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

APPEAL NO. 07F-06201

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 7, 2007, at 1:24 p.m., in Tampa, Florida. The petitioner was present. He was represented by her mother, , and his father, T... ". Present on behalf of the petitioner from Maxium Health Care were Diane Grabowski, case manger, and Barbara Workly, registered nurse. The respondent was represented by David Beaven, health program analyst. Witness for the respondent was Ann Williams, registered nurse specialist. Witness for the respondent from Keystone Peer Review Organization (KePRO South) were Raklesha Mittal, M.D., physician reviewer, and Mary Wheeler, manager of review operations.

ISSUE

The petitioner is appealing the respondent's denial in the notices of September 26 and October 7, 2007 of 64 hours of a request for 720 hours of private duty nursing for the period of September 17 through November 15, 2007. The respondent has the burden of proof in this appeal.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Denial Letter dated September 26, 2007. The petitioner received a reconsideration notice on October 7, 2007. The respondent denied 64 hours of private duty nursing.

1. The petitioner is a nine year old male. His impairments are spinal muscular atrophy, neuromuscular scoliosis, status post spinal fusion, recurrent right sided atelactasis, deformity of bilateral feet with foot drop, limited range of motion of right arm, tracheostomy and ventilator. He attends school. The petitioner is on a regular diet and is able to feed himself. The petitioner had surgery in April 2007 but due to respiratory failure he required a tracheostomy and needs to be suctioned. Due to his spinal condition he needs to be turned at least every two hours or as needed. The petitioner resides with his mother, father and four siblings. The petitioner's father works as a truck driver up to 16 hours a day with some weekends. The petitioner's mother stays at home to care for children. Three of the four of the petitioner's siblings are in school.

2. The nursing agency requested 720 hours of private duty nursing for the period of September 17 through November 15, 2007. They requested 12 hours a day. The nursing agency provided information regarding the petitioner.

3. The respondent has contracted KePRO South to determine the number of service hours for private duty nursing. Private duty nursing is reviewed every 60 days. A board certified pediatric specialty physician consultant reviewed the documentation. The physician consultant attested that no frequency or other information was submitted regarding the petitioner's seizures. Based on the documentation received from the nursing agency for the request of 720 hours, 652 hours were approved and 70 hours were denied. (This was a total of 722 hours.)

4. The nursing agency requested a reconsideration. KePRO review the new information received from the nursing agency. A second physician consultant reviewed the documentation. Of the 720 hours originally requested, 656 hours were approved and 64 hours were denied. The physician consultant recommended twelve hours a day Monday through Friday and eight hours a day on Saturday and Sundays. This notice incorporated a correction to the previous error when the hours were calculated.

3. The nursing agency requested a modification on October 3, 2007. The nursing agency requested that the hours be reduced to 10 hours a day for a total of 410 hours effective October 6, 2007 through the end of the period of November 15, 2007.

4. KePRO reviewed the request for the reduction of hours. The private duty nursing hours were reduce to ten hours a day or 410 hours effective October 6, 2007 through the end of the period of November 15, 2007. The notice

sent stated that 224 hours were denied and 496 hours were approved for the period of October 30 through November 15, 2007.

5. The nursing agency requested another modification on October 29, 2007. The petitioner's mother broke her ankle. An additional 91 hours of private duty nursing was requested for October 30 through November 15, 2007.

6. A KePRO physician reviewer approved the additional 91 hours of private duty nursing for the period of October 30 through November 15, 2007.

7. At the hearing, the family requested that they now need 12 hours a day of private duty nursing.

CONCLUSIONS OF LAW

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

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

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

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

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

> Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible...

Of the 720 hours originally requested, 656 hours were approved and 64 hours were denied. This would have been an average of 10.93 hours a day for the 60 day period of September 17 through November 15, 2007 had there been no modification during the period. The nursing agency requested that the hours be reduced to 10 hours a day effective October 6, 2007. Based on that request, the respondent approved 410 hours or 10 hours a day. An additional 91 hours of private duty nursing was requested and approved for the period of October 30 through November 15, 2007. The addition of 91 hours for the 17 days period equaled an additional 5.35 hours a day. The petitioner was then authorized to

receive 15.35 hours of private duty nursing from October 30 through November 15, 2007. This exceeds the family's request for 12 hours a day of private duty nursing. Therefore the only period of time that the petitioner did not receive the hours requested by the nursing agency was September 17 though October 5, 2007. A review of the evidence did not demonstrate medical necessity for the 64 hours of private duty nursing that was denied. The nursing agency's request to reduce the hours on October 3, 2007 further supports at that time that the additional hours were not medically necessary. Based on the above cited authorities, the respondent's action to deny 64 hours of a request for 720 hours of private duty nursing for the period of September 17 through November 15, 2007 was consistent with the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 8th day of January 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [illegible] etitioner
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting

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

APPEAL NO. 07F-06168

PETITIONER,

Vs.

CASE NO. 1267408561

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned-hearing officer convened an administrative hearing in the above-referenced matter on November 27, 2007, at 2:44 p.m., in Orlando, Florida. The petitioner did not appear. , designated representative for the petitioner, appeared. witness, 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 September 10, 2007, denying the petitioner's application for Institutional Care Program Medicaid benefits for the month of August 2007 due to income exceeding the allowable program standard. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

1. In July 2007, the petitioner resided in . . . . . r, an assisted living facility.
2. On July 25, 2007, due to declining health, the petitioner entered , a nursing facility. As a result, the petitioner's representative submitted an application on the petitioner's behalf to the respondent for Institutional Care Program Medicaid benefits on August 1, 2007.
3. The petitioner reported the following sources of monthly gross income on the application: Social Security Retirement ($783.60), annuity ($581), and Veteran's pension ($904). The income totaled $2,368.00 per month. The eligibility specialist did not count the 60 cents of the Social Security Retirement in its income calculation. When the specialist compared the total income to the limit for ICP Medicaid ($1,869, Respondent's Composite Exhibit 1), she found the petitioner exceeded the allowable standard.
4. The specialist issued a pending notice to the petitioner's representative requesting the return of several items which are not at issue in this appeal. However, the specialist informed the representative in this same notice that the petitioner's income placed her over the income limit for ICP Medicaid. She attached an explanation of the "income trust" provision and the trust agreement. An income trust is a legal instrument into to which the respondent allows an applicant to divert her income so that she may

be eligible to receive ICP Medicaid (Fla. Integrated Pub. Asst. Policy Manual, passage 1840.0110).

5. Instead of returning proof that the petitioner's income was placed into an income trust, the representative submitted documentation attempting to show that a portion of the petitioner's Veteran's pension income was designated for Aid and Attendance payment. The specialist telephoned the representative and informed her that this documentation was not acceptable as it was not directly from the Department of Veterans' Affairs.
6. On September 4, 2007, the representative obtained proper verification from the Department of Veterans' Affairs. The representative forwarded it to the respondent on September 5, 2007. This verification did not indicate a breakdown between the actual Veteran's pension and the Aid and Attendance payment. Aid and Attendance is a payment given to individuals needing assistance with daily activities of living such as bathing, dressing, or is residing in a nursing home due to physical or mental incapacity. (Fla. Integrated Pub. Asst. Policy Manual, passage 1840.0906.05).
7. The respondent issued a Notice of Case Action on September 10, 2007, denying the petitioner's application for ICP Medicaid for the month of August 2007 due to income exceeding the program standard.
8. On September 12, 2007, the respondent received information from the Department of Veteran Affairs indicating a breakdown of the petitioner's

pension into actual pension benefit ($538) versus Aid and Attendance payment ($366).

9. The petitioner deceased August 31, 2007. Her representative appeals the respondent's denial of August 2007 ICP Medicaid coverage due to an outstanding nursing facility bill. At the hearing, the representative argued that the respondent's own policy manual allows for the first month's protection of an individual's income and keeps that income from being counted in the ICP Medicaid determination when the individual has obligations for room and board in an assisted living facility. This applies in the petitioner's case because she still had obligations to pay to , her assisted living facility, during the first month of her admission to n, a nursing facility on July 25, 2007. As a result, her income should not be counted in the August 2007 eligibility determination for ICP Medicaid. The petitioner's income does not exceed the gross income standard for ICP Medicaid.

10. The respondent argued that it must evaluate an applicant's income on the basis on which it is received. In the petitioner's case, she still received the full Veteran's pension for August 2007 in the gross amount of $904. Even when the respondent discounts the pension amount by subtracting the $366 Aid and Attendance award, that leaves a benefit of $581 per month that still counts as income per month. Unfortunately, the petitioner exceeded the ICP Medicaid limit by $33 for August 2007 (See Respondent's Composite Exhibit 1).

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.713 establishes:

> **SSI-Related Medicaid Income Eligibility Criteria** [emphasis original]...(1) Income limits. An individual's income must be within limits establishes 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 over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(15)(a), 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, 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 and what is excluded as income with the following exceptions: (d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS...

An individual's income must fall within allowable guidelines to be eligible for ICP Medicaid. If an individual sets up an income trust, then the income is excluded from the budgeting process and does not count toward the ICP limit. In the present case, no income trust was funded for the petitioner and so the income must count in the ICP budget. The above provision does however, allow for the exclusion of VA Aid and Attendance benefits from the calculation. The petitioner's Aid and Attendance portion totaled $366. Although the respondent did not deduct Aid and Attendance in the original calculation, it went back and re-calculated the ICP budget and deducted the $366. This left an income total of $1,902.

Fla. Integrated Pub. Asst. Policy Manual, Appendix A-9, July 2007, entitled "ELIGIBILITY STANDARDS FOR SSI-RELATED PROGRAMS" reflects the established income limits as set forth by the rule referenced above. For an individual, the maximum income allowed for an individual for ICP Medicaid is $1,869.00, per month.

Fla. Admin. Code 65A-1.713 states in relevant part:

> (3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individual's account, or when it is set aside for their use, whichever is earlier.

During the month of August 2007, the petitioner received total income of $2,268.60 (the respondent disregarded the 60 cents in the eligibility determination). After the deduction of $366 for Aid and Attendance, the petitioner's income totaled $1,902. Although the petitioner's representative correctly argued under 38 C.F.R. § 3.551 that a Veteran who becomes institutionalized has her pension reduced to $90 per month, that reduction never literally occurred in the petitioner's case. In fact, she actually received her full pension benefit of $904 for the month of August 2007 as verified by the Veteran's Administration itself. As a result, even with the Aid and Attendance properly deducted, the respondent was correct in counting the petitioner's actual income received ($1,902) for August 2007 for budgeting purposes for the ICP Medicaid program. Unfortunately, the petitioner's income exceeded the allowable standard by $33.

In addressing the petitioner's representative's alternative argument regarding the first month's protection of an applicant's income when obligated for

room and board in an assisted living facility, Fla. Integrated Pub. Asst. Policy Manual, passage 2640.0123 states:

> ...The individual's income may "protected" for the month of admission to and the month of discharge from a facility if the individual is obligated to pay for the cost of food and/or shelter outside of the facility. **This means that income is not considered as available for patient responsibility for the month of admission to or discharge from a facility, when the individual's income for that month is directly obligated to meet the cost of food and/or shelter for the individual for that month.**[emphasis added]

This provision means that an applicant's income is protected from being used as part of the patient responsibility toward the first month's nursing home bill. It does not, however, keep the income from being counted toward the income limit in the eligibility determination for ICP Medicaid. As a result, the respondent correctly determined eligibility for August 2007.

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 22nd day of January, 2008,

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: [illegible] Petitioner
District 7 ACCESS Cassandra Johnson

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

APPEAL NO. 07F-06486

PETITIONER,

Vs.

CASE NO. 1271799286

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Pinellas
UNIT: 88605

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 4, 2007, at 1:00 p.m., in Largo, Florida. The petitioner was not present. The petitioner was represented by [redacted] planning specialist and owner of [redacted]. The respondent was represented by Suzi Jackson, economic specialist supervisor.

The record was reopened for clarification. Clarification was due not later than December 14, 2007. On December 14, 2007, clarification information was received and entered into record as Petitioner Exhibit 3. The record was closed on December 14, 2007.

ISSUE

The petitioner is appealing the respondent's action for the notice of October 24, 2007 for the amount of the community spouse income allowance and patient responsibility in the Institutional Care Program and Medicaid Program benefits.

FINDINGS OF FACT

1. The petitioner is an institutionalized spouse. His wife is the community spouse. The community spouse had applied for Institutional Care Program and Medicaid Program benefits for the petitioner effective October 1, 2007. The community spouse provided information concerning the couple's assets and income. The couple's assets were within the asset limit. The community spouse's income was $2,768.71. The petitioner income was $3,117. An Income Trust had been established for the petitioner. The household monthly expenses were:

Mortgage	$2,318.77
Home equity loan payment	308.19
Homeowner's insurance	377.42 ($4,529 annual)
Flood insurance	100.00 ($1,200 annual)
Real estate taxes	0
Electric	411.44
Telephone	124.00
Lawn maintenance	98.00
Pool maintenance	48.00
Auto insurance	66.67 ($800 annual)
Income taxes for petitioner	176.42
Income taxes for spouse	181.25
Medical insurance premium for petitioner	15.00
Medical insurance premium for spouse	30.80
Medicare premium for spouse	93.50
Medicare premium for petitioner	0
Oxygen and nebulizer for spouse	38.00

Prescriptions for spouse	1,000.00
Home health care of spouse	600.00
Total expenses	$4,263.46

The representative did clarify that the second home loan was an equity loan, the respondent paid the petitioner's Medicare premium and the real estate taxes were included in the mortgage.

2. The respondent determined the community spouse allowance budget for the process of diverting funds from the patient responsibility to the community spouse. The Minimum Monthly Maintenance Income Allowance for the community spouse was $1,712. The shelter expenses used by the respondent for the budget were the mortgage, homeowner's insurance and a utility standard of $198. The total shelter cost used was $2,894.18. The respondent computed the community spouse income allowance. The spouse's income of $2,768.71 exceeded the Minimum Monthly Maintenance Income Allowance of $1,712. The Maximum Monthly Maintenance Income Allowance allowed by policy was $2,541. The community spouse's income of $2,768.71 exceeded the Maximum Monthly Maintenance Income Allowance. Therefore, no funds could be diverted to the community spouse from the petitioner.

Patient responsibility is the amount remaining of the petitioner's income after deductions and diversion to the community spouse. No funds were diverted from the petitioner to the community spouse as the community spouse's income exceeded the Maximum Monthly Maintenance Income Allowance standard. The petitioner's gross income of $3,116.50 less the $35 personal needs allowance

resulted in an amount of the patient responsibility of $3,081.50. Notice of Case Action was sent to the petitioner on October 24, 2007.

3. The petitioner's health insurance is $15 per month. The respondent did not give the petitioner a deduction for his health insurance, as an "uncovered medical expenses", when determining his patient responsibility.

4. The community spouse has taken care of the petitioner until recently. She was unable to care for the petitioner when she was diagnosed with stage 4 lung cancer, heart failure, COPD and diabetes. She is currently receiving Hospice benefits. The community spouse's expenses of $4,263.46 exceed her income of $2,768.71. The cost of her shelter and medical expenses presented exceptional expenses. The exceptional expenses were due to her exceptional circumstance of her medical condition. The couple's countable assets are less than $2,000. The money from the home equity loan has been used to pay expenses. The spouse has no resources which she can use to pay the expenses that exceed her income. The petitioner is requesting an increase in the community spouse income allowance and a reduction in the patient responsibility.

CONCLUSIONS OF LAW

I. As to the issue of increasing the community spouse income allowance.

The Florida Administrative Code at 65A-1.716(5)(c) sets forth "Spousal Impoverishment Standards" as follows:

> (c) Spousal Impoverishment Standards
> 1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the

> community spouse is equal to the maximum allowed by 42 U.S.C. §1396r-5.
>
> 2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
>
> 3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMMIA X 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.
>
> 4. Food Stamp Standard Utility Allowance: $152.
>
> 5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. §1396r-5. This standard changes January 1 of each year.

The respondent's budgeting methodology reflect the budgeting methodology set forth in the above Florida Administrative Code in calculating that the petitioner's spouse could not retain any of the petitioner's income. However, Florida Administrative Code at 65A-1.712(4)(f) permits possible adjustment to this methodology and the resulting income allowance as follows:

> (f) Either spouse may appeal the amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist.

The State Medicaid Manual at Section 3713 sets forth the monthly income allowances for community spouses and states in relevant part:

> Unless alternative methods described in subsection C. apply, use the following methods to calculate maintenance needs allowances.
> A. Spousal Monthly Income Allowance.--Unless a spousal support order requires support in a greater amount, or a hearings officer has determined that a greater amount is needed because of exceptional circumstances resulting in extreme financial duress, deduct from community spouses gross monthly income which is

otherwise available the following amounts up to the maximum amount allowed:

o A standard maintenance amount.

o Excess shelter allowances for couples' principal residences when the following expenses exceed 30% of the standard maintenance amount. Except as noted below, excess shelter is calculated on actual expenses for -

- rent;
- mortgage (including interest and principal);
- taxes and insurance;
- any maintenance charge for a condominium or cooperative; and
- an amount for utilities, provided they are not part of the maintenance charge computed above. Utility expenses are calculated by using the standard deduction under the Food Stamp program that is appropriate to a couple's particular circumstance (or, at your option, actual utility expenses), unless such expenses are included as maintenance charges for condominiums or cooperatives...

C. Alternative Methods for Computing Monthly Income Allowances for Spouses and other Family Members.--In lieu of the methods described above, you may use:

o standards equal to the greatest amounts which may be deducted under the formula outlined in subsection A. and B. above, or

o standard maintenance amounts greater than the amount computed in A. and B. and in the case of community spouses, an additional amount for excess shelter costs described in subsection A. provided the total maintenance need standard for community spouses does not exceed the maximum.

The State Medicaid Manual sets forth that the increase up to the maximum can be used provided the total maintenance need standard for community spouses does not exceed the maximum. The community spouse's mortgage $2,318.77, homeowner's insurance $377.42 and utility allowance of $198.00 equals $2,894.19. This amount exceeds the Maximum Monthly Maintenance Income Allowance of $2,541.

In examining the relative nature of what may be defined as an individual's "needs", it is necessary to define a standard of such "needs" that is consistent

with the intent of public assistance programs in general, and more specifically with the Institutional Care Program. Since the Institutional Care Program sets the Minimum Monthly Maximum Income Allowance to equal 150 percent of the defined Federal Poverty Level, it is evident that the intent of the Institutional Care Program is confined to address an individual's basic needs of food, shelter, medical costs, and work-related expenses. Any other indicated expenses would potentially be beyond the scope of this basic need definition of the Institutional Care Program and thus, are not included or allowable in determining such basic needs.

The rule sets forth that to meet the needs of the community spouse the Minimum Monthly Maintenance Income Allowance plus excess shelter standard cannot exceed the Maximum Monthly Maintenance Income Allowance amount allowed under 42 U.S.C. §1396r-5. The standard established by Congress in 42 U.S.C. §1396r-5 provides that the Maximum Monthly Maintenance Income Allowance may be increased if the community spouse can establish that they have additional needs that are "exceptional circumstances resulting in significant financial duress." For the hearing officer to increase the Maximum Monthly Maintenance Income Allowance beyond the maximum allowed and include an expense, the expense must pass that two-part test. First, the expense must be an exceptional circumstance and, second, the expense must create significant financial duress.

Black's Law Dictionary (6th Edition 1990) defines exceptional circumstance: "Conditions which are out of the ordinary course of events;

unusual or extraordinary circumstances...". An expense related to a sudden and unexpected event is an exceptional circumstance. Expenses that are expected and are incurred in the normal course of everyday living are not exceptional circumstances. Expected everyday expenses of living, such as home ownership and medical expenses are not necessarily exceptional, extraordinary, uncommon or sudden in nature. Therefore, the community spouse's monthly bills of mortgage, equity loan, homeowner's insurance, utility allowance, income taxes, USDA "Thrifty Food Plan" $152.00, Medicare premium and health insurance are not exceptional expenses. The petitioner's recent medical conditions resulted in the need for oxygen, nebulizer, prescriptions and home health care. The petitioner has a co-payment for theses expenses in the amount of $1,638. Therefore, these expenses of $1,638 meet the exceptional circumstances. Next, the hearing officer must consider significant financial duress.

The community spouse's stated expenses of $4,263.46 exceed her income of $2,768.71. The spouse's expenses $4,263.46 less the exceptional expenses $1,638 would be $2,525.46. If the petitioner did not have the exceptional expenses, her income would be sufficient to pay the remaining expenses. Provided in the rules is resources for the community spouse. These resources were provided by law to prevent impoverishment and would be available to the community spouse as needed to prevent impoverishment. The couple's countable assets are less than $2,000. A home equity loan the spouse used to pay expenses had been exhausted. The community spouse has no assets to pay the amount of expenses that exceed her income. Therefore, the

exceptional expenses in the amount of $1,638 would present significant financial duress.

The expenses have met the two step test. The community spouse income allowance is increased to $1,638 to meet the community spouse's exceptional expenses. The amount, of $1,638, is to be diverted from the petitioner's income.

II. As to the issue of the amount of the petitioner's patient responsibility.

The regulation at 42 C.F.R. §435.725 provides for required deductions from the individual's total income in determining what the Agency must pay to the institution. The regulation sets out those required deductions from the individual's income to determine patient responsibility. The amounts required to be deducted include the personal needs allowance, maintenance needs of the spouse, maintenance needs of the family, and medical care expenses not subject to third party payment. The regulation provides:

> (4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including--
> (i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
> (ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

The regulation sets forth that an individual can receive a deduction for health insurance premiums as medical expenses that are not reimbursable in determining his patient responsibility to the nursing facility. The patient responsibility would be the petitioner's income less the $35 personal needs

allowance, $15 insurance premium and the diversion of $1,638. The amount of the patient responsibility is $1,429.

DECISION

This appeal granted. The respondent is to recompute the budgets to reflect the community spouse income allowance to the amount of the exceptional expenses of $1,638 and the amount of the patient responsibility of $1,429.

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 2nd day of January 2008, in Tallahassee, Florida.

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

Copies Furnished To: [ ] etitioner
Roseann Liriano, Suncoast Region
[ ] epresentative for the petitioner

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

APPEAL NO. 07F-06511

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 6, 2007, at 9:20 a.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by his mother . Also present was Ms. Brown's fiancée T , and her son . The respondent was represented by Loraine Wasserman, registered nurse specialist. Present on the telephone from Kepro was Dr. Robert Buzzeo, medical director of private duty nursing, and Theresa Ashey, review operations supervisor.

ISSUE

At issue is the Agency's September 30, 2007 action of approving the petitioner's skilled home nursing services for 416 hours, and denying 338 hours for September 29, 2007 to November 27, 2007. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, date of birth [is 12 years old, and he is a Medicaid benefits recipient in ..... County, Florida. He receives skilled home nursing services from Maxim Health Care Services, Inc.

2. The petitioner is requesting skilled home nursing care of 16 hours per day 4 days weekly, and 8 hours 3 days weekly, for 88 hours per week. He was approved for 416 hours of skilled home nursing services from September 29, 2007 to November 27, 2007, which is 52 hours per week.

3. Included in the evidence is a copy of a Recipient Denial Letter, dated September 30, 2007, stating that 416 hours of skilled home nursing services were approved, and 338 hours were denied for him for September 29, 2007 to November 27, 2007.

4. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld notice dated October 11, 2007. This notice informs the petitioner that upon reconsideration, the approval of 416 hours of skilled home nursing services, and the denial of 338 hours for September 29, 2007 to November 27, 2007, was upheld. The notice explains that it was determined by Kepro that the medical care of the skilled home nursing services of 416 hours was determined to be medically necessary.

5. Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner, dated September 27, 2007, stating that the petitioner was diagnosed with infantile cerebral palsy, unspecified, asthma, reflux esophagitis, and gastrostomy complications.