attends classes at the college. The petitioner leaves the facility four days per week to attend classes and to work. The petitioner smokes marijuana while away from the facility. The respondent considers the petitioner's use of an illegal substance as posing a risk to himself and other residents in the facility.

6. Medical protocol required the staff of the facility to turn the petitioner every two hours, during the night, while he was in bed to prevent pressure ulcers as the petitioner cannot turn himself. The petitioner does not want to be turned every two hours as this interrupts his sleep. The petitioner only wants to be turned at 2:00 a.m. and at 5:00 a.m. In the past, the petitioner was treated for a wound to his left buttock. According to the respondent, turning the petitioner only twice during the night increases his risk of the developing pressure ulcers.

7. The petitioner uses a catheter and as a result has a risk for urinary track infections. The petitioner recently had a urinary tract infection and his physician prescribed antibiotics to treat the infection. However, the petitioner refused to take the antibiotics because of the fear of becoming immune to the antibiotics. The petitioner later decided to take the antibiotics as prescribed. According to the director of nursing, the antibiotic treatments of the petitioner's urinary tract infections out weigh the risk of becoming immune to the antibiotics.

8. The August 6, 2007 discharge notice listed the [redacted] as the location to which the petitioner was to be discharged. However, [redacted] would not agree to admit the petitioner to its facility as it could not meet his needs. The respondent contacted other facilities as possible locations to which the petitioner could be discharged. However, none of the facilities have agreed to admit the petitioner. The respondent was aware of the responsibility of providing the petitioner with a safe and orderly transfer in the event of his discharge from the facility.

CONCLUSIONS OF LAW

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

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

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the, and not transfer or discharge the resident from the facility unless--...
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
>
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (iii) The safety of individuals in the facility is endangered;
>
> (iv) The health of individuals in the facility would otherwise be endangered;
>
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a

stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate...

(7) Orientation for transfer of discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

The Findings of Fact show that the petitioner has not followed his care plan as he has not allowed the facility staff to turn him in bed every two hours to prevent pressure ulcers, has refused to take medication as prescribed by his physician and also has been under the influence of marijuana. Based on the above findings, it is determined that the respondent has acted correctly to discharge the petitioner because his needs cannot be met by the facility.

DECISION

The appeal is denied. The respondent may proceed with the discharge to an appropriate location as determined by the petitioner's treating physician and in accordance with applicable Agency for Health Care Administration requirements.

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 5th day of February, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: J[illegible] pondent

Ms. Nancy Marsh,
Agency for Health Care Administration

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

APPEAL NO. 07N-00198

PETITIONER,

Vs.

R

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 23, 2008, at 9:40 a.m., in Lauderdale Lakes, Florida. The petitioner was not present. She was represented by her daughter. Also present was her son-in-law, and Ramon Keppis, from the Broward County Long Term Care Ombudsman Council. The respondent was represented by on, director of the Also present from the facility was , director of social services; o, assistant director of nursing; A n speech pathologist; and A r, food service director.

ISSUE

At issue is the 's action of November 6, 2007, to discharge the petitioner from the facility. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner resides at the N..... ', in Florida. Included in the evidence is a copy of Nurse's Notes stating that the petitioner was admitted to the facility on May 12, 2007, however included in the evidence is a copy of an Admission Information form listing an admission date for her on May 13, 2007.

2. Included in the evidence is a copy of a Nursing Facility Transfer and Discharge Notice, dated November 6, 2007, stating that the petitioner was being discharged from the facility because her needs cannot be met there.

3. Included in the evidence is a copy of a Refusal of Medications and Treatment Form, signed by the petitioner's representative on September 26, 2007. It states that she is refusing the medication regimen that Dr. _ nas prescribed.

4. Included in the evidence is a copy of Psychiatric Follow Up Notes from Dr. ..... dated September 21, 2007. The doctor states that he will sign off the case because the family will not allow care. He had prescribed medications for the petitioner, however the petitioner's daughter did not allow the medication regimen.

5. Included in the evidence is a copy of a Physician's Order from Dr. H dated December 6, 2007. This is a doctor's order to discharge the petitioner from the facility. Dr. H is listed as the petitioner's attending physician on an Admission Information form, included in the evidence.

6. Included in the evidence are copies of Nurse's Notes, dated May 12, 2007 to January 23, 2008. According to Nurse's Notes, dated November 3, 2007 to January 23, 2008, the petitioner continually called out to nurses that she had to go to the bathroom.

She did this when she did not have to go to the bathroom, and she even called out to nurses about going to the bathroom while sitting on the toilet.

7. According to the Nurses Notes, from November 17, 2007 to January 21, 2008, the petitioner called the nurses racist profanities. The petitioner has dementia, and she also continually called for her daughter and son-in-law.

8. The petitioner was being discharged to her representative's home in s, Florida. According to Mr. at the hearing, Ms. was previously a director of a nursing home, and a nurse. Also according to her, the petitioner lived in her home for seven years prior to admission into the facility.

CONCLUSIONS OF LAW

The jurisdiction to conduct these hearings is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. §431.200. These hearings differ from most hearings conducted by the Department's hearing staff, as the Department is not a party to the proceedings. The matter is a private dispute between two parties and not a circumstance where the individual's substantial interest has been affected by the Department's action.

In accordance with the Federal Regulations at 42 C.F.R. §483.12 (a):

> (2) *Transfer and discharge requirements.* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(vi) The facility ceases to operate.

The petitioner, a resident of the [illegible], was being discharged from the facility because her needs could no longer be met there. There is a physician's order dated December 6, 2007, signed by Dr. [illegible] the petitioner's attending physician, ordering her discharge from the facility. The findings show that Dr. [illegible] prescribed medications for the petitioner, however her representative did not allow the medication regimen. According to the petitioner's representative, the medications caused problems for the petitioner.

The respondent's position is that the petitioner's needs could no longer be met at the facility due to her behavior, and her representative not allowing the doctor to prescribe medication for her. The findings describes abusive behavior by the petitioner towards the facility's staff members. At the hearing, staff members also asserted that without her needed medication, the petitioner is restless and agitated, and her quality of life is greatly reduced when the proper care is not allowed for her.

There was discussion at the hearing concerning the petitioner being discharged to her representative's home. The respondent argued that this is a proper setting for the petitioner. The findings show that the petitioner's representative was previously a director of a nursing home, and a nurse. Also, the petitioner lived in her home for seven years prior to admission into the facility. After careful consideration, it is determined that the action to discharge the petitioner from the facility is upheld.

DECISION

This appeal is denied, and the M nter's action to discharge the petitioner from the facility is affirmed.

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 5th day of February 2008, in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished To:

Ms. Diane Reiland
Agency for Health Care Administration

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

[redacted]

APPEAL NO. 08F-00105

PETITIONER,

Vs.

CASE NO. 1270740181

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Escambia
UNIT: 88637

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 15, 2008, at 1:10 p.m., in Pensacola, Florida. The petitioner was not present. His wife, E , represented him. Present as an observer was his granddaughter, . Barry Dawson, economic self-sufficiency specialist II, represented the Department. Testifying on behalf of the Department was Tracey Alexander, economic self-sufficiency specialist I.

ISSUE

At issue is whether the community spouse income allowance in the Institutional Care Program (ICP) was correctly determined as related to expense deductions. The petitioner is seeking an increase in the spousal allowance. The petitioner bears the burden of proof.

FINDINGS OF FACT

1. The petitioner (age 83) is residing in a nursing facility. An application for Institutional Care Program (ICP) and Medicaid was submitted on his behalf on September 21, 2007. The petitioner's income consisted of Social Security (SSA) of $1,090.50 (2007), Veterans compensation of $1,232 less $97 spousal allowance, $.27 interest, and military retirement from the Department Finance and Accounting Service (DFAS) of $1,268.73. As the total income of $3,494 exceeded the ICP income limit of $1,869, the petitioner was required to establish and fund an irrevocable Medicaid income trust account. This was accomplished in December 2007.

2. The patient responsibility assigned to the petitioner was $2,430.41 according to the Notice of Case Action dated December 26, 2007 (Respondent's Composite Exhibit 2). That figure was corrected to $1,774.14 on January 14, 2008 after the petitioner requested a hearing and based on a review of the budgeting process.

3. The petitioner's wife is 74 years old and resides in the community. She will be referred to as the community spouse. The Department determines the community spouse allowance by a budgeting procedure that considers shelter and utility expenses as well as the community spouse's income. At the time of the application, the Department determined her mortgage was $766.33, homeowner's insurance was $443.50 every other month or prorated to $221.75 monthly and annual real property taxes including fire assessment fee of $156.60 prorated to $13.05. The Department uses the standard utility allowance of $198. Total shelter cost allowed was $1,199.13.

The Minimum Monthly Maintenance Income Allowance (MMMIA) was set at $1,712 effective July 1, 2007, and is based on federal law (Respondent's Composite Exhibit 2).

3. Thirty percent of the MMMIA (30% x $1712), or $514 was deducted from the community spouse's shelter costs ($1,199.13) to determine an excess shelter cost of $685.13. The excess shelter amount is then added to the MMMIA ($685.13+$1712=$2,397.13) for a beginning figure to determine the community spouse allowance. The community spouse's gross income for December 2007 consisted of SSA of $615, VA spousal allowance of $97 and interest of $.27 totaling $712.27. The community spouse's gross income of $712.27 was then subtracted from the beginning figure of $2,397.13 to determine the community spouse's income allowance of $1,684.86. At the hearing, the respondent acknowledged that the amounts used for taxes and mortgage payments varied from the amount originally reported to the agency and used by the Department in calculating the amount of income allocated to the community spouse. The mortgage was $766.51, homeowner's insurance was $443.50 every other month or prorated to $221.75 monthly and annual real property taxes including fire assessment fee of $165.39 prorated to $13.78. The Department uses the standard utility allowance of $198. Total shelter cost allowed was $1,200.04. After completing the calculations, excess shelter was $686.04. The community spouse's gross income of $712.27 was then subtracted from the beginning figure of $2,398.04 to determine the community spouse's income allowance of $1,685.77.

4. To determine the corrected patient responsibility for December 2007, the

respondent began with the petitioner's (institutional spouse's) gross monthly income of $3,494. From his income of $3,494 a standard personal needs allowance of $35 and the community spouse's income allowance of $1,684.86 was subtracted to arrive at a patient responsibility of $1,774.14 for December 2007.

5. The petitioner's income for January 2008 increased as follows: SSA of $1115 after rounding, VA compensation of $1,161 after allocating $99 to the community spouse, interest of $.27 and DFAS pension of $1,294.45. The petitioner's total gross income effective January 2008 was $3,570.72. Effective February 2008, the petitioner's income from DFAS increased to $1,498.07. Thus, his total gross income beginning February 2008 increased to $3,774.34.

6. The community spouse income increased effective January 2008 due to the cost of living adjustment. Her SSA was $629, VA pension $99 and interest of $.27 totaled $728.27. Her shelter costs totaled $1,200.04. After subtracting 30% of the current MMMIA or $514, the excess shelter cost was $686.04. This was added to the state's current MMMIA of $1,712 to arrive at an adjusted MMMIA of $2.398.04. After subtracting the community spouse's income of $728.27, the community spouse income allowance was $1,669.77 beginning January 2008. However, the community spouse total income of $728.27 plus the spousal allocation of $1,669.77 continues to be $2,398.04. Medicaid pays the petitioner's Medicare premium so no deduction is allowed for that expense.

7. There was an increase in the petitioner's DFAS income beginning February 2008 which may have an impact on his patient responsibility. The Department has not yet determined the new patient responsibility as a result of the change in income.

8. The community spouse believes that she will not be able to meet her obligations in the community unless she is allowed to keep more of her institutionalized spouse's income. There was no dispute of the income but there was a slight difference in her shelter obligations. However, the resulting available income to the community spouse continues to be $2,398.04. Her monthly expenses are mortgage $766.51, car insurance $67.14, car payment $349.47, average homeowners insurance of $221.75, average property taxes and fire assessment of $13.78, life insurance premiums of $23.55 for herself, Gerber Life insurance premium of $20.47 for her granddaughter, Globe life insurance premium of $36.89 paid every three months, Allstate Life Insurance premium of $23.55 for the petitioner, cell phone of approximately $47 and landline telephone bill of $137.74, electricity of $157.67, water/sewerage of $85.72, gas with City of Pensacola of $157.37, garbage of $15.82, annual Sam's club membership fee of $40, annual car tag fee of $46.10, $25 reimbursement of a loan taken out against the cash surrender value of VA life insurance, cable charges of $84.90, food expenses of approximately $200 biweekly, Medicare premium of $93.50 for 2007 and $96.40 effective 2008, and other miscellaneous expenses.

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.712, ***SSI-Related Medicaid Resource Eligibility Criteria,*** states in part:

> (4) Spousal Impoverishment. The department follows 42 U.S.C. § l396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse...(c) The community spouse resource allowance is equal to the maximum resource allocation standard allowed under 42 U.S.C. § 1396r-5 or any court-ordered support, whichever is larger.
> (d) After the institutionalized spouse is determined eligible, the department allows deductions from the eligible spouse's income for the community spouse and other family members according to 42 U.S.C. § 1396r-5 and paragraph 65A-1.716(4)(c), F.A.C...
> (f) Either spouse may appeal the post-eligibility amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist. Exceptional circumstances that result in extreme financial duress include circumstances other than those taken into account in establishing maintenance standards for spouses. An example is when a community spouse incurs unavoidable expenses for medical, remedial and other support services which impact the community spouse's ability to maintain themselves (sic) in the community and in amounts that they could not be expected to be paid from amounts already recognized for maintenance and/or amounts held in resources. Effective November 1, 2007, the hearing officers must consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. If the expense causing exceptional circumstances is a temporary expense, the increased income allowance must be adjusted to remove the expenses when no longer needed.

Florida Administrative Code 65A-1.7141, ***SSI-Related Medicaid Post-Eligibility Treatment of Income,*** states in part:

> After an individual satisfies all non-financial and financial eligibility criteria

for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income".

(1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:

(a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance...

(d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses...

(f) For ICP or institutionalized Hospice, income is protected for the month of admission and discharge, if the individual's income for that month is obligated to directly pay for their cost of food or shelter outside of the facility.

(g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.

Florida Administrative Code 65A-1.716, ***Income and Resource Criteria,*** states in part:

(c) Spousal Impoverishment Standards...
2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMIA *x* 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.

The State Medicaid Manual, Part 03, ***Eligibility,*** Section 3700, states in part:

Subsequent to determining Medicaid eligibility for persons living in medical and remedial care institutions...determine how much such persons contribute to the cost of their institutional care and/or waiver services. This latter calculation is referred to as the post-eligibility process. This chapter sets forth requirements for the post-eligibility process for institutional persons...**3700.1 Background** – Section 1902(a)(17) of the Act is the general authority for the post-eligibility process. However, other provisions have been added to refine and clarify the rules governing this process...**3701 GENERAL STATEMENT OF POST-ELIGIBILITY PROCESS.** Reduce Medicaid payments to medical and remedial care institutions...by the amount remaining after specified deductions are made from the income of ***institutional persons***...Income remaining after these deductions are applied is the amount persons are liable to pay for institutional and/or waiver services...**3701.3 Determination of Amounts of Medical Expenses**.—In determining the amounts of the individual's liability for the costs of institutional care, certain required and optional amounts for medical or remedial expenses are deducted from the ***individual's*** income...Determine the amounts of the medical or remedial expenses to be deducted from total income...**3703.4 Maintenance Needs Of A Spouse At Home** – For an individual with only a spouse at home, deduct from the individual's total income an amount for the maintenance needs of the spouse. Base this amount on a reasonable assessment of the needs of the spouse, which includes consideration of the spouse's income and resources. The amount deducted for the needs of the spouse must be reduced dollar for dollar for each dollar of the noninstitutionalized spouse's own income...**3703.8 Expenses for Health Care:** Deduct from the ***individual's*** total income amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including: Medicare and other health insurance premiums, deductibles, or coinsurance charges; and Necessary medical or remedial care recognized under State law but not covered under the State plan, subject to reasonable limits the agency may establish on amounts of these expenses. **3710.1 Definitions**...**Exceptional Circumstances Resulting in Extreme Financial Duress**. Pending publication of regulations, a reasonable definition is: Circumstances other than those taken into account in establishing maintenance standards for spouses. An example is incurment by community spouses for expense for medical, remedial and other support services which contribute to the ability of such spouses to maintain themselves in the community and in amounts that they could not be expected to pay for amounts already recognized for maintenance

and/or amounts held in resources...**3713 MONTHLY INCOME ALLOWANCES FOR COUMMNITY SPOUSES AND OTHER FAMILY MEMBERS...A. Spousal Monthly Income Allowance.** Unless a spousal support order requires support in a greater amount, or a hearings officer has determined that a greater amount is needed because of exceptional circumstances resulting in extreme financial duress, deduct from community spouse's gross monthly income which is otherwise available the following amounts up to the maximum allowed...**3712 MANDATORY DEDUCTIONS FROM INCOME** Deduct from the total income of an institutionalized spouse the following amounts:...subject to reasonable limits you impose consistent with §3701.3, incurred medical and remedial care expenses recognized under State law, not covered under the plan, and not subject to payment by a third party...**3713 MONTHLY INCOME ALLOWANCES FOR COMMUNITY SPOUSES AND OTHER FAMILY MEMBERS** A. Spousal Monthly Income Allowance. Unless a spousal support order requires support in a greater amount, or a hearings officer has determined that a greater amount is needed because of exceptional circumstances resulting in extreme financial duress, deduct from community spouses gross monthly income which is otherwise available the following amounts up to the maximum amount allowed:

- A standard maintenance amount.
- Excess shelter allowances for couples' principal residences when the following expenses exceed 30% of the standard maintenance amount. Except as noted below, excess shelter is calculated on actual expenses for—
  - rent
  - mortgage (including interest and principal);
  - taxes and insurance;
  - any maintenance charge for a condominium or cooperative; and
- an amount for utilities, provided they are not part of the maintenance charge computed above. Utility expenses are calculated by using the standard deduction under the Food Stamp program that is appropriate to a couple's particular circumstance...When there is a deficit remaining after a community spouse's gross income is compared to the total standard computed above, the remaining deficit is the amount of the community spousal income allowance. When there is no deficit, there is no monthly spousal income allowance... 3714.2 Hearings and Appeals. Hearings and appeals must conform to 42 CFR §431 Subpart E. When spousal maintenance allowances are based on amounts determined necessary by hearings officers to avoid extreme financial duress, you may: have hearing officers grant greater amounts conditioned on the existence of exceptional circumstances determined to be the cause of extreme

> financial duress...When hearings officers condition additional allowances based on the existence of the exceptional circumstances, it is your responsibility to monitor cases to assure that the exceptional circumstances continue to exist and that you make necessary adjustments in maintenance allowances when the special conditions no longer exist."

The Department's Integrated Policy Manual, 165-22, section 2640.0122, Minimum Monthly Maintenance Income Allowance (MSSI), explains in part:

> The following policy applies to ICP...
> This income allowance is the basic monthly allowance the state recognizes for a community spouse whose spouse was institutionalized on or after 9/30/89. The state's minimum monthly maintenance income allowance (MMMIA), is based on 150% of the poverty level for two individuals.

The Department's published transmittal I-07-06-0009 dated June 8, 2007 provides the spousal impoverishment standards effective July 1 used to compute income allowance for community spouses of institutionalized individuals under the Institutional Care Program. It states in relevant part:

Spousal Impoverishment Income Standards

Minimum Monthly Maintenance Needs Allowance (MMMIA):

July 1, 2006	July 1, 2007
$1,650	$ 1,712

Excess Shelter Standard:

July 1, 2006	July 1, 2007
$ 495	$ 514

> The maximum monthly community spouse income allowance (MMMIA plus excess shelter costs) remains $2,541. This cap (maximum) standard changes annually in January.

The Department's budgeting methodology, as outlined in the Findings of Facts and in the Respondent's Exhibits 2 and 3, correctly reflects the budgeting methodology set forth in the above authorities in calculating a possible spousal income diversion allowance. However, Florida Administrative Code permits possible adjustment to this methodology and the resulting spousal diversion amount, if proof is presented of exceptional circumstances that result in financial duress.

The petitioner's wife believes that she will not be able to meet her monthly living expenses and that the patient responsibility causes a financial hardship.

The rule requires that there first be an exceptional circumstance resulting in extreme financial duress before the community spouse allowance can be upwardly adjusted. An exceptional circumstance resulting in extreme financial duress is defined in the Florida Administrative Code and the State Medicaid Manual as a circumstance other than one already considered in establishing the maintenance standards for spouses.

No evidence of exceptional circumstances causing financial duress to the community spouse has been presented. The community spouse is able to keep her income of $712.27 plus $1,684.86 diverted from her institutionalized spouse, which totals $2,397.13. Her basic allowable expenses as presented total $1,200.04. This total includes monies she spends on rent, property taxes, homeowner's insurance and a standard utility allowance. As her total income exceeds her allowable basic shelter expenses, the undersigned cannot find that any additional funds should be diverted to

the community spouse. No provision could be found to allow a deduction for car payments, car insurance or gasoline expenses, car tags, life insurance premiums or repayment of loans and credit card expenses.

Based on the testimony, the undersigned authority determined there was a minor mathematical error found in the calculation of the petitioner's spousal allotment based on the community spouse shelter expense. The undersigned authority concludes the correct spousal diversion for December 2007 is $1,685.77 and the correct patient responsibility is $1,773.23. In addition, the correct spousal diversion for January 2008 is $1669.77 and the correct patient responsibility is $1,865.95. As there has been a subsequent increase in the petitioner's income effective February 2008, the Department is to determine the impact of this increase on the spousal diversion and patient responsibility.

DECISION

The appeal is denied as related to the spousal diversion amount.

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 25th day of February, 2008, in Tallahassee, Florida.

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

Copies Furnished To: J [illegible], Petitioner
1 DPOES: Jan Blauvelt

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

APPEAL NO. 07F-05328

PETITIONER,

Vs.

CASE NO. 1069498807

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 11 Dade
UNIT: 66251

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 18, 2008, at 2:45 p.m., in Miami, Florida. The petitioner was not present, but was represented by George M. Lucas, Esquire. Javier. A Ley-Soto, assistant district legal counsel, represented the Department. Lavern Vialet, economic self-sufficiency specialist II, appeared as a witness for the Department. This hearing was previously scheduled for November 7, 2007, but was continued at the request of both parties. The record was held open for seven days to give the petitioner the opportunity to submit additional information. The additional evidence received subsequent to the hearing has been marked as Respondent Exhibit 5.

ISSUE

At issue is the respondent's decision to deny Institutional Care Program (ICP) and Medicaid benefits for the months of October and November 2006 and for the months of

January, February, April and May 2007. As this was an application, the petitioner will have the burden of proof.

FINDINGS OF FACT

1. The respondent submitted into evidence Respondent Exhibits 1 through 11 consisting of copies from the case record to support the Department's action.

2. The petitioner was admitted to [illegible]ty in September 2006. The petitioner's attorney applied for ICP and Medicaid Program benefits on December 18, 2006, as the petitioner's representative. The petitioner's attorney assisted the family in establishing an Irrevocable Income Trust for the petitioner. The initial Irrevocable Income Trust was submitted to the District Legal Counsel for review and was returned for correction and amendment. The corrected Irrevocable Income Trust document was resubmitted on March 5, 2007 and was approved by District Legal Counsel on May 22, 2007.

3. On May 2, 2007, the petitioner's attorney reapplied for ICP and Medicaid Program benefits.

4. As part of the eligibility process, the Department must consider among other things, the petitioner's income. The petitioner's monthly reported income for May 2007 was public retirement of 1,523.93 and Social Security of $1,387.90. The petitioner's total income was $2,911.83. The maximum income limit for an individual under programs for institutional care was $1,869.

5. On July 18, 2007, the Department sent Notices of Case Action to the petitioner's representative informing him that his Institutional Care Program and Medicaid application

dated May 2, 2007 had been approved for March, June and July 2007. The notice also informed him that ICP and Medicaid for May 2007 was denied because the petitioner's income was more than the Program allowed to receive assistance.

6. The respondent explained that the Income Trust needed to be funded in the proper amount each month coverage was requested; however, it was only funded in December 2006, March 2007, June 2007 and on-going.

7. The petitioner's representative explains that during the eligibility determination process and due to his ignorance of what had to be done, the entire petitioner's income was deposited in a particular account and he did not move the money to the Income Trust Account on a monthly basis. The petitioner's representative purported that he had no intention of putting the money anywhere else but into that account. He believes that it is a matter of form over substance. The petitioner's representative believes that the initial Income Trust should have been approved as there is nothing in there that denies the state everything that was in the trust. He feels that the substance of the trust was adequate. The petitioner's representative alleges that he had trouble communicating with the Department and stated that if the respondent had approved the initial Income Trust, he would have only lost two months worth of benefits.

7. The Department's representative responded that the Department is bound by Federal Regulations, Florida Statutes and Florida Administrative Code in that they can only provide Medicaid benefits for those months where income was actually deposit in the Medicaid qualified income trust.

CONCLUSIONS OF LAW

Fla. Admin Code 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria, states in part:

> 1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.
> (f) For hospice services, income cannot exceed 300 percent of the SSI federal benefit rate or income must meet Medically Needy eligibility criteria, including the share of cost requirement. Effective October 1, 1998, institutionalized individuals with income over this limit may qualify for institutional hospice services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(14)(a), F.A.C.

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

> (15) Trusts. (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

The Department's Fla. Integrated Pub. Policy Manual, 165-22, Appendix A-9, January 2007, set forth the ICP income limit at $1,869 for an individual for the time period at issue.

The Department's Fla. Integrated Pub. Policy Manual, passage1840.0110 Income Trusts (MSSI) states:

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

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

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

2. it is irrevocable;

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

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

The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.

The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.**

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

Once the District Legal Counsel returns the income trust transmittal through the District Program Office, the Economic Self-Sufficiency Specialist must promptly process the Medicaid application, making sure proper notification of eligibility and patient responsibility is given.

The Department informed the petitioner's representative to establish and fund a qualified income trust, as the petitioner's income exceeded the institutional Care Program and Medicaid eligibility limits. The above authorities set forth that a sufficient amount of income must be placed in the trust for each month that eligibility is to be determined, in the month that the income is received, to reduce the countable income. The amount of monthly income not placed in the qualified income trust must be compared to the institutionalized Hospice and ICP income limit.

The Findings show that the petitioner had monthly income of $2,911.83. The institutionalized Hospice and ICP income limit was $1,869 for an individual. The findings show that for October and November 2006 and for January, February, April and May 2007, the petitioner had income in excess of the ICP limit.

The hearing officer finds that since no deposits were made to the income trust in the months of October and November 2006 and January, February, April and May 2007, the Department correctly denied ICP institutionalized Hospice Medicaid eligibility for those months.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of

the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 11th day of February 2008,

in Tallahassee, Florida.

Alfredo Fernandez SS

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

Copies Furnished To: C [redacted]
District 11, ESS: Teresa Zepeda
Javier Ley-Soto, Esq.
GEORGE LUCAS, Esq.

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

APPEAL NO. 07F-07005

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 January 11, 2008, at 9:09 a.m., at the Sony Service Center, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's father, [redacted] and his mother, [redacted]

Also present on behalf of the petitioner was Barbara Sharief, nurse practitioner from the petitioner's home health agency, Pediatric Home Care. The Agency was represented by Yvonne Vargas, human service program specialist from the Agency For Health Care Administration (AHCA). Also present from the Agency was Sheila Samuels, registered nurse specialist from the Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Mittel Rakesh, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the

Agency was Mary Wheeler, review operation manager from KePRO. KePRO is located in Tampa, Florida. in was present as an observer.

ISSUE

At issue is the Agency's action of November 5, 2007 and again on reconsideration on November 13, 2007, to reduce the petitioner's request for continued private duty nursing services a total of 180 hours, for the period of November 4, 2007 through January 2, 2008. The reduction of hours totals three hours a day from 7:00 p.m. to 10:00 p.m., for seven days a week of the above service. The Agency has the burden of proof.

FINDINGS OF FACT

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

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on November 5, 2007, that the petitioner's request for about 1,140 hours of private duty nursing was going to be denied/reduced by 180 hours for the period of November 4, 2007 through January 2, 2008. The hours that were reduced or denied were for seven days a week from 7:00 p.m. to 10:00 p.m.

3. A reconsideration of the above was requested by the petitioner's representative(s). KePRO upheld the above decision of November 13, 2007.

4. KePRO's decision was based on the information provided by the petitioner's provider or home health agency as part of the request for the service. KePRO determined that petitioner's mother, though about to be being employed, is quite capable of caring for the petitioner for the hours of 7:00 p.m. to 10:00 p.m., seven days a week.

5. The petitioner's witness and provider indicated that they had incorrectly "provided" information about the petitioner's mother concerning her actual work schedule. This new service period has been updated to reflect "correct" information about the petitioner's mother's work schedule. The petitioner's mother's correct work schedule does not; however, occur during the hours of 7:00 p.m. to 10:00 p.m., seven days a week.

6. The petitioner's representative submitted into evidence, Petitioner Exhibit 1, which are copies of three medical reports from the petitioner's treating physicians. All three reports were not previously provided to KePRO. These reports were read into the record. The respondent indicated that the information provided on these reports was previously known to the Agency.

7. The petitioner timely requested a hearing and the Agency reinstated the nursing hours as previously approved.

CONCLUSIONS OF LAW

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

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

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

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

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

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

The Agency, through KePRO, took action on November 5, 2007 to reduce the petitioner's request for continued private duty nursing services by 180 hours of the service. This decision was based (partly) on the information as provided by the petitioner's nursing service and the petitioner's medical necessity need of the request for the service.

The petitioner's representatives argued that the petitioner is in need of the requested private duty nursing, based on the petitioner's mother is unable to handle any serious medical situation that may arise if a nurse was not present. The petitioner's representative indicated that the petitioner's G-tube had come out once and without the nurse being there; she could not herself, properly assist the petitioner. She also argued that she has to take care of her elderly mother in law; which adds an undue burden on her.

The respondent argued that even with the new information about the petitioner's employment; the Agency's decision remains correct. 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 finds that the Agency has met its burden of proof and that the Agency's action of November 5, 2007, to reduce the petitioner's request for continued private duty nursing services for the 180 requested hours of the service for the period of November 4, 2007 to January 2, 2008,

which was for the three hours a day, seven days a week, from 7:00 p.m. to 10:00 p.m., is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21st day of February, 2008, in Tallahassee, Florida.

Robert Akel

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

Copies Furnished To:
Gail Wilk, Area 10 Medicaid Adm.
Mary Wheeler
Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-6232

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 January 9, 2008, at 11:10 a.m., in Miami, Florida. The petitioner was present and was represented by attorneys Gary L. Printy, Jr. and John W. Frost, II (appeared telephonically). Present, on behalf of the petitioner were his parents, [redacted]. Appearing telephonically as witnesses for the petitioner was: [redacted]. The respondent was represented by Daniel Lake, attorney (appeared telephonically) with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the respondent were: Dr. Rakah Miettel, physician reviewer and Mary Wheeler, nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. Present, on behalf of the respondent was Judith Rosenbaum, administrative manager for area 11 Medicaid and Jeffrey Douglas, program administrator. Robyn Clark, paralegal with AHCA was present telephonically for observation. The hearing was previously scheduled for

November 21, 2007 and November 28, 2007, but was continued at the request of both parties.

ISSUE

At issue is the agency's action in denying 480 hours of private duty nursing (PDN) and approving 240 hours from the requested 720 hours of PDN. The certification period is for October 13, 2007 through December 11, 2007. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is four years old and a Medicaid beneficiary in the state of Florida. The petitioner resides with both parents and an older (seven year old) sibling. The petitioner has been diagnosed with "1. Seizure Disorder, 2. Encephalopathy, 3. Tracheostomy, 4. G-tube."

2. On October 11, 2007, the provider (Maxim Healthcare Services Inc.) requested 720 hours (12 hours [7 am to 7 pm] a day, 7 days a week) of skilled nursing for the petitioner for the certification period of October 13, 2007 through December 11, 2007.

3. The agency has contracted KēPRO South to perform medical reviews for the 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 submitted by the provider, in order for KēPRO to make a determination on medical necessity for the level of service being requested.

4. On October 14, 2007, a screening of the request was completed by the registered nurse reviewer. Additional information was requested and received. The nurse reviewer referred the request to a physician reviewer, board certified in pediatrics.

5. On October 15, 2007, the physician consultant reviewed the information submitted and denied in part the request for services. The record is documented "4 yo with hx. [history] of intractable seizures. Nursing assistance required for trach, 02, GT, ADLs. Mother currently at home but looking for work. DENY 720 hrs RN 10/13/2007 7a-7p. Hours are excessive as the mother is currently at home. Would only approve 10a-2p 7d/wk (the father works up to 7d/wk)." A PDN/PC Recipient Denial Letter was issued to the petitioner approving 240 (4 hours a day) hours of PDN 7 days a week.

6. On October 16, 2007, the provider submitted a request for reconsideration stating, "Mother is the sole caregiver in the home when the father is not home. PDN 12 hours per day is necessary so that she can begin working. She will not be able to commit to a job if she has no PDN to count on daily. Mother has to care for 6 year old daughter on weekends and cares for [ ] the evenings and overnight and requires time to run errands and rest."

7. A second board certified in pediatrics physician reviewer, agreed with the initial approval of 240 hours of PDN. It documents that "This will allow PCG to have enough time each day to either seek an interview for employment and/or attend to any errands out-side the home."

8. On October 23, 2007, a PDN/PC Recipient Reconsideration-Denial Upheld notice was issued to the petitioner and provider, informing them of the approval (240) and denial (480) of hours. The petitioner appealed the decision.

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.

Florida Statute 409.905 addresses Mandatory Medicaid services and states as follows:

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

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.

(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-4.130 *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. ...

The Home Health Services Coverage and Limitations Handbook (October 2003), pages 2-15 and 2-16 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.

The petitioner's parents stated that even with the agency's approval of the 4 hours daily, they were unable to find a provider that would accept a 4 hour daily PDN assignment. The petitioner as of the day of the hearing was not receiving PDN services

even though it was approved by the agency. The petitioner previously was receiving 12 hours daily PDN services, through private insurance that ended October 11, 2007. The petitioner requires suctioning during the night and with no PDN services, he is sleeping with the parents. The petitioner was hospitalized in November 2007 and December 2007 and although they had requested 12 hour PDN services, they state that they will be requesting 24 hour PDN.

The petitioner's mother testified as to the daily care she provides for her son, which among other things consists of 4-5 feedings; suctioning throughout the day; administer medication; trach care; monitor blood pressure and oxygen; clean equipment; bathe; breathing (nebulizer) treatments; and taking him to therapies twice a week.

The petitioner's treating and attending physicians (D[illegible]) testified on his behalf making recommendations on different amount of hours of private duty nursing, required to care for the petitioner. They all considered the petitioner's medical condition and social information and recommended or prescribed anywhere from 8 hours, to 12, to 24 hours daily PDN services.

Testimony was received from Dr. Miettel on the respondent's approval of 240 hours of PDN and the denial of 480 hours. She was not the original reviewing physician consultant, nor the second physician reviewer that upheld the initial approval of hours. However, Dr. Miettel states that they look for medical necessity of the level of care, based on facts and information provided. She acknowledged having heard testimony during the hearing from the petitioner's treating/attending physicians. The respondent considered all medical history of the petitioner; oxygen needed; tracheotomy care and suctioning; and gastrostomy tube. She states that social information was also considered such as the

mother was not working, but states that she is looking for work; the Dad travels, one other child is in the home; and that the petitioner has been taken care of by the family since October 11, 2007. She explained that if the mother starts working or going to school, she can request a review of hours. Dr. Miettel states that the approval of 4 hours daily of PDN met medical necessity.

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible and the agency's responsibility to supplement that care. In this case, the mother is not working and has been caring for the petitioner since October 2007. The family's ability to provide care for the petitioner is considered however, medical necessity as defined above must be met as well. The recommendation of the petitioner's physicians differed. The minimum recommendation was that of 8 hours of PDN.

After careful consideration of all evidence and based on the above cited authorities, the respondent's action to deny 480 hours and approve 240 hours of the requested 720 PDN hours, is not upheld. Therefore, the minimum amount of 8 hours as recommended by one of the petitioner's physician is granted. The petitioner has met his burden in establishing medical necessity for 8 hours daily of PDN services.

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 20th day of February 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

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Daniel Lakes, Esq.