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

APPEAL NO. 08F-07417

PETITIONER,

Vs.

CASE NO. 1204040842

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 02 Bay
UNIT: 88113

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 7, 2009, at 3:00 p.m., in Panama City, Florida. The petitioner was not present. She was represented by her son, Present on behalf of the petitioner was her daughter-in-law, The Department was represented by Tammy Paridon, economic self-sufficiency specialist supervisor.

The hearing was originally scheduled to be held on December 4, 2008 but was continued at the request of the petitioner's representative. The record was held open for seven days or until January 14, 2009 to allow the respondent to submit additional evidence which was received and entered as Respondent's Exhibit 4.

ISSUE

At issue is an increase in the petitioner's Institutional Care Program (ICP) Medicaid patient responsibility. The Department bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a resident of a nursing home in Panama City, Florida. The petitioner is 86 years old. The petitioner's income consisted of gross Social Security (SSA) of $972 and a pension from Chrysler Corporation with gross entitlement of $404.28. Her total monthly gross income for 2008 was $1,376.28. Effective January 2009, the petitioner's gross SSA income increased to $1,028 due to a cost of living adjustment. Her total gross monthly income for 2009 is $1,432.28.
2. The petitioner has been a resident of a nursing home since July 2004. On October 6, 2005 the petitioner's representative completed an interim contact letter indicating she had income from Social Security and a Daimler Chrysler pension (Petitioner's Exhibit 1). The Department determined the patient responsibility by counting the gross income less $35 for personal needs allowance. The Department continued to count income from both sources for the patient responsibility until November 1, 2006.
3. On October 4, 2006, the petitioner received a Notice of Case Action informing her that her patient responsibility would be reduced from $1,291.91 to $920.25 effective November 2006. The petitioner's representative believed

that the Department waived the Chrysler pension. The Department's position is that an error was made during the redetermination for eligibility. The Department erroneously ended the pension income from the calculation of the patient responsibility. The error continued from November 1, 2006 through at least October 1, 2008.

4. During the annual recertification for ICP and Medicaid benefits in October 2008, the Department noted the omission of the Chrysler pension and began counting it in the calculation of patient responsibility. The patient responsibility increased effective December 2008 to $1341.28. As the Department anticipates an annual cost of living increase in the SSA income effective January 2009, the patient responsibility is anticipated to increase accordingly.

5. The petitioner's representative disagrees with the amount of patient responsibility as he believes the Chrysler pension was waived by the Department and should not be considered when calculating patient responsibility. During the appeal, the petitioner's representative submitted Florida Statute, Title X, Chapter 120 of the Administrative Procedures Act, Section 120.542, Variances and Waivers along with a written request for a waiver of the Chrysler pension requesting the Department to waive the pension as income.

6. In addition, the petitioner's representative does not believe that the gross amount of income should be counted as the remaining income for personal needs is not $35. The petitioner's gross Chrysler pension is $404.28. There is a $2.00 deduction for union dues leaving a net pension of $402.28.
7. The petitioner has been tithing to her church, paying for diapers and other personal items, and has been sending monthly contributions to her grandson who is an inmate in the Florida State Prison System in monthly amounts ranging from $85 to $175 (Petitioner's Composite Exhibit 1). It is her belief that a hardship would occur if she is not permitted to continue to tithe to her church or to contribute funds to her incarcerated grandchild.
8. The Department submitted copies of the Interim Contact worksheets dated September 26, 2007 and October 8, 2008 showing the representative reported income from SSA only. The income from the Chrysler pension was omitted from each document (Respondent's Exhibit 3). The representative acknowledged that he omitted the pension information on the documents because it was his belief that the income from that source was waived.

CONCLUSIONS OF LAW

Florida Administrative Code 65-2.060, Evidence, states:

(1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is

> denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

The burden of proof was on the Department as it increased the patient responsibility.

Florida Administrative Code 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

> (2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and income as provided in 42 C.F.R. §§ 435.211 and 435.231 Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

The above rule explains that the ICP Program is a Medicaid coverage group that provides for institutional provider payment.

Florida Administrative Code 65A-1.701, Definitions, explains:

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

The above rule defines patient responsibility as the amount of monthly income available to pay for the individual's institutional care.

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

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

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

Appendix A-9 of the Department's online Integrated Policy Manual 165-22 shows the income limit for the ICP program for an individual as $1,911 for 2008 and $2,022 for 2009.

The above authority explains that the Department first determines if an individual meets financial and non-financial criteria to meet eligibility requirements for the institutional care program. The petitioner met the criteria as her total income of $1,326.78 was within program eligibility limits established. Once the Department determines the amount of the individual's patient responsibility it must calculate the patient responsibility by a process called "post eligibility treatment of income". The above rule established that the Department protects the first $35 of income which is designated for a personal needs allowance.

Florida Administrative Code 65A-713, SSI-Related Medicaid Income Eligibility Criteria, states in relevant 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. ... (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income... (4)(b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:
> 1. To determine if the individual meets the income eligibility standard the **client's total gross income**, excluding income placed in qualified income trusts, is counted in the month received. The **total gross income** must be less than the institutional care income standard for the individual to be eligible for that month. (emphasis added by hearing officer)

The above rule defines the ICP income limit and explains that the client's total gross income is used to determine income eligibility and the total gross income must be less that the ICP income standard for the individual to be eligible for that month. This rule also explains for all SSI-related coverage groups the Department follows the SSI policy specified in 20 C.F.R. 416.1100 and defines a few exceptions. The petitioner does not have income that falls under the exceptions listed.

Federal Requlations at 20 C.F.R. §416.1102, What is income, states:

> Income is anything you receive in cash or in kind that you can use to meet your needs for food and shelter. Sometimes income also includes more or less than you actually receive (see Sec. 416.1110 and Sec. 416.1123(b)). In-kind income is not cash, but is actually food or shelter, or something you can use to get one of these.

20 C.F.R.§416.1121, Types of unearned income, states in part:

> Some types of unearned income are--
> (a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

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

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

The above regulations explain that the Department must consider total gross income to determine if the individual meets the income standard. The above also states that the Department counts gross income rather than net income if income is withheld to pay a debt or other payments such as Medicare premiums.

The Department's Integrated Public Assistance Policy Manual, 165-22, at passage 1840.0900, Benefits, states in part:

> Section 1840.0900 (inclusive) discusses types of benefits payable to individuals and their treatment as unearned income, including benefits such as:
> 1. Social Security payments;
> 2. private benefit income such as annuities, pensions, retirement, or disability (other than SSA);
> 3. veterans payments ...

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

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

The above policy explains what types of payments received by an individual are included as unearned income. The policy indicates that SSA and pensions are counted as unearned income. In addition, the policy explains that some deductions withheld from gross income must be included as income such as optional deductions.

> The Department's Integrated Policy Manual, 165-22, Section 1840.0905 states:
>
> Annuities, pensions, retirement or disability payments are all included as unearned income. These payments result from the purchase of an annuity, retirement from employment, survivor benefits for a former employee's dependents, or injury or disability, and may be made by an employer, an insurance company, or public or private fund.
>
> The Department's Integrated Policy Manual, 165-22, Section 1840.0904 states:
>
> Benefits that are paid by SSA are unearned income...The gross entitlement amount (prior to any deduction) is entered into the FLORIDA system on AFMI.

The Department's Integrated Policy Manual, 165-22, Section 2640.0117 states:

> After the individual is determined eligible, the amount of monthly income to be applied to the cost of care (patient responsibility) is computed as follows:
> Step 1 – Deduct the personal needs allowance and one half of the gross therapeutic wages up to the maximum of $111 if applicable, for adults in ICF/DDs.
> Step 2 – Deduct the community spouse income allowance, family member allowance, or the dependent's allowance, if applicable.
> Step 3 – Consider protection of income policies for the month of admission or the month of discharge, if appropriate... for the following programs.
> 1. Institutional Care Programs, (including institutionalized MEDS and Hospice)..
> Step 4 – For ICP, Institutionalized MEDS, Institutionalized Hospice...deduct uncovered medical expenses ...

The above cited rules allow for specific deductions from income to determine the patient responsibility in the ICP Program.

It is the petitioner's argument that the pension was waived by the Department. There was no evidence to support the petitioner's belief. The Findings show that an error was made during a redetermination for eligibility that continued for approximately two years.

The Department's fair hearing process is conducted under the Administrative Procedures Act, Florida Statute 120.569 addressing the application of the law and disputed facts. The petitioner's representative submitted a written request to waive a rule that requires the pension income to be considered in the Medicaid patient responsibility and provided Florida Statute 120.542 to support his request. The undersigned does not have authority to waive a Department rule. If the petitioner

wishes to seek a variance or waiver to a Department rule, he would need to file a separate petition with the Department's agency clerk requesting such.

It is also the petitioner's belief that a "higher authority" requires her to make monthly tithing to her church. No provision could be found to allow tithing as a deduction in determining ICP patient responsibility.

The above federal regulation directs that income will be counted even if it is more than the individual actually receives due to paying a debt or other legal obligation. A personal needs allowance and actual amounts of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, are the only allowable deductions found in the above authorities for a single individual in the petitioner's situation. The Department allowed a personal needs allowance when determining her patient responsibility. Further, the above authorities do not allow a waiver of the pension income. The Findings of Fact show the petitioner received SSA gross monthly income of $972 for 2008 and $1,028 monthly effective January 2009. She also received Chrysler pension of $404.28 monthly. There is a $2.00 deduction from the Chrysler pension for union dues resulting in a net income of $402.28. The $2.00 deduction for union dues is considered an optional deduction. Therefore, the Department's action to count the gross pension rather than the net is correct.

After a review of the Department's policies and the controlling authorities, the hearing officer finds the Department correctly included both the SSA and Chrysler

pension and correctly increased the petitioner's ICP patient responsibility to $1341.28 for December 2008.

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 3rd day of February, 2009, in Tallahassee, Florida.

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

Copies Furnished To
[redacted]

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

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
DISTRICT: 12 Volusia
UNIT: 88216

RESPONDENT.
_____/

APPEAL NO. 08F-08800
09F-00282

CASE NO. 1292950587

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 12:45 p.m. on January 23, 2009 in Daytona Beach, Florida. The petitioner was not present, but she was represented by attorney, with testimony available from her son, The respondent was represented by Lisa Bosch, attorney, with testimony available from Patricia Klecan, ACCESS supervisor.

ISSUE

At issue was whether or not denial of SSI - Related Medical Assistance was correct in the Institutional Care Program (ICP) due to transfer of assets. Burden of proof was on the petitioner.

FINDINGS OF FACT

1. ICP applications were filed on September 8, 2008 and October 28, 2008 (Respondent's Exhibits 5 and 6). Both applications were denied (Respondent's Exhibit 1 and 2) as related to transfer of assets. Those denials were challenged.

2. The first application was denied with the respondent saying "improper transfer of assets" as the reason. The second was denied with reason "did not receive the information needed..."

3. During March 2008, the petitioner gave her son and daughter money from her bank accounts. She gave her son $9,441.53 and her daughter $9,212.03. Total was $18,653.66. This is undisputed and the figures appear in the "Notice of Determination of Asset (or Income) Transfer," dated November 06, 2008 as given to the attorney during a November 2008 eligibility interview. The document is Respondent's Exhibit 4.

4. The document (a Department form) informed in part, "...When you give an asset away...for less than it is worth, we must presume that you did this to receive Medicaid benefits...." The document set an ineligibility period as four full months, from October 2008 through January 2009. (The respondent's witness noted that the period should have begun from the September application, through December 2008, for a total of 3.7 months, rather than beginning in October 2008 through the full month of January 2009.) The document also informed that rebuttal could be successful if "clear and convincing evidence"

established another reason for transfer or existence of undue hardship. A fifteen-day response time was offered, but response did not occur.

5. At time of transfers, the petitioner lived independently in a HUD (Housing and Urban Development) apartment. She was 92 years old, took some medications, was under physician's care, attended to her own shopping and hygiene, and had a weekly monitoring visit from a nurse. Respondent's Exhibit 4a (rebuttal information), related to a November 2008 eligibility interview, described her health at time of transfer as "perfect." There is no finding as to perfect state of health.

6. During March 2008, her children did not live with her and had their own financial difficulties. The son last worked in December 2007, and since then was travelling throughout the country seeking work in his field as a surveyor. The daughter allegedly faced home foreclosure. Both were described as unemployed. The son testified that his mother gave them the money to help them through their difficult financial periods and that the money was a kind of "inheritance." (Account ownerships were titled to one or the other of the children, individually, as joint tenant with the petitioner.)

7. At some point after the transfers, the petitioner fell in her apartment. Not immediately after her fall, but some time later, the visiting nurse urged the son to take her to an emergency room and he did so. The son was unable to attend her care at her apartment. He said his mother was evaluated for self-care at her own apartment and professionals concluded she was no longer able. Institutional care was recommended.

8. By September 2008, the petitioner entered a nursing home and initial ICP request was filed. Assistance was requested to begin September 2008.

9. Using bank information in Respondent's Exhibit 7, presented by the attorney for both applications, it is found the petitioner had a monthly Social Security deposit of less than $800. Medicare would be a related Social Security benefit. There is no finding of long-term care insurance.

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.712 addresses "**SSI-Related Medicaid Resource Eligibility Critieria**" regarding transfers, in relevant part as follows:

> (3) Transfer of Resources and Income. ... The look back period is 36 months prior to the date of application...
> ...
> (a) The department follows the policy for transfer of assets mandated by 42 U.S.C. §§ 1396p and 1396r-5. Transfer policies apply to the transfer of income and resources.
> ...
> 4. A transfer penalty shall not be imposed if the individual provides proof that they disposed of the resource or income solely for some purpose unrelated to establishing eligibility.
> ...
> (e) Each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the purpose of qualifying for Medicaid. No period of ineligibility shall be imposed if the individual provides proof that they intended to dispose of the resource or income at fair market value or for other valuable consideration, or provides proof that the transfer occurred solely for a reason other than to become Medicaid eligible or if the individual's total countable resources (including the transferred resources) are below the program limits.
> ...
> (g) ... For transfers made on or after November 1, 2007, periods of ineligibility begin with the later of the following dates: (1) the day the individual is eligible for medical assistance under the state plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period; or (2) the first day of the month in which the

> individual transfers the asset; or (3) the first day following the end of an existing penalty period. The department shall not round down, or otherwise disregard, any fractional period of ineligibility of the penalty period but will calculate the period down to the day. There is no limit on the period of ineligibility. ...
> 1. Monthly periods of ineligibility due to transferred resources or income are determined by dividing the total cumulative uncompensated value of all transferred resources or income computed in accordance with paragraph 65A-1.712(3)(f), F.A.C., by the average monthly private pay nursing facility rate at the time of application as determined by the department (refer to paragraph 65A-1.716(5)(d), F.A.C.

Additional guidelines at Florida Administrative Code 65A-1.716 establish basic resource limits of $2000 and $5000 in the ICP categories. The lower standard is for individuals with higher incomes while the higher asset standard is for those with lower income levels. In either case, assets of $18,000 would exceed standards.

The parties' arguments have been considered along with facts and guidelines cited. From viewpoint of the petitioner's representative, the funds were transferred while the petitioner would not have been anticipating any need for long term institutional care, and transfer occurred solely to help her financially troubled children. From viewpoint of the respondent's representative, the rebuttals were unsuccessful because insufficient evidence established that transfers were unrelated to creating Medicaid eligibility.

Also relevant is Florida Integrated Public Policy Manual passage 1640.0616 addressing the monthly nursing home rate standard described in the Florida Administrative Code. Policy informs: "...The current average private nursing home rate ($5,000) is used for all transfers..." Thus, the regulation

would provide for an ineligibility period of 3.7 months, following transfer of $18,653.66, if rebuttal were unsuccessful.

It is evident that if the petitioner had retained ownership, the $18,000+ could have been used for her own needs, in a foreseeable time of declining health, when she had no known medical care supplement other than Medicare, and no known reason not to anticipate life's customary and serious health adversities. She was under medical care, had weekly nursing visits, and lived alone without live-in help of any sort. Her children may have been suffering financial obstacles and that may have been a factor in the transfer. Desire to distribute assets before death, to achieve a sort of pre-death inheritance, may also have been a factor.

The children's misfortunes in the face of her own obvious age and other difficulties, do not reflect or establish that transfers occurred solely unrelated to creating Medicaid eligibility. There was no indication of how the petitioner would have met her own needs without her own money in the face of normal factors of her own advancing age. Desire to help her unemployed and struggling adult children may have been kind-hearted, but it falls short of a reasonable explanation as the sole cause for transfer, given the petitioner's real and obvious circumstances at the time. Rebuttal standards were not met.

However, it is also concluded that the signficant eligibility determination relates to the September 2008 application. This conclusion is appropriate because the second application intended, by mutual perception, to incorporate the financial verification submitted for the first application and the first application

was the critical one. The second application was essentially a reinforcement of the first, the same assets were being reviewed, and the same beginning point of eligibility was desired for both. Because transfer-ineligibility rules now pertain to date of application, using the first date of application will result in a slightly improved ineligibility period. Additionally, the respondent's witness endorsed that position. The ineligibility period shall be 3.7 months and the application date to be used shall be September 08, 2008. It is concluded that denial was correct due to insufficient rebuttal.

DECISION

The appeal is denied and the respondent's action is affirmed, with the specific revisions noted herein. Ineligibility period is shortened to 3.7 months rather than four, and shall begin September, not October 2008.

NOTICE OF RIGHT TO APPEAL

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

incurred will be the petitioner's responsibility.

DONE and ORDERED this 10th day of February, 2009, in Tallahassee, Florida.

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

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

APPEAL NO. 08F-07950

PETITIONER,

Vs.

CASE NO. 1255045019

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 February 4, 2009, at 9:27 a.m., in West Palm Beach, Florida. The petitioner is deceased. Representing the petitioner was his wife, Appearing as witness was , friend. Both appeared telephonically at their request. Representing the respondent was Mildred Talbert, specialist supervisor.

ISSUE

At issue is whether the respondent was correct in terminating Institutional Care Program (ICP) Medicaid due to the petitioner failing to correctly fund an appropriate income trust. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner was residing in a nursing facility until his death July 2008. Prior to this, a Qualified Income Trust was established December 2006. Eligibility for ICP Medicaid was established.
2. The respondent set a February 2008 date for a case review. Information was pended for verification of the trust being funded. There was a question as to whether the trust was being funded in the proper amount.
3. In June 2008 the nursing facility submitted an application for ICP Medicaid. As part of the eligibility determination process, the respondent must consider, among all factors, the petitioner's income.
4. The respondent noted that there was no income trust funding for the six month period prior to the petitioner's death. That application was denied.
5. An additional application for ICP Medicaid was submitted September 30, 2008 seeking retroactive benefits. The respondent denied this application because funding cannot be done retroactively.
6. The representative does not deny that the trust was not funded for the period in question but explains that the wife received no billing from the nursing facility from April through July 2008. She believed she was following the rules as required.

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.

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).

Fla. Integrated Pub. Policy Manual states in part:

1840.0110 Income Trusts (MSSI)

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

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

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 eligibility specialist must forward all income trusts to their Region or Circuit 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-22.1, "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 eligibility specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received (my emphasis). (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 Region or Circuit Program Office, the eligibility specialist must promptly process the Medicaid application, making sure proper notification of eligibility and patient responsibility is given.

Upon review, the respondent correctly sought information concerning the funding of the income trust. As required by Rule, the excess funds must be set aside each month that the ICP is requested and each month it is received.

Therefore, there is no retroactive funding because the money was already received. Also, the money had to be placed in the trust each month that eligibility

is requested. Because neither of these requirements was met, the respondent correctly denied the benefit.

It is incumbent upon the petitioner to insure that the trust is funded correctly, not the facility.

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 11th day of February, 2009,

in Tallahassee, Florida.

Melvyn Littman

Melvyn Littman
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 08F-06003

PETITIONER,

Vs.

CASE NO. 1252078731

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

RESPONDENT.
_____/

FINAL ORDER

The undersigned hearing officer convened an administrative hearing in the above-referenced matter on January 6, 2009, at 1:04 p.m., in Orlando, Florida. The petitioner did not appear. petitioner's authorized representative, appeared for the petitioner. Reginald Schofield, economic self-sufficiency specialist supervisor, appeared and represented the respondent-Department.

ISSUE

At issue is the respondent's action of June 27, 2008, denying the petitioner's application dated April 9, 2008, for retroactive Medicaid benefits for the months of December 2007, January 2008, and March 2008, due to income exceeding the program limit. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

1. The petitioner resides in a nursing facility. Her authorized representative submitted an application on her behalf for Institutional Care Program (ICP) Medicaid on April 9, 2008.
2. The petitioner's representative sought retroactive ICP Medicaid to cover the months of December 2007, January 2008, February 2008, and March 2008. She sought Medicaid coverage for April 2008 and the ongoing months as well.
3. The petitioner's representative informed the respondent on the application that the petitioner's gross monthly income consisted of the following: Social Security (SSA) income - $1,442.00 (December 2007), $1,474.70 (January 2008 and February 2008) and $1,475.00 (March 2008 and ongoing), and a retirement pension from the state of New Jersey - $2,026.89 (December 2007) and $2,054.68 (January 2008 and onoing).
4. The respondent informed the petitioner's representative that she needed to set up an irrevocable income trust for the petitioner and have the petitioner's income deposited into the trust. Upon doing this, the petitioner's income would be protected and brought under the Medicaid income limit for ICP because the state of Florida would become owner of the trust funds upon the petitioner's death. The representative did create the trust and had the petitioner's SSA benefit direct deposited into the trust. She was unable to have the state of New Jersey direct deposit the

pension into the trust and instead received a monthly pension check for the petitioner. She deposited this check into a different bank account.

5. The respondent totaled the petitioner's income to determine what amount was needed to fund the irrevocable trust. It arrived at the following figures: $3,468.89 (total income for December 2007) minus the ICP Medicaid limit for one person ($1,869) = $1,599.89 required to be placed into the trust for funding; $3,529.68 (total income for January 2008, February 2008, March 2008, and ongoing) minus ICP income limit ($1,911) = $1,618.68 required to fund the trust.
6. The respondent found the petitioner eligible for ICP Medicaid benefits for April 2008 and ongoing. However, in reviewing the retroactive months of December 2007, January 2008, February 2008, and March 2008, the respondent found that the trust was only properly funded for February 2008. Medicaid coverage was approved for that month only. The remaining months, those at issue in this appeal, were denied because the respondent found that the petitioner's representative, for whatever reason, did not place the required amount of income into the trust for each of those months. Essentially, the trust was short-funded which made the petitioner ineligible for the requested months.
7. The respondent issued the petitioner a Notice of Case Action, dated June 27, 2008, informing of the approval for April 2008 and the ongoing months. Once the petitioner's representative received notice from the nursing home that the petitioner had incurred a nursing home bill in the amount of

$9,864.76, for the months of December 2007, January 2008, and March 2008, she requested a hearing.

8. The petitioner's representative appeals to have those months approved so that the nursing home bill may be satisfied in full.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.713 establishes:

> **SSI-Related Medicaid Income Eligibility Criteria** [emphasis original] (1) Income limit. 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 paragraph 65A-1.702(14)(a), F.A.C. ...

Fla. Integrated Pub. Asst. Policy Manual, Appendix A-9 adopts the federal income limit discussed in the administrative rule above for a household of one (1) person for the ICP Medicaid program...$1,869 (effective July 2007) and $1,911 (effective July 2008). The evidence shows that the petitioner's income exceeded the ICP Medicaid Program limit. The rule states that the petitioner can qualify for ICP Medicaid by placing her income into a trust.

Fla. Admin. Code 65A-1.702 establishes:

> **Special Provisions** ... (15) Trusts. (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d). (b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the

> trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary...
>
> This rule adopts the federal regulation for the requirement of trusts

established for Medicaid purposes.

Fla. Integrated Pub. Asst. Policy Manual, passage 1840.0110 states in relevant part:

> **Income Trusts** [emphasis original] The following policy applies only to the Institutionalized Care Program (ICP)...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...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 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 eligibility specialist must advise the individual that they cannot qualify for Medicaid institutional care services...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. ...
>
> The evidence shows that the petitioner's representative set up an

irrevocable income trust. The respondent did not dispute the validity of this trust and found that it complied with the above rule. The petitioner's representative was required to fund the income trust each month that the petitioner sought Medicaid eligibility. In this case, the months needing Medicaid coverage are December 2007, January 2008, February 2008, and March 2008. The

representative provided bank statements showing that in February 2008, the petitioner's trust was properly funded and she is therefore Medicaid eligible for that month.

However, the bank statements for the remaining months show that the trust was underfunded. This caused the petitioner's income to exceed the ICP income standard, resulting in Medicaid ineligibility for those months – December 2007, January 2008, and March 2008. The petitioner's representative argued that she had records of all expenses paid out of the petitioner's income and that the funds were properly used. The respondent stated that what the funds were paid out for was not at issue in this appeal, only the fact that the monies were not placed into the trust account. The petitioner's representative further argued that the petitioner's pension check from New Jersey could not be direct deposited into the trust account because that was considered a violation of New Jersey law. As a result, she received the petitioner's monthly pension check from New Jersey and placed it into a regular bank account. Once deposited, she then spent the funds on the petitioner's needs and placed the remainder into the trust account. The respondent argued that it was allowable for the pension check to be placed into a regular account and then moved over to the trust. The sole problem with the months at issue were due to the representative failing to move the minimum required amount during each month from the pension check to the trust so that it was properly funded.

Upon reviewing all evidence, the hearing officer concludes that the petitioner's representative failed to sufficiently fund the petitioner's income trust

with the required amount for the months of December 2007, January 2008, and March 2008. As a result, the petitioner is not eligible for ICP Medicaid for those months. Any balance owed to the nursing home for these months is an issue outside this appeal.

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 3rd day of February, 2009,

in Tallahassee, Florida.

Jeannette Estes

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

Copies Furnished To

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

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 02 Leon
UNIT:

RESPONDENT.
_____/

APPEAL NO. 08F-08074

CASE NO. 435873617

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 5, 2009, at 12:45 p.m., in Tallahassee, Florida. The petitioner was present and represented herself. The respondent was represented by Arlene Walker, medical health care program analyst, Agency for Health Care Administration (AHCA). Testifying on behalf of the respondent was Kristen Russell, program administrator, Department of Health (DOH) Brain and Spinal Cord Injury Program (BSCIP).

The hearing was originally scheduled to be held on January 22, 2009 but was continued at the request of the petitioner.

ISSUE

At issue is the respondent's action of October 20, 2008 to place the petitioner on the Brain and Spinal Cord Injury Medicaid Waiver Program (BSCIP) waiting list.

FINDINGS OF FACT

1. The petitioner is a 58 year old female with a spinal cord injury. The Petitioner has numerous medical issues including frontal lobe impairment, chronic seizures, sleep apnea, post-traumatic stress disorder and visual problems. She has limited use of her arms and legs and uses a wheelchair to ambulate. She lives on her own without any assistance. She is a student at Florida State University (FSU).
2. The petitioner applied for the BSCIP Medicaid Waiver Program on or about August 3, 2008 and was placed on the waiting list that same month.
3. The Waiver Program provides home and community based services to allow individuals who would otherwise require nursing home care or other institutional care to receive services in their own homes or in home-like settings. Under the provisions of the Medicaid Act, states may include as medical assistance, the cost of home and community based services, which if not provided, would require care to be provided in a nursing home, hospital or other institutional setting. The BSCIP Medicaid Waiver specifically provides personal and companion care services. Due to budgetary constraints, there is a wait list for program services.
4. In August 2008, the Waiver Program received a referral from the central registry. The referral was assigned to a case manager for Leon County for prioritization screening. The case manager contacted the petitioner and

completed the screening for prioritization on the wait list on or about August 3, 2008. The questions asked in the screening process are to determine the individual's functional ability, nutritional status, living arrangement and caregiver status. The questionnaire is then scored. The petitioner achieved a prioritization score of 91 of 170 (total possible score). On October 20, 2008, the Medicaid Waiver Program sent the petitioner a Notice of Decision advising her that there were no openings at that time. The petitioner was advised to keep the Agency and Florida Department of Health/BSCIP Medicaid Waiver Program advised of changes to her condition or situation.

5. The petitioner requested the program provide her with help around the house as her spinal injury makes it difficult to do chores. She asserts her human and civil rights are being denied by the Agency's action to place her on a wait list. Further, the petitioner is concerned that without assistance from the Medicaid Waiver program, she will be unable to continue living in the community and will be forced to enter a nursing home. She does not receive Medicaid. She receives Medicare parts A and B. She receives income from Social Security Disability Insurance (SSDI) and wages from employment.
6. There is limited program funding and a waiting list. There are 590 on the wait list state-wide. There are currently 329 people being served with care plans in the entire state of Florida. The last annual funding for fiscal year July 1, 2008 through June 30, 2009 available to operate the BSCIP Medicaid

Waiver program was $10.3 million. No additional people can be placed on the program until July 2009, pending available funding. The petitioner will be considered to fill one of the openings depending on her placement on the wait list.

7. The respondent explained that for purposes of determining the most appropriate person to be transferred from the wait list to the Medicaid Waiver Program, a "Wait List Review Team", comprised of the five BSCIP Regional Managers, the BSCIP Waiver Administrator and the BSCIP Bureau Chief has been established. Based on where an individual is placed on the wait list, the date of initial contact is used to determine which individual will be considered to have a higher ranking. The individual with the earlier date of initial contact will be ranked higher.

8. During the hearing, the petitioner reported she fell and broke her patella approximately one month ago. Her mental ability has deteriorated due to chronic seizures and she has left-sided weakness. The petitioner was encouraged to contact the BSCIP case manager if there are other changes to her condition or situation.

CONCLUSIONS OF LAW

Fla. Statutes Title XXIX Chap. 408.301 in part states:

408.301 Legislative findings.--The Legislature has found that access to quality, affordable, health care for all Floridians is an important goal for the state. The Legislature recognizes that there are Floridians with special health care and social needs which require particular attention. The

people served by the Department of Children and Family Services, the Agency for Persons with Disabilities, the Department of Health, and the Department of Elderly Affairs are examples of citizens with special needs. The Legislature further recognizes that the Medicaid program is an intricate part of the service delivery system for the special needs citizens. However, the Agency for Health Care Administration is not a service provider and does not develop or direct programs for the special needs citizens. Therefore, it is the intent of the Legislature that the Agency for Health Care Administration work closely with the Department of Children and Family Services, the Agency for Persons with Disabilities, the Department of Health, and the Department of Elderly Affairs in developing plans for assuring access to all Floridians in order to assure that the needs of special citizens are met.

Fla. Statutes Title XXIX Chap. 408.302 states in part:

(1) The Agency for Health Care Administration shall enter into an interagency agreement with the Department of Children and Family Services, the Agency for Persons with Disabilities, the Department of Health, and the Department of Elderly Affairs to assure coordination and cooperation in serving special needs citizens. The agreement shall include the requirement that the secretaries or directors of the Department of Children and Family Services, the Agency for Persons with Disabilities, the Department of Health, and the Department of Elderly Affairs approve, prior to adoption, any rule developed by the Agency for Health Care Administration where such rule has a direct impact on the mission of the respective state agencies, their programs, or their budgets.

Fla. Admin. Code 59G-13.080 entitled "Home and Community-Based Services Waivers" establishes:

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

meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness.
(2) Definitions. General Medicaid definitions applicable to this program are located in Rule 59G-1.010, F.A.C. Additional descriptions of services available under this program are provided in subsection (3) of this rule. The following definitions apply:
(a) "Agency" means the Agency for Health Care Administration, the Florida state agency responsible for the administration of Medicaid waivers for home and community-based (HCB) services.
(b) "Department" means the Florida Department of Elderly Affairs (DOEA).
(3) Home and Community-Based (HCB) Waiver Services are those Medicaid services approved by the Health Care Financing Administration under the authority of Section 1915(c) of the Social Security Act. The definitions of the following services are provided in the respective HCB services waiver, as are specific provider qualifications. Since several similar services with different names may be provided in more than one waiver, this section lists them as a cluster...The availability of these services to waiver program participants is subject to approval by the Medicaid office and is subject to the availability of the services under the specific waiver program for which a recipient has been determined eligible.
(5) Service Limitations -- General. The following general limitations and restrictions apply to all home and community-based services waiver programs:
(a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.
(b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient.
(c) Additional service limitations applicable to specific waiver programs are specified in subsections (10) through (14) of this rule.
(6) Program Requirements -- General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements are applicable to all HCB services waiver programs:
(a) The Medicaid program will deny an applicant's enrollment request if

> the proposed enrollment could cause the program to exceed the maximum enrollment level authorized by the Health Care Financing Administration in the applicable HCB services waiver.
> **(b) A person can not receive Medicaid waiver services until he is determined eligible, waiver funding is available, and is enrolled in the appropriate waiver program** [emphasis added]. ...

Florida Administrative Code 59G-13.130 Traumatic Brain and Spinal Cord Injury Waiver Services, states:

> (1) This rule applies to all traumatic brain and spinal cord injury waiver services providers enrolled in the Medicaid program.
> (2) All traumatic brain and spinal cord injury waiver services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook, April 2006, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, which is incorporated by reference in Rule 59G-13.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.
> (3) The following forms that are included in the Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook are incorporated by reference: Appendix C contains the Home and Community-Based Waiver Referral Agreement, April 2006, seven pages; Appendix D contains the Brain and Spinal Cord Injury Program Request for Level of Care, April 2006, two pages; Appendix E contains the Notification of Level of Care, which is incorporated by reference in Rule 59G-13.030, F.A.C.; Appendix F contains the Brain and Spinal Cord Injury Program Waiting List Policy for the Traumatic Brain/ Spinal Cord Injury Medicaid Waiver Program, April 2006, five pages, and Home and Community-Based Medicaid Waiver Prioritization Screening Instrument, April 2006, four pages; Appendix G contains the Notice of Decision, April 2006, two pages; and Appendix H contains the Brain and Spinal Cord Injury Program Medicaid Home and Community-Based Waiver Service Plan, April 2006, one page.

The Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook, June 2006, Appendix F, Brain And Spinal Cord

Injury Program Waiting List Policy For The Traumatic Brain/Spinal Cord Injury Medicaid Waiver Program And Home And Community-Based Medicaid Waiver Prioritization Screening Instrument, states:

Brain and Spinal Cord Injury Program Waiting List Policy for the Traumatic Brain/Spinal Cord Injury Medicaid Waiver Program

I. Introduction
The purpose of the Brain and Spinal Cord Injury Program (BSCIP) waiting list policy for the Traumatic Brain /Spinal Cord Injury Medicaid Waiver (TBI/SCI Medicaid Waiver) Program is three-fold:
1. to provide for statewide consistency for developing and managing the TBI/SCI Medicaid Waiver waiting list;
2. to provide a valid process for ranking individuals requesting services when budgetary restraints necessitate that they be placed on the waiting list log rather than referred for application and eligibility determination; and
3. to provide a reliable process for referring individuals for face-to-face assessment, application, and eligibility determination from the waiting list log in priority order into the TBI/SCI Medicaid Waiver program when funding is available. ...
IV. Funding Available to the TBI/SCI Waiver Program
A. Allocation Methodology
Funds will be allocated to the BSCIP Regional Offices for the TBI/SCI Medicaid Waiver program at the beginning of each fiscal year. The allocation of funds to the program will be based on the total annualized authorized Care Plan costs of active clients in the TBI/SCI Medicaid Waiver program in each Region. The balance of the funds will be maintained in a control account to be used for amending existing care plans or adding new individuals to the TBI/SCI Medicaid Waiver program.
B. Funding Unmet Need
1. It is the intent of federal policy that the TBI/SCI Medicaid Waiver program will meet identified and medically necessary Care Plan needs which are within the range of services offered by the TBI/SCI Medicaid Waiver for individuals enrolled in the program. Any unmet needs of recipients enrolled in the Medicaid Waiver program will be funded prior to moving the highest-ranking individuals off the TBI/SCI Medicaid Waiver waiting list into the program.
2. The TBI/SCI waiting list policy is written in order to discourage the moving of individuals from the TBI/SCI Medicaid waiver list while

> recipients enrolled in the waiver program have unmet needs. In order to accomplish this, case managers must:
> a.) Keep accurate records of Care Plan costs associated with each current Medicaid Waiver recipient; and,
> b.) Annualize, and update as necessary, the cost of each TBI/SCI Medicaid Waiver Care Plan. ...

The respondent agrees that the petitioner meets the basic eligibility requirements for the program; however the respondent argues that because of a lack of funding, services must currently be denied and the petitioner must be placed on a waiting list until sufficient funds are available.

The state is allowed to limit participation to waivers based on available funding. Both the Florida Constitution and Florida Statutes prohibit agencies from contracting or agreeing to spend any moneys in excess of the amount appropriated to them unless authorized by law. *See* Art. VII, Sec. 1(c), Fla. Const.; § 216.311(1), Fla. Stat. (2002). Applicants are entitled to receive services only within available resources, and the respondent has discretion to prioritize how it will distribute funds. § 393.13(3)(c)-(d), Fla. Stat. (2002); *see also* Dep't of Health & Rehab. Servs. v. Brooke, 573 So.2d 363 (Fla. 1st DCA 1991) (holding budgetary decision-making was within agency head's executive discretion).

In Bridget Ellingham v. Dept. of Children and Family Services, 896 So.2d 926 (Fla. 1st DCA 2005) the court concluded that lack of funding is an affirmative defense to a claim for developmental disabilities services, analogous to the defense of impossibility

of performance in a contract action. The party seeking to assert the affirmative defense has the burden of proof as to that defense.

As this case involves the petitioner's assertion of eligibility for waiver services and the respondent is asserting that the petitioner must be placed on a waiting list because of a lack of funding, the respondent has the burden to show that there is insufficient funding for the petitioner to receive benefits.

The hearing officer concludes that there is limited funding which results in the petitioner being evaluated under the waiting criteria. As the respondent has met its burden of showing the lack of funding, the petitioner now has the burden to establish eligibility for benefits under the Medicaid Waiver Program.

The petitioner is on the waiting list effective August 2008, the month she applied for services. The program will next fill openings in July 2009. The petitioner will be considered to fill one of the openings based on the prioritization screening set forth in the above Medicaid handbook.

Based on all the evidence and testimony presented, the hearing officer concludes that the respondent's action concerning the petitioner's request was correct. There was no evidence presented to show that the petitioner is eligible for immediate services. The budgetary constraints faced by the respondent mandate service provision limitations and the petitioner remains on the wait list.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18th day of February, 2009,

in Tallahassee, Florida.

Linda Garton

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

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

APPEAL NO. 08F-7190

PETITIONER,

Vs.

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

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on December 23, 2008, at 12:10 p.m., in Miami, Florida. The petitioner was represented by his mother, The respondent was represented by Jeffrey Douglas, program administrator and Monica Otoriola, program specialist with the Agency for Health Care Administration (AHCA). Telephonically present, as witnesses for the respondent was Dr. Robert A. Buzzeo, physician consultant and Edna Clifton, RN operations manager, both with Keystone Peer Review Organization (KēPRO) South. The hearing was previously scheduled for November 25, 2008 but was continued at the request of the petitioner.

ISSUE

At issue is the respondent's action of September 30, 2008, October 10, 2008 and November 7, 2008, in ultimately denying 900 hours of home health aide (for personal

care) and approving 900 hours of the 1,800 hours requested for the certification period of May 9, 2008 through November 4, 2008. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is five years old and a Medicaid beneficiary in the state of Florida. The petitioner's diagnosis as reported to the respondent, "Epilepsy NOS w intr epil [not other wise specified with intractable epilepsy], mental retardation NOS, incontinence of feces..." Services have continued throughout the appeals process.
2. The respondent has contracted KēPRO South to perform medical reviews of Private Duty Nursing and the Personal Care Prior Authorization Program for Medicaid beneficiaries. This prior authorization review determines medical necessity of the hours requested, under the terms of the Florida Medicaid Program. The request for service is only submitted by the provider, along with all information required, in order for KēPRO to make a determination on medical necessity for the level of service being requested.
3. In September 2008, the provider (Healing Care Inc.) requested 1,800 hours for the certification period. The provider submitted some medical and social information on the petitioner. However, more specific information was requested on the reason that services were requested while the petitioner was asleep from 5 pm to 3 am. The information was not provided.

4. On September 30, 2008, the request was reviewed by a board certified in physician consultant and was denied as the information provided was not sufficient.
5. The provider requested a reconsideration review and on October 10, 2008 and November 7, 2008 overturned the original decision and approved the hours from 5 pm to 10 pm 7 days a week (900 hours for the certification period). The hours of 10 pm to 3 am were denied because it was not clarified why personal care was needed when the petitioner was asleep. The petitioner appealed the decision on October 27, 2008.

CONCLUSIONS OF LAW

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

Fla. Stat. 409.905 addresses Mandatory Medicaid services and states in part:

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary...
>
> (4)(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services...The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. ...

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

> Medical necessity or medically necessary means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity...
>
> Fla. Admin. Code 59G-4.130 Home Health Services states in part:
>
> (1) This rule applies to all home health agencies licensed under Chapter 400, Part III, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.
>
> (2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, July 2007, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. ...

The petitioner's mother explained that the petitioner has multiple seizures during the night and has 3-4 accidental bowel movements. The aide cleans and provides personal care to the petitioner and she (Mom) administers the medication.

The physician consultant stated that the provider did not submit this information to them on the bowel movements and the need for assistance during the night. The consultant stated that with this new information he would see no problem in approving the night hours.

As a de novo hearing is conducted by this hearing officer, new or additional evidence not previously considered by the respondent in making its decision is now considered. The agency's decision was correct at the time it was made, given the information provided. However, the hearing officer agrees with the physician consultant's

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

APPEAL NO. 08N-00248

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 3, 2009, at 8:40 a.m., in Pensacola, Florida. The petitioner was not present but was represented by her niece, . The Respondent was represented by administrator, . Facility (herein referred to as the nursing facility). Testifying on behalf of the respondent was Director of Social Services and R.N., Director of Nursing.

ISSUE

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

FINDINGS OF FACT

1. The petitioner (Date of Birth · ,) is a resident of the nursing facility. The petitioner is diagnosed with psychotic disorder, dementia, a history of seizures, hypertension, rhabdomyolysis, urinary tract infections (UTI) and osteoarthritis (Respondent's Exhibit 13).
2. The respondent entered into evidence records of incidents of physically abusive behavior to residents and staff members of the facility. In addition the respondent presented evidence to show the petitioner was sent to the hospital under the Baker Act on at least two separate occasions: October 1, 2008 and November 25, 2008.
3. Testimony and clinical notes submitted show that the petitioner behaves violently such as hitting an employee with a trash can lid and spitting on a deputy sent to escort her to the hospital. This behavior occurred on November 25, 2008. She has exhibited behavior potentially dangerous to the safety and well being of the residents and staff of the facility. Some of the incidents occurred on the following dates: September 17, 2008, September 18, 2008 (following readmission to the facility from the Pavillion on September 16, 2008), September 24, 2008, , September 25, 2008, September 26, 2008, September 30, 2008, October 1, 2008, October 3, 2008, October 6, 2008,and continued reported episodes of spitting, attempts to hit residents and staff, spitting at her niece, and interfering with the facility's attempts to provide care

to other residents. The petitioner's representative was contacted on several occasions in reference to the petitioner's behavior. On some occasions, the relative was able to redirect the petitioner.

4. The facility attempted to alleviate the inappropriate behaviors by assigning one-to-one supervision to the petitioner. The petitioner does not exhibit any further behavior problems as long as she receives individual attention. The petitioner becomes agitated when she does not receive the undivided attention of the staff. The facility does not believe that it can continue to provide one-to-one supervision for the petitioner. In addition, the facility physician and psychologist reviewed the medication taken by the petitioner in an effort to alleviate or control her behavioral issues. The facility staff tries to redirect the petitioner when her behavior is inappropriate. These actions were not successful in stopping the petitioner's abusive and inappropriate behavior until she was assigned one-to-one supervision.
5. The petitioner's medications have included Zanax, Seroquel, Ativan, Lithium, Dilantin, Gabapentin, Folic acid, Thorazine as needed for agitation and aggression and Lortab. The medications have not been successful in controlling the petitioner's behavior. Her behavior is under control as long as the facility provides one-to-one supervision.
6. On December 8, 2008, the respondent, by Nursing Home Transfer and

Discharge Notice, notified the petitioner that it was their intent to discharge the petitioner, effective January 8, 2009, because the safety of other individuals in the facility was endangered. The Nursing Home Transfer and Discharge Notice was signed by the nursing home administrator designee and the physician, as well as the petitioner's representative. The respondent arranged for an orderly transfer to another skilled nursing facility in the local area. However, the petitioner's family did not agree with the proposed relocation. Given the petitioner's limitations, it is not possible to permit her to live alone in the community. The facility stipulated at the hearing that it would continue to pursue a more appropriate placement for the petitioner.

CONCLUSIONS OF LAW

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

Federal regulations at 42 C.F.R. §483.12 states in part:

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

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

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--
(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
(ii) Record the reasons in the resident's clinical record; and
(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice.
(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;...

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

> Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--...(iii) The safety of individuals in the facility is endangered....(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

The Findings of Fact show that the petitioner's behavior includes physical abuse and attacks against the staff, residents and family. The facility has completed medication reviews, and made changes to her supervision in an attempt to modify her behavior and to protect other residents of the facility. In spite of the facility's efforts, the petitioner continues to exhibit agitated behaviors when she believes she is not receiving one-to-one supervision. The Findings show that the petitioner was sent to the hospital on at least two occasions under the Baker Act due to inappropriate behavioral issues.

According to the above authorities, a facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. The facility attempted to complete the required orientation and preparation for the transfer or discharge from the facility but the transfer was not completed because of the objection of the petitioner's representative.

Based on the above findings, it is determined that the petitioner's behavior has endangered the safety of other residents in the facility. Therefore, the respondent's proposed discharge of the petitioner from the facility, dated December 8, 2008, is in accordance with the reasons stated in the Federal Regulations. The facility may

proceed with the discharge and arrange for a more appropriate placement for the petitioner in accordance with the Agency for Health Care Administration's rules.

DECISION

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

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 27th day of February, 2009, in Tallahassee, Florida.

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

Copies Furnished

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

APPEAL NO. 08N-00216

PETITIONER,

Vs.

CASE NO.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on January 15, 2009, at 3:15 p.m., in Winter Garden, Florida. The petitioner appeared. ombudsman, appeared and represented the petitioner. district ombudsman manager, and regional ombudsman program administrator, appeared as witnesses for the petitioner. risk manager, appeared and represented the respondent-facility. executive director; director of social services; director of nursing; and director of admissions, all appeared as witnesses for the facility.

ISSUE

At issue is the respondent's action of November 17, 2008, intending to discharge the petitioner effective December 18, 2008, due to his needs not being able to be met at the facility. The respondent bears the burden of proof in this appeal.

FINDINGS OF FACT

1. The petitioner is a wheelchair-bound patient residing at the respondent's skilled nursing facility. At the time of admission, he was advised of the facility's leave of absence (LOA) policy. This policy requires residents to sign in and out when/if they leave facility grounds.
2. On June 10, 2008, the respondent educated the petitioner on the facility's approved smoking policy which included the appropriate times and place for residents to smoke. The petitioner signed a copy of this policy acknowledging his understanding.
3. Between the signing of this policy and the date of notice of discharge, the petitioner violated the smoking policy by smoking in unapproved places and/or times. After each violation, the respondent reminded the petitioner of its smoking policy. Each time the petitioner apologized and asked for another chance to comply.
4. On September 10, 2008, the petitioner left the facility around 6:00 p.m. He refused to sign out for his absence. At 11:00 p.m. that same night, the petitioner had not returned to the facility. At 3:50 a.m., on September 11, 2008, the respondent received a call from the Police

Department informing that the petitioner was at a certain location and unable to return to the facility because the battery operating his wheelchair died. The petitioner was returned to the facility with police assistance.

5. This incident prompted the petitioner's attending physician to issue an order stating that he is not to leave the facility except between the hours of dawn to dusk, unless granted special permission. The physician ordered this because of his concern that the petitioner placed himself into an unsafe condition by traveling down busy Highway which had no sidewalks or lights near the facility as well as the potential of having a repeat incident such as that on September 11, 2008.
6. Between September 11, 2008, and the date of the hearing, there were six more documented violations where the petitioner left the facility's property after approved hours. On most of these occasions he refused to sign out as well. After most of these incidents, facility staff reminded the petitioner of his doctor's order regarding LOA.
7. The petitioner is diabetic. On numerous occasions, he refused to submit to blood testing to check his glucose levels. Each time, the attending nurse reminded him of the importance of complying with glucose checks in order to manage his diabetes. He still refused, on most of these occasions, to comply with testing even after being reminded.
8. Because of the petitioner's constant refusal to comply with medical orders, smoking violations, and leave of absence violations, the respondent felt it could not longer meet the petitioner's needs. On November 18, 2008, it

issued a notice of discharge effective December 18, 2008. Numerous attempts to place the petitioner in another facility were unsuccessful. The respondent listed Coalition for the Homeless as the discharge location per the petitioner's doctor's order.

9. After issuing the notice and the petitioner's appeal was filed, the respondent continued to experience incidents with the petitioner. The respondent observed the petitioner engaging in suspicious behavior outside on facility property. This behavior included the petitioner (who has a substance abuse history) on several occasions meeting up with a particular vehicle and engaging in an exchange of some type. The facility contacted Police Department on one occasion when the suspicious vehicle was outside with the petitioner during one of these exchanges. The vehicle was stopped by police and the driver found with possession of crack cocaine. There was also one additional incident similar to this where the police were involved.

10. On December 22, 2008, the respondent held a conference with the petitioner, his mother, and his ombudsman. Several issues were discussed including discharge planning and orientation and the discharge notice itself.

11. At the hearing, the respondent stated on the record that it would provide the petitioner the necessary medical supplies to manage his diabetes and that this was discussed with him. Also, transportation from the facility to

the discharge location has been arranged and discussed with the petitioner as well.

CONCLUSIONS OF LAW

Jurisdictional boundaries to conduct this hearing have been assigned to the department by Federal Regulations appearing at 42 C.F.R. § 431.200. Regarding transfer and discharge rights from a facility, 42 C.F.R. § 483.12 states in relevant part:

> ...(2) *Transfer and discharge requirements.* The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (iii) The safety of individuals in the facility is endangered;
>
> (iv) The health of individuals in the facility would otherwise be endangered;
>
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
>
> (vi) The facility ceases to operate.
>
> (3) *Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must-

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) *Timing of the notice.* (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

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

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

The evidence shows that the notice of discharge is dated properly and lists a discharge location with an address. The numerous incidents involving smoking violations and refusals to comply with medical testing along with the police incidents show that the facility's reasoning for discharge is sound and supported. Based on all evidence and testimony presented, the hearing officer concludes that the facility has followed the requirements of the law regarding the notice.

The petitioner strongly objected to the discharge location arguing that it was inappropriate due to its inability to meet his needs. In reference to the location listed on this discharge notice, the facility has complied with the federal regulation cited above. Complaints about the appropriateness of an intended discharge/transfer location are not within the jurisdiction of this hearing officer. These issues lie under the purview of the Agency for Health Care Administration (AHCA) and should be addressed with the agency accordingly.

The petitioner also argued that discharge planning and orientation was not completed. The evidence, written documentation and oral testimony, indicates otherwise. The discharge location, medical supplies, and transportation were discussed and arranged.

Based on the evidence, the hearing officer concludes the facility complied with the federal regulation cited above regarding the petitioner's discharge and transfer.

DECISION

The appeal is denied. The facility's action is affirmed. The facility may proceed with its discharge accordingly.

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 12th day of February, 2009, in Tallahassee, Florida.

Jeannette Estes

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

Copies Furnished

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

APPEAL NO. 08N-00100

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on January 14, 2009, at 11:20 a.m. at the respondent facility in Jacksonville, Florida. The petitioner was not present. He was represented by attorney , facility administrator, represented the respondent. , social services director, risk manager and assistant to petitioner's attorney were present as observers.

The record was held open until January 21, 2009 for both parties to submit additional evidence. Evidence was received from the respondent and entered as Respondent's Composite Exhibit 8. No evidence was received from the petitioner.

ISSUE

At issue is whether or not the nursing home's April 30, 2008 proposed action to transfer and discharge the petitioner is an appropriate action based on the federal

regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because his "bill for services at the facility has not been paid after reasonable and appropriate notice to pay". The nursing home has the burden of proof at the level of clear and convincing.

FINDINGS OF FACT

1. The petitioner has been a resident at the respondent nursing facility since August 2007. The petitioner's payer source at the time of entry was Medicare. For the first 20 days of the petitioner's stay, Medicare paid 100% of the facility's charges; for another 80 days Medicare paid approximately 20% of the facility charges. All Medicare coverage ended in November 2007. The petitioner was then considered private pay. An application for Institutional Care Program Medicaid was submitted for the petitioner during at this time. The facility billed the petitioner $774 monthly based on an anticipated patient responsibility (the amount the petitioner is obligated to pay the facility if Medicaid is approved).

2. On April 30, 2008, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner effective "thirty days from date received or 30 days from date on certified receipt." The Notice indicated the reason for transfer as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The balance due shown on the notice was $33,592.74. The notice reads "Resident's application for Medicaid repeatedly denied for failure to provide appropriate info and set up irrevocable trust. Facility has filed Medicaid applications for resident beginning August 2007 – present. Resident now private pay."

3. As of the day of the hearing, the petitioner's balance due had been reduced to $9779.50. The facility explained that subsequent to issuing the discharge notice, the Medicaid application was approved and all the charges except the petitioner's patient responsibility for November 2007 through April 2008 (totaling the aforementioned $9779.50) had been paid.

4. The facility provided evidence which proves that bills were mailed by regular mail monthly to the petitioner's daughter who is also his Power of Attorney. The facility asserted that in addition to mailing the monthly bills, numerous calls were made to the petitioner's daughter regarding the outstanding bill. In early 2008 the facility was instructed to no longer call her. The facility initiated discharge action and filed a complaint in civil court. The location to which the petitioner is to be discharged is the daughter's home.

5. The petitioner's attorney did not dispute that monies are owed to the facility, however, the balance due to the facility is in dispute, in part, because the facility has provided different balances at various times. The April 2008 Discharge Notice shows $33,592.74 balance due; an August 2008 email from the facility to the petitioner's daughter shows $2586.39 balance due; the court complaint filed shows $15,000 in damages is being sought by the facility; the documentation submitted during the January 2009 hearing shows $9779.50 balance due. The petitioner's attorney argued that the facility has not provided a satisfactory explanation for these conflicting balances and therefore it is unknown how much is truly owed to facility. The facility explained that the April 2008 balance at discharge did not include adjustments for Medicaid payments which were not received until July 2008 (after the notice was issued). The balance

contained in the August 2008 email to the daughter explains the charges for a specific time period only. The court complaint includes damages. The facility reiterated that $9779.50 is the current balance due.

CONCLUSIONS OF LAW

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

Federal regulations at 42 C.F.R. §483.12 states in part:

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
> (vi) The facility ceases to operate.
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

The legal authority cited above explains the reasons for which a Medicaid or Medicare certified nursing facility may discharge a resident.

Florida Statutes 400.0255, Resident transfer or discharge; requirements and procedures; hearings, states in part:

(15)(b) ...The burden of proof must be clear and convincing evidence...

The facility wishes to discharge the petitioner. The legal authority cited above makes it clear that the facility holds the burden of proof at the level of clear and convincing.

The fact that the petitioner owes a balance to the facility is not disputed; what is disputed is the exact amount that is owed to the facility. The facility provided evidence which shows that $9779.50 is the current balance due. The facility explained how it arrived at that balance.

After carefully reviewing all the evidence, the undersigned concludes the respondent met its burden of proof; the proposed discharge of the petitioner from the facility is in accordance with the controlling Federal Regulations.

DECISION

The appeal is denied. The facility may proceed with the discharge 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 12th day of February, 2009, in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To [redacted]

[redacted]

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

APPEAL NO. 08N-00213

PETITIONER,

Vs.

CASE NO.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 17, 2008, at 2:38 p.m., in Port Charlotte, Florida. The petitioner was not present. She was represented telephonically by her niece and guardian, . The facility was represented by the administrator, . Present to assist the petitioner was district ombudsman manager. Present as witnesses for the facility telephonically were VIP care management; and , assistance benefits specialist with VIP care management. Present as an observer was ombudsman in training.

The facility was allowed 10 days to return further evidence. Evidence was received from the facility on December 18, 2008. It was accepted as Respondent exhibit 6.

ISSUE

At issue is the November 5, 2008 action by the respondent issuing a Nursing Home Transfer and Discharge Notice to the petitioner notifying her that they proposed to discharge the petitioner on December 5, 2008. They proposed discharging the petitioner due to her failure to pay her bill at the facility after reasonable and appropriate notice to pay.

FINDINGS OF FACT

1. The petitioner resided in the facility as a private pay patient until May 1, 2008. She applied for Institutional Care Program benefits to help her pay her expenses at the facility beginning May 1, 2008. She receives a civil service pension that she has been paying to the facility pending the application to have Medicaid pay the remaining balance each month.
2. The facility submitted collection progress notes recording their conversations with the petitioner's guardian (niece). They document her efforts to obtain Medicaid for her aunt. Her aunt's civil service pension is $2,913.34 monthly. The income limit for the Institutional Care Program is $1,911. In order to qualify for the Institutional Care Program, the petitioner needed to form and fund a qualified income trust. Once formed and funded the state would pay the difference between the petitioner's income and the Medicaid payment for nursing home care (minus $35 for a personal needs allowance).
3. Communications with the niece revealed that the income trust was signed on October 30, 2008. However, she has not established that the trust is

funded in a manner for the petitioner to qualify for Medicaid. Even if the trust were properly formed and funded so that Medicaid could begin on December 1, 2008, the back payments for May 1, 2008 through November 30, 2008 are at issue. The bill issued by the facility on November 30, 2008 showed an unpaid balance of $9,567.04.

4. The niece has experienced a problem getting the bank to establish the bank account that will be used for her aunt's guardianship. The petitioner does not dispute the balance owed to the facility. However, even if Medicaid is finally approved, she does not have the funds to pay the back balance for previous months.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at § 400.0255. Matters that are considered at this type of hearing are the decision by the facility to discharge the patient. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that she would be discharged from facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12:

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

The proposed action to discharge the petitioner is due to a failure of the petitioner to pay all of her bill at the facility. As of the billing received on November 30, 2008, the total amount due to the facility was $9,567.04. The petitioner does not dispute that this is the amount owed. However, she has experienced problems with changing her guardian that delayed the processing of the application for Medicaid.

The evidence establishes that the petitioner is aware that there is a debt to the facility. The facility has given the petitioner and her representative reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial arrangements have not resulted. The petitioner still did not intend to pay her monthly patient responsibility. Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is in accordance with federal regulations. The respondent may proceed with the discharge to an appropriate location as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

DECISION

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

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District

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

DONE and ORDERED this 12th day of February, 2009,

in Tallahassee, Florida.

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

Copies Furnished To:

[redacted]

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

APPEAL NO. 08N-00208

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on January 5, 2009, at 12:10 p.m., in Vero Beach, Florida. The petitioner was not present. He was represented by his son, .

, nursing home administrator, represented the respondent.

ISSUE

At issue is whether or not the nursing home's November 15, 2008 proposed action to transfer and discharge the petitioner is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to transfer and discharge the petitioner because his "bill for services at the facility has not been paid after reasonable and appropriate notice to pay". The nursing home has the burden of proof to establish that the transfer and discharge action is consistent with the federal regulations.

FINDINGS OF FACT

1. The petitioner is a resident of a skilled nursing facility. He entered the facility on February 12, 2008 under Medicare. The petitioner's coverage for nursing home care under Medicare ended on April 17, 2008. He was then considered private pay. His Medicaid application of June 7, 2008 was approved in October 2008 and a patient responsibility was assigned. The petitioner is residing in the nursing facility pending the outcome of this appeal.

2. On November 15, 2008, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner with an effective transfer date of December 15, 2008. The Notice indicated the reason for transfer as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". It also indicated there were "numerous unsuccessful attempts to contact the family concerning the balance owed, letters sent & phone messages left with no response" (Respondent's Composite Exhibit 1).

3. By the statement date of November 10, 2008, the petitioner had incurred a bill in excess of $26,000 for services rendered for his care. By the hearing date, the petitioner owed $31, 914.26 (Respondent's Exhibit 2). Currently, there is no payment plan in place and there have been no payments made on the account.

4. The respondent asserts that bills were mailed by regular mail monthly to the petitioner's wife and son, and one was sent certified mail. Contact was made with the family in April 2008 after Medicare benefits expired to urge them to apply for Medicaid. In May 2008, the business office manager met with the family to discuss the Medicaid

application process and setting up a Qualified Income Trust. Calls were made each month regarding the outstanding bill.

5. On June 7, 2008, an application for Medicaid benefits was submitted to the Department. It was approved on October 15, 2008 assigning the petitioner a patient responsibility of $2647.10. The son disagrees with the amount of the patient responsibility and has retained an attorney to petitioner the court for support. He believes that the attorney can get the patient responsibility dismissed and that it will be retroactive to the date of the Medicaid application. A meeting set up for October 24, 2008 to discuss the outstanding bill was cancelled. A letter was sent on November 3, 2008 for lack of response to the bill for services. The petitioner's son was referred to the Department of Children and Families to dispute the amount of the patient responsibility. The petitioner's son acknowledges there is an outstanding bill. He did not recall receiving monthly bills, but he did receive notices and summaries.

6. The location to which the petitioner is to be discharged was listed on the above notice as the petitioner's son's home. The petitioner's son asserts that it is not an appropriate placement and believes the discharge notice is defective because of it. His home is not safe for his father with his multiple diagnoses and physical limitations. His treating physician, opines that it would not be safe for the petitioner to live with his son and family. He asserts he needs to stay in a skilled nursing facility that is capable of handling patients with dementia and physical disabilities (Petitioner's Exhibit 2). The petitioner's son objects to the discharge because he wants him to be allowed to remain at the facility.

7. The nursing facility has stipulated that discharge planning is on hold, pending the outcome of this appeal. Going home with 24 hour care provided by a home health care agency was one possibility.

CONCLUSIONS OF LAW

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

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

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

Pursuant to federal guidelines, the nursing facility issued a Nursing Home Transfer and Discharge Notice to the petitioner on November 15, 2008. The nursing home administrator signed the notice.

The Notice, as required, indicated the reason for transfer or discharge, as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The effective date of the transfer or discharge was given as December 15, 2008.

The Findings of Fact show that the petitioner has an undisputed balance owed to the facility for the cost of his care. The facility has notified the petitioner and his family

of the balance due for the cost of his care. No payment arrangements have been made. The petitioner's son argues that it takes all of his father's money to pay other bills. He does not agree with the patient responsibility the Department of Children and Families assigned to his father, and believes he will able to get it reduced to nothing, retroactively to the date of his application through an attorney.

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

Since discharge planning has not been completed, the undersigned finds that the Discharge Notice is not defective. Once discharge planning has been completed to include a safe and appropriate location, the respondent may proceed with its discharge in accordance with the guidelines established by the Agency for Health Care Administration.

The petitioner's son has some issues about the care his father has received at the nursing facility. He would need to contact the Agency for Health Care Administration with any concerns related to this as the undersigned has no jurisdiction over the care received at the facility.

DECISION

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

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 9th day of February, 2009,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To

[redacted]

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

APPEAL NO. 08N-00206

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 26, 2009, at 11:20 a.m., in Jacksonville, Florida. The petitioner was present and testified. The petitioner was represented by his daughter, and Ombudsman, a resident at the respondent facility, appeared as a witness for the petitioner. The respondent was represented by facility administrator. director of nursing; , social worker; certified nursing assistant (CNA) and physician assistant appeared as witnesses for the respondent.

ISSUE

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

FINDINGS OF FACT

1. The petitioner has been a resident of the respondent facility since November 22, 2007. The petitioner is 64 years old and is diagnosed with stroke, peripheral vascular disease, cerebrovascular disease, amputated left leg below the knee and depression. The petitioner is alert and oriented; his main method of transport is an electric wheelchair.

2. The respondent entered into evidence records and testimony of incidents of verbal and physically abusive behavior by the petitioner to other residents and staff members of the facility. The incidents occurred February 2008, July 2008 and November 2008.

3. During the month of February 2008, the petitioner repeatedly struck a female resident suffering from dementia. The resident entered the petitioner's room and refused to leave. The petitioner admitted that he hit the resident. The petitioner believes he had good cause to hit the other resident because, per the petitioner, she spit at him and "trashed" his room.

4. Facility CNA, asserted that during July 2008, the petitioner cursed and verbally insulted her, hit her with a pillow and pursued her down a hall in his electric wheelchair. The petitioner admitted throwing a pillow, but believes the pillow hit the wall, not the

CNA. The petitioner admitted cursing and verbally insulting the CNA. The petitioner's behavior was caused by the CNA pulling back the privacy curtain between the petitioner and his roommate while the CNA cleaned their room.

5. In November 2008, the petitioner struck a female resident across the face while smoking outside on the facility patio. The petitioner admitted that he hit the resident; he asserted that the resident hit him first and he defended himself. another resident of the facility, who was present during the incident, appeared as a witness for the petitioner. She substantiated the petitioner's testimony that the petitioner hit the resident after first being struck himself. The facility entered into evidence a letter written by a few days after the incidents which asserts that the petitioner hit the other resident because she was verbally harassing him. She now has a different recollection of the events.

6. The facility asserted that as a result of repeated incidents of violence, the petitioner was referred to a psychologist and prescribed the drug, Xanax. The records show the petitioner refused to see the psychologist and after a short time, stopped taking the Xanax. On November 11, 2008, the facility served the petitioner with a discharge notice. The notice shows another nursing facility as the proposed

discharge location. The petitioner admitted that he refused to see the facility's psychologist. The petitioner explained that he had sessions with the psychologist during his stay in another facility and he "didn't like her attitude or anything about her." The petitioner's daughter explained that it was she who instructed the petitioner to refuse the Xanax. She believes the dosage prescribed to the petitioner was too high and caused him to behave in a "loopy" manner; the petitioner would fall asleep during their visits and during subsequent conversations would have no recollection of the visits.

7. the assistant to the facility's treating physician appeared as a witness for the respondent. He spoke with the petitioner after the November 2008 incident and asserted that the petitioner felt no remorse and felt that there was no reason for him to see a psychologist. The physician assistant concurs with the decision to discharge the petitioner from the facility.

8. The petitioner's daughter asserted that the petitioner was wrong to hit the other residents and that she has "gotten on him about it." However, she believes the petitioner was provoked both times. She believes the petitioner may need psychotherapy and medication. She believes the petitioner's behavior is caused, in part, by depression and lack of family visitors. She assured the facility that the petitioner would attend

therapy and take any reasonable medication prescribed if he is allowed to stay. In response to his daughter's assertions, the petitioner argued that he does not believe that he needs help. The facility declined the daughter's offer. The facility administrator explained that the same promises were made after the February 2008 incident; there have been subsequent incidents. The facility would like to go forward with the discharge.

CONCLUSIONS OF LAW

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

Federal regulations at 42 C.F.R. §483.12 states in part:

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

(vi) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

The legal authority cited above explains the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient.

Florida Statutes 400.0255, Resident transfer or discharge; requirements and procedures; hearings, states in part:

(15)(b) ...The burden of proof must be clear and convincing evidence...

The facility wishes to discharge the petitioner. The legal authority cited above sets forth the facility's burden of proof at the level of clear and convincing. The evidence presented proves that the petitioner's behavior includes verbal abuse and physical violence against facility staff and other residents. The facility has offered counseling and medication which the petitioner has declined.

After carefully reviewing all the evidence, the undersigned concludes the respondent met its burden; it is determined that the petitioner's behavior has endangered the safety of other residents in the facility. The respondent's proposed discharge of the petitioner from the facility is in accordance with the reasons stated in the Federal Regulations.

DECISION

The appeal is denied. The respondent met the burden of proof to show the discharge reason meets the reasons stated in the Federal Regulation. The facility may proceed with the discharge 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 9th day of February, 2009,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To

[redacted]

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

APPEAL NO. 09N-00004

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 10, 2009, at 8:27 a.m., at , Florida. The petitioner was present. Present on behalf of the petitioner was . ombudsman. The respondent was represented by , administrator. Witnesses for the respondent were , social services director; director of nursing, and , assistant for social services.

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge from the notice of December 31, 2008 is in accordance with the requirements of the Code of Federal Regulations at 42 C.F.R. § 483.12:

(a)(2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility

FINDINGS OF FACT

1. The petitioner is a resident of the facility. The petitioner refuses treatment by two certified nursing assistants. The administrator opined that if no personnel were available the facility would be unable to meet the petitioner's needs. The administrator attested that the petitioner does not follow her prescribed diet. The petitioner's orders meals from outside of the facility. The facility is concerned as the petitioner's weight has made the petitioner unable to walk or move by herself from her bed.

2. The petitioner was to have lap-band surgery. The petitioner attested that the physician refused to do the surgery as the petitioner was unable to walk into his office. The petitioner expressed her concern that the facility may not have been able to meet her needs if she did have the surgery. As the surgery will not happen, the petitioner opines that the facility is able to meet her needs. The petitioner attested that she has improved her diet and is participating therapy with a goal of getting out of bed by herself.

CONCLUSIONS OF LAW

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

(a)(2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility

Situations that may demonstrate the facility cannot meet a resident's needs is when the resident's condition is such that the resident needs to go to a hospital or needs care that the current nursing facility is unable to provide to the resident. The administrator attested that the facility can meet the petitioner's medical needs. The administrator expressed the facility's concern for the petitioner as she refused treatment by two certified nursing assistants and that the petitioner did not follow her prescribed diet. This demonstrates that the facility can provide both nursing care and appropriate diet even though the petitioner refuses the services.

The Nursing Home Transfer and Discharge Notice stated on page one: "The following reasons require either this form be signed by a physician or a physician's written order for discharge or transfer be attached...". The Notice was not signed by a physician nor was a physician's written order attached. At the hearing, the facility did not submit any physician's written order or documentation from the clinical record that the discharge is necessary for the petitioner's welfare and the petitioner's needs cannot be met in the facility.

The hearing officer concludes that the facility has not met their burden of proof that the discharge is necessary for the petitioner's welfare and the petitioner's needs cannot be met in the facility. Based on the above cited regulation, the facility action to discharge the petitioner is not consistent with the regulations of the Program.

DECISION

This appeal is granted. The facility may not proceed with the discharge as indicated in the Notice of December 31, 2008.

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 18th day of February, 2009,

in Tallahassee, Florida.

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

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

APPEAL NO. 08F-08015
08F-08016

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 4, 2009, at 2:15 p.m., in Miami, Florida. The petitioners were not present. Representing the petitioners was ____, petitioners' mother. Present on behalf of the petitioners was ____, petitioners' father. The agency was represented by Jeffrey Douglas, program operations administrator, Agency for Health Care Administration (AHCA). Also present as witnesses for the agency, via the telephone, from Keystone Peer Review Organization (KePRO), were Dr. Robert A. Buzzeo, physician reviewer and Edna Clifton, registered nurse, operations manager. This hearing was originally scheduled for January 14, 2009, but was continued at the request of the petitioner.

ISSUE

At issue are the agency's actions of November 13, 2008, to deny 930 hours of private duty nursing services (PDN) for the period of November 2, 2008 through April 30, 2009, because the medical care as described to them is not medically necessary. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioners, and are preemie twins who have been diagnosed with early onset delivery-del, respiratory distress, anemia of prematurity, patent ductus arterious and primary apnea.

2. The petitioner's mother is a single mother with a total of six children. She is not working.

3. On November 10, 2000, as the provider, submitted a request on behalf of the petitioners for 4,320 hours of private duty nursing, 24 hours a day, 7 days a week, for the period of November 2, 2008 through April 30, 2009.

4. The agency has contracted KePRO to determine the number of service hours for private duty nursing. Private duty nursing is reviewed every 180 days.

5. In addition to the clinical information, the provider submitted the following social information: "Mom is a young woman, single mom with four children ages: 12, 10, 8 and 4 and the twins in total their 6 children. She is a single mom. No caregiver. No husband. She does not work. Given these reasons she is unable to work..."

6. On November 11, 2008, a board certified pediatric specialty physician consultant reviewed the request. Based on the documentation provided, the physician consultant denied skilled nursing care from 7:00 a.m. to 2:00 p.m. Monday to Friday and approved the rest. A total of 930 hours of Private Duty Nursing hours were denied for the period of November 2, 2008 through April 30, 2009.

7. Notices were sent to the petitioners on November 13, 2008 and November 14, 2008. The notices denied 903 hours and approved 3,417 hours of private duty nursing for the period of November 2, 2008 through April 30, 2009.

8. On November 17, 2008, the provider requested a reconsideration and submitted additional information that was reviewed by a second board certified pediatric specialty physician consultant who had not issued the initial denial. This physician consultant agreed with the denial of hours stated for Monday through Friday.

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 2-17 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 13, 2008 to deny 903 hours of private duty nursing services for the period of November 2, 2008 through April 30, 2009.

The petitioners' representative argues that the information submitted by the provider concerning her children's ages was incorrect. The petitioners' representative stated that her children's ages are twelve, seven, three and one. She explained that her two youngest children do not go to school, so she wonders how she is going to take care of four children at the same time.

The respondent's position is that this decision was correct based on the clinical and social information provided by the petitioner's nursing service provider and the petitioners' medical necessity for the service. However, in light of this new information, Dr. Buzzeo agreed to approve home health aid services from 7:00 a.m. to 2:00 p.m. Monday to Friday for the rest of the certification period.

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 of November 13, 2008, to deny 903 hours of private duty nursing services for the period of November 2, 2008 through April 30, 2009.

DECISION

The appeals are 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 10th day of February, 2009,

in Tallahassee, Florida.

Alfredo Fernandez

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

Copies Furnished T [redacted]

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

APPEAL NO. 08F-07911

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 08 Bradford
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 9, 2009, at 10:05 a.m., in Starke, Florida. The petitioner was present and represented herself. Present as witnesses for the petitioner were her husband, and her mother, The respondent was represented by Jon Rhoads, Agency For Health Care Administration. Present testifying by telephone as witnesses for the respondent were Dr. Maureen Levy, medical director, KePRO and Edna Clifton, operations manager, KePRO.

ISSUE

The petitioner is appealing the respondent's denial of a prior authorization request for inpatient hospital services for a complete abdominal hysterectomy.

The petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner is Medicaid eligible and resides in Bradford County, Florida. The petitioner is 30 years old.

2. Keystone Peer Review Organization (KePRO) is under contract with the Agency for Health Care Administration to perform medical reviews for Medicaid prior authorization for Inpatient Hospital Medical Services Program for Medicaid recipients. KePRO determines medical necessity under the terms of the Florida Medicaid Program.

3. KePRO received a prior authorization request from the petitioner's treating physician for a complete abdominal hysterectomy and for two inpatient days from December 1, 2008 through December 3, 2008. The petitioner was diagnosed with chronic pelvic pain for one and a half years. She had dyspareunia, dysmennorhea and could not sleep due to severe cramps. The pain initially decreased with Provera. However, the pain was recurring. The petitioner had physical therapy with no decrease in the pain. A pap smear and sonogram were normal.

4. On October 29, 2008, a physician consultant board-certified in gynecology/obstetrics reviewed the petitioner's prior authorization request for a complete abdominal hysterectomy. On October 29, 2008, the physician consultant denied the request because the medical documentation did not reveal the etiology of the pain and there was no pathology to support the total abdominal hysterectomy. Typical conservative measures had not been done.

5. On October 29, 2008, a Recipient Denial Letter was mailed to the petitioner denying her prior authorization request.

6. On October 31, 2008, the petitioner's treating physician requested a reconsideration review and provided KePRO with a transvaginal ultrasound dated July 25, 2008 which revealed hemorrhagic corpus luteum but was otherwise normal and a second ultrasound dated August 4, 2008 which revealed a normal uterus, tubes and ovaries. The treating physician also indicated that the patient had refused both laparoscopy and Lupron. On October 31, 2008, a second KePRO physician consultant completed a reconsideration review. The reconsideration was denied as the medical documentation revealed that her uterus, tubes and ovaries were normal and the medical documentation did not reveal the etiology of the pain and standard conservative measures had not been taken.

7. Dr. Levy explained the medical necessity criteria (Respondent's Composite Exhibit 1) as it relates to an abdominal hysterectomy. Chronic pelvic pain is not an indicator for approving a hysterectomy. Standard conservative measures include first undergoing a laparoscopy to find the source of the pain or empiric trial of Lupron, which shrinks tissue. Dr. Levy explained that removing a uterus is not treatment for pain when the etiology is undetermined; removing a uterus is not a diagnostic or therapeutic measure. There must be pathology evidence to support a hysterectomy. To date, this has not been provided.

8. On October 31, 2008, a Recipient Reconsideration Denial Upheld letter was mailed to the petitioner denying the prior authorization reconsideration request.

9. The petitioner believes that she did not refuse to have a laparoscopy; she has not yet had a laparoscopy and is willing to have one performed. However, she did refuse to take Lupron because of her seizure disorder.

CONCLUSIONS OF LAW

Florida Statutes Chapter 409 Section 409.905 in part states:

Mandatory Medicaid services.--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. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program.

The above statute explains that any service under this section shall be provided only when medically necessary and in accordance with state and federal law. It also explains that the Medicaid agency (AHCA) is authorized to implement prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older as well as limiting prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses.

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

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

The above authority explains the Medicaid agency's definition for Medically Necessary, which the above-cited statute requires payment from Medicaid only when found to have met this definition.

Florida Administrative Code 59G-4.150, Inpatient Hospital Services, states:

> (1) This rule applies to all hospital providers enrolled in the Medicaid program.
> (2) All hospital providers enrolled in the Medicaid program must comply with the Florida Medicaid Hospital Services Coverage and Limitations Handbook, incorporated by reference in Rule 59G-4.160, F.A.C., and the Florida Medicaid Provider Reimbursement Handbook, UB-04, incorporated by reference in Rule 59G-4.003, F.A.C. Both handbooks are available from the fiscal agent's Web Portal at http://mymedicaid-florida.com. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Paper copies of the handbooks may be obtained by calling the Provider Contact Center at (800) 289-7799 and selecting Option 7.

Florida Medicaid Hospital Services Coverage and Limitations Handbook, June 2005, page 2-28 explains prior authorization and states:

> 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.

The above Medicaid handbook explains the purpose of authorizing inpatient admissions is to ensure that inpatient services are medically necessary.

The petitioner's treating physician requested prior authorization for inpatient hospital services for a complete abdominal hysterectomy. The request was made because the petitioner had chronic pelvic pain. The findings show that the etiology of the pain was not identified on the prior authorization request submitted by the