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.

6. The petitioner has functional limitations in endurance, ambulation, speech, he has visual impairment, he is incontinent in bowel and bladder, and he has a severe neuro deficit. He uses a wheelchair, oxygen, and a suction machine.

7. Included in the evidence is a copy of a Kepro Synopsis of Case Report, concerning the reconsideration dated October 11, 2007. This reconsideration was done by a second Kepro physician consultant board certified in pediatrics, who did not issue the initial denial. This was done by Dr. Buzzeo, who took into consideration the petitioner's condition, his mother's work schedule, and the petitioner attending school during the week.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. Fla. Admin. Code 59G-1.010 states in part:

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

be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. The petitioner's skilled home nursing services was approved for 416 hours, and denied for 338 hours for the time period of September 29, 2007 to November 27, 2007. It was determined by Kepro that skilled home nursing services of 416 hours was medically necessary for the petitioner during that time.

The Agency's determination takes into account what is medically necessary for the petitioner, and his parent's availability to help care for him. The physician that testified at

the hearing asserted the medical necessity of 416 hours of skilled home nursing care for the petitioner during that time. After careful consideration of the proper authorities and evidence, including the petitioner's diagnosis and condition, it is determined that the Agency's action of the skilled home nursing services, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 28th day of January 2008,

in Tallahassee, Florida.

Stuart Imberman SJ

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

Copies Furnished To , Petitioner
Gail Wilk, Area 10 Medicaid Adm.

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

APPEAL NO. 07F-06414

PETITIONER,

Vs.

CASE NO. 1252649649

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 12 Volusia
UNIT: 88209

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on December 4, 2007, at 11:50 a.m., in Daytona Beach, Florida. The petitioner was not present. His wife, _____, presented him. Parrey Hardwick, eligibility specialist, and Ernestine Bethune, eligibility specialist II, represented the Department.

ISSUE

At issue is whether the Department correctly denied Institutional Care Program and Medicaid for March, April, and May 2007 based on the contention that his income exceeded the Program standard. The petitioner holds the burden.

PRELIMINARY STATEMENT

Before the hearing could move forward, it had to be established if this was a timely appeal. The Notice of Case Action the petitioner is appealing is dated June 29, 2007. The case record shows that a hearing was requested on October 31, 2007. Brief testimony revealed that the petitioner's authorized representative requested a hearing on July 3, 2007. The request was not forwarded to the Office of Appeal Hearings until November 6, 2007. Since the appeal was filed timely, testimony and evidence was taken, and the hearing moved forward.

FINDINGS OF FACT

1. On November 16, 2006, the petitioner applied for and was eligible to receive Institutional Care Program (ICP) and Medicaid. A qualified income trust (QIT) was set up and it was funded with $69 each month as his income was over the Program limit. ICP benefits stopped at the end of February 2007 when the petitioner was hospitalized (Petitioner's Exhibit 1).

2. On May 14, 2007, an application for Institutional Care Program (ICP) and Medicaid benefits was submitted to the Department on the petitioner's behalf by an authorized representative from the nursing facility where he resides. Retroactive ICP Medicaid was requested for March and April. The application shows the petitioner receives Social Security income of $1754, which was under the income limit (Respondent's Exhibit 2).

3. As part of the eligibility process, the Department must consider among other things, the petitioner's income and assets. A Verification List was generated on May 23, 2007 and mailed to the authorized representative at [redacted] requesting

additional information necessary to determine the petitioner's eligibility. Among the items requested were bank statements for the last three months of all bank accounts. The information was due on June 4, 2007 (Respondent's Exhibit 3). The Verification List was not mailed to the petitioner's wife.

4. On June 6, 2007, the authorized representative requested an extension to provide the asset information. On June 11, 2007, the Department received verification of the bank accounts and a copy of the Irrevocable Qualified Income Trust (QIT) (Respondent's Composite Exhibit 4). The bank accounts revealed that the deposit into the trust was $69 per month. On June 26, 2007, the Department faxed the authorized representative a notification informing that the QIT needed to be funded with $84 each month ICP benefits was requested. On the same day, a deposit was made for $75, (Respondent's Exhibits 5 & 6). Another deposit was made in June resulting in the petitioner being under the ICP income limit once the trust was properly funded. The petitioner's income was verified through an on-line query from the Social Security Administration. The amount of income is not in dispute. The amount to fund the trust was derived by subtracting the actual income of $1953 minus the ICP income limit of $1869.

5. The Department denied ICP benefits for March, April, and May 2007 because the QIT was not adequately funded in those months, resulting in the petitioner's income exceeding the ICP income limit.

6. The petitioner's wife understands why ICP was denied for the months in question, however, she believes that she should "have been kept in the loop" as her husband's power of attorney, and would have done everything she needed to do to get

ICP reinstated. She did not receive a Verification List or anything telling her how much to fund the QIT each month. The authorized representative from the facility advised her to continue funding it with $69, and social services assured her that his ICP would be reinstated. She funds the QIT with $100 a month now as she understands if his income increases the amount needed to be deposited will increase. The petitioner's wife is also concerned that she may not get notifications in the future of how much to deposit into the QIT, again causing this problem. She now owes the nursing facility over $14,000.

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.713, 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 paragraph 65A-1.702(14)(a), F.A.C.

Appendix A-9, January 2007, of the Department's Integrated Policy Manual, 165-22, shows the ICP income limit for an individual at $1869. This income limit changes in January of each year, based on Social Security's federal benefit rate.

The Department's Integrated Manual 165-22, Section 1840.0110 states in relevant part:

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

> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.**
>
> The Economic Self-Sufficiency Specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received. (This may require the individual to begin funding an executed income trust account prior to its official approval by the District Legal Counsel.)
>
> The trustee of the qualified income trust must provide quarterly statements identifying the deposits made to the trust each month...

> The Department's Integrated Policy Manual, 165-22, states in relevant part:
>
> 0640.0109 Designated Representatives (MSSI)
> A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility...

The Findings of Fact shows that the petitioner was previously approved for ICP Medicaid in 2006 and had a Qualifying Income Trust (QIT) which required deposits of $69 monthly to allow eligibility. Due to a discharge from the nursing home, the petitioner's ICP coverage was terminated. A facility employee advised the petitioner's wife to continue funding the QIT with the same amount, rather than refer her to the Department for ICP eligibility questions. A facility employee reapplied for ICP on behalf of the petitioner in May 2007 and listed income that was lower than the ICP income limit. The Department corresponded with the individual who applied on the petitioner's behalf rather than his wife. The QIT document was submitted to the Department in June 2007. The Department first learned of the insufficient amount of deposit into the

QIT in June 2007 when the representative submitted the requested bank statements. A few days later, and in the same month, the Department notified the representative of the amount needed to achieve eligibility. The sufficient amount was deposited and ICP eligibility was approved beginning June 2007.

The petitioner's wife raised concerns about the ICP eligibility process taking place without her knowledge and the fact that she was never notified by the Department of the need for verification or the amount needed to fund the QIT. She was also concerned about not getting future notifications of needed changes in the deposit amount required to remain eligible. According to the above authority, the Department allows a representative to be self-designated and should determine if this is the most appropriate person. Therefore, the undersigned concludes that the Department did not err to act on the application submitted by a self-designated representative. However, it appears appropriate for the Department to now consider the petitioner's wife the representative and include her in all ICP eligibility notifications, to include notifications of when she would need to change the amount she deposits into the QIT.

Based on the above authorities, evidence and testimony, the undersigned concludes that the petitioner was not eligible on income for the months at issue due to insufficient income going into the QIT. The earliest ICP eligibility was correctly established as June 2007.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 14th day of January, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: Petitioner
12 DPOES: Theola Henderson

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

APPEAL NO. 07F-06093

PETITIONER,

Vs.

CASE NO. 1263580629

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 07 Brevard
UNIT: 66394

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on November 20, 2007, at 1:55 p.m., in Cocoa, Florida. The petitioner was not present. David Jacoby, attorney, represented her. , the petitioner's representative and guardian, appeared as a witness for the petitioner. Stacy Robinson, District 7 legal counsel, represented the Department. Bobbi Van Cott, economic specialist supervisor, appeared as a witness for the Department. Margaret Scheffield, court reporter, King Reporting Services, was also present.

The record was left open until the close of business on December 5, 2007, for the petitioner and the respondent to submit additional evidence. No information was received from either party and the record was closed.

ISSUE

At issue is whether the Department correctly denied Institutional Care Program and Medicaid benefits for March, April, and May 2007. The petitioner holds the burden.

FINDINGS OF FACT

1. On March 27, 2007, the petitioner's attorney submitted an application for Institutional Care Program (ICP) and Medicaid benefits to the Department on the petitioner's behalf. The telephone interview scheduled for April 10, 2007, at 9:00 a.m. did not take place as the Department sought permission from the petitioner's guardian to conduct an interview with a third party. The application was withdrawn on April 26, 2007 (Respondent's Exhibit 4). The record was left open for the Department to provide the Notice of Case Action that would show the application's disposition. The Department's representative did not know if a notice was sent, and none was provided. The petitioner's attorney does not recall receiving notice of its disposition.

2. On May 31, 2007, another application was submitted requesting ICP benefits. Counsel for the petitioner stipulated that ICP benefits for February 2007 was no longer an issue. The petitioner was seeking ICP benefits beginning in March 2007. The petitioner's spouse refused to support her. An Assignment of Rights to Support was signed on May 4, 2007 (Petitioner's Exhibit 5). The Department lacked all of the necessary information it needed to determine the petitioner's eligibility for ICP benefits, and pended the application for information. The information was not returned, and the application was denied for failure to follow through in establishing eligibility. Both parties stipulate to these facts.

3. On July 26, 2007, another application was submitted requesting ICP benefits.

The Department approved ICP benefits from that application, effective June 2007, but not for the months of March, April, and May 2007. March and April were denied because the Assignment of Rights to Support was not signed until May 4, 2007, and because the petitioner's assets exceeded the Program limits. All factors of eligibility must be met for each month that ICP was requested. Because the form was not signed until May 2007, eligibility could not be authorized for the prior months due to excessive assets. ICP was denied for May 2007 because the Department believes that the money in the petitioner's attorney's trust account was an available asset to the petitioner. Her asset limit for ICP is $5000. In May 2007, the balance in the petitioner's attorney's trust account was in excess of $27,000. A Notice of Application Disposition was mailed on October 18, 2007 informing the petitioner's attorney of the Department's decision (Respondent's Exhibit 1).

4. The Petitioner's Exhibit 1 is an Order Approving Settlement Stipulation. It is dated May 18, 2007. The Petitioner's Exhibit 2 is the Settlement Stipulation. It is not the entire document. Some of it was withheld from the Department because of the nature of its contents and confidentiality concerns. The Settlement Stipulation resulted from contested issues relating to the guardianship of the petitioner. The record was left open for additional information concerning the effective date of the Settlement Stipulation, but it was not provided. Counsel for the petitioner believed the effective date was in February 2007.

5. Paragraph three of the Settlement Stipulation shows that in addition to the money already paid for legal fees, the petitioner's husband was to give Mr. Jacoby $27,609.58, and it was to be deposited in the attorney's trust account. Payments were ordered from

that money in the sums of $4,307.50 for legal services rendered for the petitioner, $5515.00 for guardianship services rendered to the petitioner, $10,287.06 for legal services to the plenary co-guardians, and $7500 to Gray Robinson, P.A. to be used to pay legal and guardian fees and others accrued on and after the date of the execution of the Settlement Stipulation.

6. On May 3, 2007, Mr. Jacoby wrote a check for $27,609.56 to the Gray Robinson Trust Account. The money was from the Settlement Stipulation. On October 15, 2007, Mr. Shuman sent a trust detail showing how the money had been spent. In addition to the expenditures listed above, $95 was paid to King Reporting for a deposition transcript. Legal services rendered to the co-guardians by Gray Robinson were paid in the amounts of $4441.54 and $660.00. In June 2007, the balance of the settlement was $2303.46. Mr. Shuman explains that those funds are non-refundable and are to be used for payments of final attorney fees and guardian fees (Petitioner's Exhibit's 3 & 4). The funds are not available to the petitioner and are in that account to pay certain bills. The petitioner could not ask for money from the fund and neither could her co-guardians. Only the presiding judge could change the court order. It was ordered that if any money was left in the account, it reverts to the petitioner's husband. Because of the unavailability of the funds, the petitioner's attorney believes that the petitioner's assets did not exceed the program limit for ICP.

7. Counsel for the petitioner believes that he was erroneously denied the chance to apply for Medicaid benefits for the petitioner in March 2007. He asserts it took over two months to learn that only the court appointed guardian of the petitioner had the legal right to apply for assistance for her. The delay caused the Assignment of Rights to

Support not being signed until May 4, 2007. He further believes that the Assignment of Rights to Support specifically states that it is retroactive from October 1, 1989 to the present.

CONCLUSIONS OF LAW

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

> (9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
> (a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services.

Fla. Admin. Code 65A-1.710, SSI-Related Medicaid Coverage Groups, states:

> The department covers all mandatory coverage groups and the following optional coverage groups:
> (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.

Fla. Admin. Code 65A-1.712. SSI-Related Medicaid Resource Eligibility Criteria states:

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions:
>
> (4)(g) The institutionalized spouse shall not be determined ineligible based on a community spouse's resources if all of the following conditions are found to exist:
> 1. The institutionalized individual is not eligible for Medicaid institutional services because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse; and

2. The institutional spouse assigns to the State any rights to support from the community spouse by submitting the Assignment of Support Rights form referenced in Rule 65A-1.400, F.A.C., signed by the institutionalized spouse or their representative; and
3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and
4. The institutionalized spouse has no other means to pay for the nursing home care.

The Department's Public Assistance Policy Manual at passage 1640.0314.03 Assignment of Support Rights (MSSI) states:

If the community spouse refuses to make available assets attributed to the institutionalized spouse, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits. This situation may arise when assets allocated to the client actually solely belong to the community spouse who, in turn, refuses to make them available to the client. The institutionalized spouse may complete CF-ES Form 2504, Assignment of Support Rights, which allows the state to pursue recovery from the community spouse. Refer to CF Manual 165-24, Integrated Public Assistance Forms Manual, for proper completion (including who can sign the form). The original copy of this form is to be sent to Economic Self-Sufficiency Services, Policy Bureau, in Tallahassee, Attention: SSI-Related Medicaid Program staff. This form is not an option that an ESS suggests to an ineligible couple, but rather a solution to an existing situation which is brought to the ESS' attention. When all conditions in passage 1640.0314.04 are met, the allocated assets being withheld by the community spouse will no longer be considered available to the institutionalized spouse. If the institutionalized spouse does not assign the rights of support to the state, continue to consider the assets available to the institutionalized individual.

The Department's Integrated Public Assistance Policy Manual passage 0640.0107, Who May be Interviewed (MSSI, SFP), states:

Conduct interviews with a responsible member of the SFU (except for a sponsor) or a designated representative. A responsible member is any member able to represent the SFU by providing sufficient and accurate information concerning the SFU's circumstances.
The responsible member may be an adult or a responsible minor in the SFU. If the responsible member is a minor under the parental control of an

adult, confirm the minor's representative status with an adult household member.
Exceptions:
Do not interview or allow the following to act as a designated representative:
1. Eligibility staff, unless no other individual is available to act on behalf of the applicant/recipient. The ESS Zone Program Office must provide written approval for each designation.
2. A nursing home administrator (including administrators of ICF/MRs and State Hospitals), or anyone in a position to act as nursing home administrator, unless the administrator is the individual's legal guardian.

It further states at passage 0640.0109, Designated Representatives (MSSI):

A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An applicant must authorize a designated representative in writing prior to eligibility determination or anytime during the review period. The applicant does not have to be functionally or legally incompetent to have a designated representative.
If the individual has been **declared legally incompetent and has a legal guardian, the legal guardian must act as the designated representative**. If the legal guardian will not cooperate or cannot be located, someone else may act as designated representative. When someone other than the legal guardian is the designated representative, send a written notice to the legal guardian advising him that a designated representative has been appointed. Maintain a copy of the written notice in the case record.
If the household member or a designated representative is not responsible, that member may not represent the SFU and may not designate a representative. Record the information that supports this decision.
Designated representatives or minors serving as designated representatives assume responsibility for the accuracy of the information provided and are subject to the same penalties and possible prosecution as responsible household members.

The above-cited authority shows that if the institutionalized spouse does not assign his or her rights to the state, the assets of the community spouse are available to the institutionalized spouse. In this appeal, the assignment of rights form was signed on

May 4, 2007. Prior to that, the community spouse's assets were available to her and caused ineligibility. The authorities were researched and there were none found to allow ICP eligibility in a month prior to the month the form was signed when there are excessive assets involved. After researching the authorities, the undersigned concludes that counsel for the petitioner misinterpreted the language on the Assignment of Rights to Support Form to mean that the assignment of rights can be retroactive from the date it was signed. The undersigned does not interpret the form to mean that. The petitioner held the burden and did not provide an authority to prove that position. Therefore, the hearing officer concludes that the Department's action to deny ICP for March and April 2007 was correct.

Counsel for the petitioner argued that the Department erred by not allowing an application from anyone but the legal guardian and withdrawing the March 31, 2007 application. No notice was presented to show the disposition of that application. However, the undersigned finds that all months of ICP coverage that are sought could have been achieved from the May 2007 application. Also, it is clear that the petitioner's attorney was aware of the need to have the form signed, although it was not signed in March or April, the first two months that ICP coverage was requested.

Testimony concerning the availability of the Attorney's Trust Account showed that money in the fund was not available to the petitioner. Therefore, the undersigned finds that the petitioner's assets were within the Program limit for ICP during the month of May 2007. The month of May 2007 is both the month that the Assignment of Rights form was signed and the month that the Order Approving Settlement Stipulation was dated. Therefore, the action taken by the Department to deny ICP benefits for the

month of May 2007 is reversed. The Department is hereby ordered to determine eligibility for ICP benefits for May 2007, considering that the petitioner is eligible on the factor of her assets being within Program limits for that month.

DECISION

The appeal is partially granted and partially denied. The Department correctly determined that the petitioner was not eligible for ICP benefits for March and April 2007. The Department erred when it determined that the petitioner's assets exceeded the ICP Program limits for May 2007. The action to deny ICP for May 2007 for assets in excess of the ICP asset limit is hereby reversed. The Department is ordered to determine eligibility for May 2007 considering the petitioner's assets are within the Program limits. The eligibility determination should be initiated within ten days from the date of this order.

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 18th day of January, 2008, in Tallahassee, Florida.

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

Copies Furnished To: Petitioner
District 7 ACCESS Cassandra Johnson
Stacy Robinson
David Jacoby

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

APPEAL NO. 07F-06262

PETITIONER,

Vs.

CASE NO. 1265600082

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 13 Hernando
UNIT: 88141

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on November 20, 2007, at 1:35 p.m., in Brooksville, Florida. The petitioner was not present, but was represented by Richard Padgett, attorney. The petitioner's daughter and power of attorney, [redacted] appeared as a witness for the petitioner. The respondent was represented by Ralph McMurphy, attorney with the Respondent. Vickie Siornicki, senior eligibility processor, appeared as a witness for the respondent.

The hearing record was held open for an additional fourteen-day period to allow any submission of written arguments from the parties. The petitioner's counsel also requested an additional 7 day period. Closing arguments have not been received.

ISSUE

At issue is the respondent's decision of October 1, 2007 to deny the petitioner's Institutional Care Program and Medicaid (ICP) application because of an asserted failure to provide requested verification of interest income, bank account transaction activity, and a completed level of care process. The petitioner disputes this decision and seeks ICP eligibility retroactive to May 2007. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner has been a resident of a Brooksville area nursing home since July 9, 2006. The petitioner is 85 years old. The petitioner's spouse deceased on August 26, 2006.
2. The petitioner's daughter and power of attorney, [redacted], submitted an application for ICP benefits in the petitioner's behalf on June 26, 2007. The petitioner received notice dated October 1, 2007 that this ICP application was denied. The listed reason for denial is failure to follow through in establishing eligibility.
3. The petitioner received a Request For Information (RFI) document from the respondent labeled Respondent Exhibit 1. This document is dated July 19, 2007, and lists 29 items needed to determine ICP eligibility. The due date for return of all the items is July 30, 2007. The respondent determined the petitioner sufficiently completed all the requested items, except those listed below.

4. One of the requested items is a completed form CF-MED 3008, page 1 and page 2, and, a form CF-ES 2040, Informed Consent. The respondent received the informed consent form by the July 30, 2007 due date. The CF-MED 3008 form is to be completed by the nursing home and not by the petitioner. The 3008 form completed by the nursing home, along with medical documentation, is to be received by the respondent and sent to another CARES unit to determine if petitioner meets level of care. It is not established if the nursing home received a request for this information. The respondent had not completed the level of care process by the listed due date of July 30, 2007.
5. The RFI notice also requested the petitioner to provide information on bank accounts for the months of April, May, June, and July of 2007. This RFI notice also requested proof of all interest income amounts paid on all bank accounts for April, May, and June 2007. The respondent received the first page of the bank statements from the petitioner for each of the months of April, May, June, and July 2007 by the deadline of July 30, 2007. However, pages 2 through 5 of each of these bank statements were not submitted along with the larger composite group of documentation to the respondent. The first page of these bank statements do not list any interest earned in this interest bearing account or show detail of transaction activity. The respondent did not follow-up with the petitioner's representative to request the additional pages of the bank account statements.

6. The respondent believes the petitioner had an adequate opportunity to provide the complete bank statements, which are believed to show any interest income received and the transaction activity. The petitioner did not provide pages 2 through 5 of the bank accounts due to oversight. The petitioner would have immediately provided such pages if she had been told that such was needed, per testimony. On October 1, 2007, the respondent denied the petitioner's June 26, 2007 ICP application based on the non-receipt of the completed 3008 form and level of care process, and the non-receipt of the additional bank account pages.

CONCLUSIONS OF LAW

The respondent's interpretive FLORIDA on-line manual sets forth the following regarding a request for additional information:

> 0640.0401 Requests for Additional Information/Time Standards (MSSI,SFP)
>
> If the Department needs additional information or verification from the applicant, provide:
>
> 1. a written list of items required in order to complete the application process.
> 2. the date the items are due, in order to process the application timely, and
> 3. the consequences for not returning additional information by the due date.

The petitioner was provided written notice of the items needed to complete the ICP application process. The petitioner submitted sufficient documentation on the majority of the requested items. The completed level of care

determination process is one of the items not completed. Section 0640.0400 sets forth the following regarding a level of care determination:

1. Request a level of care determination on ICP cases from the CARES unit within two days of the receipt of appropriate medical information.
2. The CARES unit provides the level of care decision within 12 days of receipt of the request.

The petitioner completed the informed consent form as her direct part of the level of care determination. There is not sufficient evidence to establish if the nursing facility received a request for the completed 3008 form along with the request for medical documentation. Such information is then sent to the respondent and forwarded to CARES to complete the level of care determination.

The second requested item of information not provided was proof of any bank account interest income, and transaction activity to show withdrawals or transfers from the account. The complete bank account statements for each of the months at issue are believed to satisfy this requested information requirement. The respondent submitted only the first page of the bank statements, rather than the total five pages. The first page of the bank accounts is not sufficient to show any interest income or specific transaction activity.

The respondent did not make any follow-up request for the additional pages of this bank account before the denial of the petitioner's application on October 1, 2007. The question is whether or not the respondent had responsibility to make such follow-up request for the complete bank account statements when only the first page was submitted. The ACCESS Customer Service Center Guide on page 7 of 41 entitled PUBLIC ASSISTANCE

PROGRAMS: THE APPLICATION PROCESS gives guidance on this question. An excerpt from this page states the following: "Applicants provide all required verification, resolve any discrepancies and clarify unclear or incomplete information, as necessary."

The above excerpt shows that applicants are to clarify incomplete information, as necessary. This statement implies that the ACCESS program processor has the responsibility to inform an applicant when unclear or incomplete information is submitted, that is necessary to determine eligibility. The respondent did not meet this implied responsibility to contact the petitioner and request the complete bank account statements to resolve incomplete information.

In sum, the petitioner fulfilled her direct responsibility to complete the requested informed consent form inherent in the level of care determination process by the due date. Thus, it is not correct to deny the petitioner's application based on her alleged failure to follow through with this specific request for information. However, the level of care process needs completion with nursing facility information and CARES determination, before ICP eligibility can be determined. Further, the respondent had responsibility to contact the petitioner about the incomplete bank account statements to resolve the question of interest income and account transaction history. Since the petitioner fulfilled her direct responsibility in the level of care determination process and the respondent did not contact the petitioner about incomplete bank account information, the respondent's denial action can not be upheld.

DECISION

This appeal is partially granted since the respondent's denial action of October 1, 2007 is not upheld. The respondent is ordered to re-open the petitioner's June 26, 2007 application for ICP benefits, and re-determine ICP eligibility retroactive to the month requested, May 2007. The respondent is to provide a written request to allow ten days for the return of the complete bank account statements for the months at issue, May 2007 and ongoing. The written request should show the consequences for failure to return these complete bank account statements. Further, the respondent is ordered to initiate and allow sufficient time to complete the necessary level of care determination process for ICP eligibility. At the end of this time period, the respondent is ordered to re-determine ICP eligibility on all relevant eligibility factors. This appeal is partially denied in that it is not known whether or not the petitioner will be actually determined eligible for ICP benefits after appropriate completion of this re-review.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 7th day of January, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
District 13 ACCESS: Micheal Holder

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

APPEAL NO. 07F-06028

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 30, 2007, at 10:08 a.m., in Tampa, Florida. The petitioner was present. She was represented by her mother, r, and her father, The respondent was represented by David Beaven, healthcare program analyst. Witness for the respondent was Ann Williams, registered nurse specialist. Witness for the respondent from Keystone Peer Review Organization (KePRO South) were Rakesh Mittal, M.D., physician reviewer. Mary Wheeler, review operations manager was present for the respondent but was there for technical assistance only and did not testify.

., nurse and C), nurse were present and testified for the petitioner.

ISSUE

The petitioner is appealing the respondent's denial in the notices of October 3 and October 11, 2007 of 683 hours of a request for 960 hours of private duty nursing for the period of October 4 through December 2, 2007. The respondent has the burden of proof in this appeal.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Denial Letter dated October 3, 2007. The petitioner received a reconsideration notice on October 11, 2007. The respondent denied 683 hours of private duty nursing.

1. During this certification period, the petitioner was fifteen years old. The petitioner condition is schizencephaly, convulsions and seizures. The petitioner is trach dependent, which requires suctioning. She is monitored for oxygen saturation. She has a G-tube for feeding and administration of medication. She requires repositioning every two hours. She resides with her mother, father and two siblings.

2. The nursing agency requested 960 hours of private duty nursing for the period of October 4 through December 2, 2007. The nursing agency provided information regarding the petitioner. The information included the petitioner complex medical condition, medication, status and synopsis of care. The nursing agency indicated that the father works two jobs and the mother works at home.

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 960 hours, 102 hours were approved and 858 hours were denied.

4. The nursing agency requested a reconsideration. KePRO review the new information received from the nursing agency of a change in the mother's work schedule and that the petitioner required a nurse when she attended school and for therapy. The nursing agency indicated that the petitioner attends school on Monday, Wednesday and Friday from 9:00 a.m. to 12 p.m. and has speech therapy on Monday and Wednesday from 3:00 to 3:30 p.m. A second physician consultant reviewed the documentation. Additional hours of private duty nursing were approved. Of the 960 hours originally requested, 277 hours were approved and 683 hours were denied.

3. The following evidence was attested to at the hearing. The petitioner's father works four jobs and is at work approximately 14 hours a day, seven days a week. During the week, he starts at 7:30 a.m. and gets home at 10:00 or 10:00 p.m. On weekends, he starts at 7:00 a.m. and get home at 9:00 p.m. The mother works approximately 35 hours a week. The mother also does volunteer work about 35 hours a week to offset the cost of activities for the petitioner's two siblings. The mother also has degenerative disk disease. She is restricted from lifting any weight. The mother's doctor provided a letter that states she can lift no more than 25 pounds. The mother unable to lift the petitioner who weighs approximately 75 pounds. The petitioner attends school on Monday and

Wednesday from 1:00 p.m. to 4:00 p.m. and Fridays from 9:00 a.m. to 12:00 p.m. There is a teacher in the home on Tuesday and Fridays from 4:00 p.m. to 6:00 p.m. The petitioner has therapy on Tuesdays and Thursday from 8:30 a.m. to 12:30 p.m. and speech therapy on Tuesday and Thursday from 1:30 to 2:00 p.m. The petitioner's mother submitted a home log of all of the petitioner's seizures from September through November 2007.

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...

Based on the information submitted by the provider the respondent was correct at the time of their decision that medical necessity for the request of 960 hours of private duty nursing was not met. As this is a de novo hearing, any additional evidence is considered. The hearing officer did not consider the hours the mother volunteers to offset the cost of activities for the other children. Those hours were not considered as those hours did not meet the definition of medical necessity. However, the evidence indicates that the nursing agency did not submit accurate information regarding the mother work hours, the mother's medical condition, the petitioner's requirement for repositioning, the frequency of the petitioner's seizure, the hours the petitioner attended school or when the petitioner received therapy. The respondent has not met their burden that a

reduction from 960 hours to 277 hours was medically necessary. Therefore, the respondent has failed to show that a reduction is demonstrated in this case.

DECISION

This appeal is granted in favor of the petitioner.

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 7th 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: [redacted], Petitioner
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting

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

APPEAL NO. 07F-6831

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 27, 2007, at 10:20 a.m., in Miami, Florida. The petitioner, , represented herself at the hearing. Representing the agency was Oscar Quintero, senior human services program specialist with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses was Dr. Marion Levy, medical director and Teresa Ashey, both with Keystone Peer Review Organization (KēPRO South).

ISSUE

At issue is the agency's November 7, 2007 denial of a prior authorization request for a "Total Abdominal Hysterectomy with Unilateral Salpingo-Oophorectomy, Abdominal Colposcopy, Insertion of Vaginal Sling" procedure with subsequent hospitalization from November 15th through November 18th, 2007. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner (age forty-two) is a beneficiary of the Florida Medicaid Program. The petitioner had been diagnosed with "myomatous uterus."

On November 2, 2007, the provider (physician) submitted to AHCA a prior authorization request for a pending "total abdominal hysterectomy with unilateral salpingo-oophorectomy, abdominal colposcopy, insertion of vaginal sling" procedure to be performed on November 15, 2007. The request included a total of three days inpatient hospitalization through November 18, 2007.

This request was reviewed by KēPRO, an organization under contract with AHCA that conducts medical reviews for Medicaid prior authorizations, for inpatient hospital medical services for Medicaid recipients in the state of Florida. This review is for determining medical necessity under the terms of the Florida Medicaid Program. KēPRO considered all clinical information made available to them by the provider on the petitioner's condition.

Upon review by a registered nurse reviewer, the clinical information submitted by the petitioner's physician did not meet the InterQual® criteria (procedures criteria used by first level reviewer). The request was referred to a physician consultant, board-certified in gynecology which documented, "Denied based on the information provided for this patient with fibroids and bleeding where conservative management has not been presented as having failed."

On November 7, 2007, the hospital, treating physician and petitioner were notified that the request was denied, stating in the notice, "Based on the information provided, it

has been determined that your medical care as described to us does not appear to require inpatient services."

KēPRO records documents several attempts to contact treating physician in an attempt to have him submit a reconsideration request with additional information needed on the conservative treatments done to decrease the bleeding, the outcome and what other procedures have been tried along with any contradiction in any of the treatments.

The denial was then reviewed by the medical director (Dr. Levy), which upheld the original denial and attempted to obtain information requested from the treating physician. Dr. Levy stated that the information was not provided therefore, they did not demonstrate medical necessity in order to approve the request. No reconsideration request was received. The hearing request was received by the Office of Appeal Hearings on November 28, 2007.

CONCLUSIONS OF LAW

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

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

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

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

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

Fla. Admin. Code 59G-4.150 Inpatient Hospital Services states as follows:

(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 Coverage and Limitations Handbook and the Florida Medicaid Provider Reimbursement Handbook, UB-92, both incorporated by reference in Rule 59G-4.160, F.A.C. Both handbooks are available from the fiscal agent contractor.

The Florida Medicaid Coverage and Limitations Handbook, Hospital Services (June 2005) states as follows:

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

> services are medically necessary. Certain types of admission, e.g., emergencies, are exempt from prior authorization by the PRO; other types do not require authorization to be admitted to the hospital, but the PRO must authorize the concurrent and continued inpatient stays. ...

The petitioner states that she continues bleeding and her condition is getting worse. She states that she will contact her physician in an attempt to have him provide the requested information to the respondent.

After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer finds that the medical consultant's decision to deny coverage for November 15, 2007 through November 18, 2007, due to insufficient documentation on medical necessity was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 14th day of January, 2008, in Tallahassee, Florida.

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

Copies Furnished To: Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 15 Indian River
UNIT: 88500

RESPONDENT.
_____/

APPEAL NO. 07F-05950

CASE NO. 1261939115

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on November 15, 2007, at 2:50 p.m., in Vero Beach, Florida. The petitioner was not present. His son, [redacted] represented him. Erika Delgado, economic specialist supervisor, represented the Department.

ISSUE

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

FINDINGS OF FACT

1. The petitioner is residing in [redacted] nursing facility. In February 2007, the petitioner was involuntarily removed from his home by court order and placed in a nursing facility. His family believed that the State would pay for his nursing home care because of information they received from the adult protective investigator at the time. An application for Institutional Care Program and Medicaid was submitted on his behalf on August 24, 2007 and retroactive benefits were requested.

2. The patient responsibility assigned to the petitioner was $377.76 according to the Notice of Case Action dated August 27, 2007 (Respondent's Exhibit 1). That figure was corrected to $377.71 during testimony.

3. The petitioner's wife is 84 years old and resides in the community and will be referred to as the "community spouse". The Department determines the community spouse allowance by a budgeting procedure that considers shelter and utility expenses as well as the community spouse's income. At the time of the application, her rent was $675. The Department uses the standard utility allowance of $198. Total shelter cost allowed is $873. The Minimum Monthly Maintenance Income Allowance (MMMIA) was set at $1712 effective July 1, 2007, and is based on federal law (Respondent's Exhibit 4. Thirty percent of that figure (30% X $1712), or $514, was deducted from the community spouse's shelter costs ($873) to determine an excess shelter cost amount of $359. The excess shelter amount is then added to the MMMIA ($359+$1712=$2071) for a beginning figure to determine the community spouse allowance. The community spouse's gross income of $871.80 was then subtracted from that figure to determine the community spouse's income allowance of $1199.20. The community spouse's income

consists of $116.67 pension, $16.85 interest, $.28 interest, and $738.50 from Social Security Retirement Income (Respondent's Exhibits 3, 9 and Respondent's Composite Exhibit 8).

5. To determine the patient responsibility, the Department began with the petitioner's (institutional spouse's) gross monthly income of $1611.91. That amount is a combination of $1245.50 Social Security, $298.35 AXA annuity, $57.60 Mellon Bank, and $10.96 from MetLife (Respondent's Composite Exhibit 6). From his income of $1611.91 a standard personal needs allowance of $35 was subtracted, and the community spouse's income allowance of $1199.20, leaving a patient responsibility of $377.71 (Respondent's Exhibit's 2 & 10). Medicaid pays his Medicare premium so no deduction was allowed for that expense.

6. The community spouse believes that she will not be able to meet her obligations in the community unless she is allowed to keep more of her institutionalized spouse's income. There is no dispute of the incomes and her shelter obligations. Her monthly expenses are: rent $675, car insurance $128, Medicare Supplement $186, medication co-pays $170, food $410, gasoline for her car of at least $135, telephone $80, electric $80 average, and miscellaneous $100.00. These monthly bills total $1964. The petitioner's son wants the patient responsibility waived so his mother can live in the community and see her husband. He asserts they were never told they would have a patient responsibility and his father now owes the nursing facility $2700 because his mother cannot pay the patient responsibility and afford to live in the community.

CONCLUSIONS OF LAW

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

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

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

After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income".

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

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

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

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

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

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

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

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

Subsequent to determining Medicaid eligibility for persons living in medical and remedial care institutions...determine how much such persons contribute to the cost of their institutional care and/or waiver services. This latter calculation is referred to as the post-eligibility process. This chapter sets forth requirements for the post-eligibility process for institutional persons...**3700.1 Background** – Section 1902(a)(17) of the Act is the general authority for the post-eligibility process. However, other provisions have been added to refine and clarify the rules governing this process...**3701 GENERAL STATEMENT OF POST-ELIGIBILITY PROCESS.** Reduce Medicaid payments to medical and remedial care institutions...by the amount remaining after specified deductions are made from the income of ***institutional persons***...Income remaining after these deductions are applied is the amount persons are liable to pay for institutional and/or waiver services...**3701.3 Determination of Amounts of Medical Expenses**.—In determining the amounts of the individual's liability for the costs of institutional care, certain required and optional amounts for medical or remedial expenses are deducted from the ***individual's*** income...Determine the amounts of the medical or remedial expenses to be deducted from total income...**3703.4 Maintenance Needs Of A Spouse At Home** – For an individual with only a spouse at home, deduct from the individual's total income an amount for the maintenance needs of the spouse. Base this amount on a reasonable assessment of the needs of the spouse, which includes consideration of the spouse's income and resources. The amount deducted for the needs of the spouse must be reduced dollar for dollar for each dollar of the noninstitutionalized spouse's own income...**3703.8 Expenses for Health Care:** Deduct from the ***individual's*** total income amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including: Medicare and other health insurance premiums, deductibles, or coinsurance charges; and Necessary medical or remedial care recognized under State law but not covered under the State plan, subject to reasonable limits the agency may establish on amounts of these expenses. **3710.1 Definitions**...**Exceptional Circumstances Resulting in Extreme Financial Duress.** Pending publication of regulations, a reasonable definition is: Circumstances other than those taken into account in establishing maintenance standards for spouses. An example is incurment by community spouses for expense for medical, remedial and other support services which contribute to the ability of such spouses to maintain themselves in the community and in amounts that they could not be expected to pay for amounts already recognized for maintenance and/or amounts held in resources...**3713 MONTHLY INCOME ALLOWANCES FOR COUMMNITY SPOUSES AND OTHER FAMILY MEMBERS...A. Spousal Monthly Income Allowance.** Unless a spousal support order requires support in a greater amount, or a hearings officer has determined that a greater amount is needed because of exceptional

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

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

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

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

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

Spousal Impoverishment Income Standards

Minimum Monthly Maintenance Needs Allowance (MMMIA):

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

Excess Shelter Standard:

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

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

The Department's budgeting methodology, as outlined in the Findings of Facts and in the Respondent's Exhibits 2 and 3, correctly reflects the budgeting methodology set forth in the above authorities in calculating a possible spousal income diversion allowance. However, Florida Administrative Code permits possible adjustment to this

methodology and the resulting spousal diversion amount, if proof is presented of exceptional circumstances that result in financial duress.

The petitioner's son argued that his mother has additional expenses due to her medical expenses and the patient responsibility causes a financial hardship.

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

No evidence of exceptional circumstances causing financial duress to the community spouse has been presented. The community spouse is able to keep her income of $871.80 plus $1199.20 diverted from her institutionalized spouse, which totals $2071.00. Her expenses as presented total $1964. This total includes monies she spends on prescription co-pays and Medicare supplements. As her total income exceeds her expenses, the undersigned cannot find that any additional funds should be diverted to the community spouse. No provision could be found to allow a deduction for car insurance or gasoline expenses. No mathematical errors were found in the calculation of the petitioner's patient responsibility.

DECISION

The appeal is denied and 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 7th day of January, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
15 DPOES, Judy Sickles
Erika Delgado
[redacted]

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

[redacted]

APPEAL NO. 07F-06221

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 6, 2007, at 10:14 a.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was present, but was represented at the hearing by the petitioner's mother, [redacted]. Also present on behalf of the petitioner were [redacted], director of clinical services; [redacted] case manager and [redacted], nurse (LPN), all from the petitioner's provider, or home health agency; [redacted] The Agency was represented by Sandra Moss, administrator from the Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the Agency was Mary Wheeler, review operation manager from KePRO. KePRO is located in Tampa, Florida. A continuance was granted

on behalf of the petitioner for a hearing previously scheduled on November 20, 2007.

Maria Hernandez was present as an observer.

ISSUE

At issue is the Agency's action of October 2, 2007 and again on reconsideration on October 21, 2007, to reduce the petitioner's request for continued private duty nursing services a total of 54 hours, for the period of September 21, 2007 through November 19, 2007. The reduction of hours totals three hours a day from 8:00 p.m. to 11:00 p.m., for Saturdays and Sundays, of the above service. The Agency has the burden of proof.

FINDINGS OF FACT

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

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on October 2, 2007, that the petitioner's request for about 1,040 hours of private duty nursing was going to be denied/reduced to 986 hours for the period of September 21, 2007 through November 19, 2007. The hours that were reduced or denied were for two days a week (Saturday and Sunday) from 8:00 p.m. to 11:00 p.m.

3. A reconsideration of the above was requested by the petitioner's representative(s). KePRO upheld the above decision of October 21, 2007.

4. KePRO's decision was based on the information provided by the petitioner's provider or home health agency as part of the request for the service. KePRO determined that petitioner's mother, though being employed and a single mother; taking care of another child with similar problems; is quite capable of caring for the petitioner for the hours of 8:00 p.m. to 11:00 p.m., Saturdays and Sundays.

5. The information provided by the petitioner's provider had indicated that on Thursdays, after the petitioner's mother's employment, the petitioner's mother was taking care of the petitioner without the nursing assistance. The petitioner's representative and mother indicated, at the hearing, that the petitioner was recently approved for the Medicaid Waiver Program and that the "Waiver" was providing a "service aide" for the petitioner on Thursdays, otherwise she could not, by herself, take care of the petitioner. The petitioner's provider, KePRO and the Agency representative indicated that until now, they were not aware the petitioner receives the services through the Medicaid Waiver Program.

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

CONCLUSIONS OF LAW

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

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

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

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

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

Fla. Admin. Code 65-2.056 sets forth the basis of hearings and states in part:

3) The Hearing Officer must determine whether the department's decision on

eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision.

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

The Agency, through KePRO, took action on reconsideration on October 2, 2007 to reduce the petitioner's request for continued private duty nursing services by 54 hours of the service for the period of September 21, 2007 through November 19, 2007. The reduction amount, was for the hours of 8:00 p.m. to 11:00 p.m., Saturdays and Sundays. This decision was based on the information as provided by the petitioner's nursing service and the petitioner's medical necessity need of the request for the service.

The petitioner's representative argued that the petitioner is in need of the three hours of the nursing service as she herself cannot medically take care of her son. She also argued that she is overwhelmed by her living circumstance and that she alone cannot take care of the petitioner. She argued that she has a service aide supplied to her from the Medicaid Waiver Program who assists her on the day that the Agency understood that she took care of the petitioner by herself. The respondent argued that the home health agency can submit another request for services and supply any updated information about the petitioner and his mother's overall situation. The home health agency/petitioner's representative agreed to do so.

The respondent reiterated and argued that based on the information provided, the Agency action remains correct. As indicated in the above noted Fla. Admin. Code Rule, this hearing is de novo. The petitioner's mother has provided relevant and creditable testimony indicating she is unable to care for the petitioner without assistance. This testimony included the fact that on Thursday when KePRO believed the representative was caring for the petitioner there was a helper in the home paid for by a Medicaid Waiver Program. This information was unavailable to KePRO's experts when making their determination. As that determination was not based the petitioner's actual situation, it can only be given limited weight.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer finds that the Agency has not met its burden of proof and that the Agency's action of October 2, 2007, to reduce the petitioner's request for continued private duty nursing services for the 54 requested hours of the service for the period of September 21, 2007 to November 19, 2007, which was for the three hours a day, for Saturdays and Sundays from 8:00 p.m. to 11:00 p.m., is not supported by the record.

DECISION

This appeal is granted and the Agency's action is not upheld.

NOTICE OF RIGHT TO APPEAL

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

law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 30th day of January, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

[redacted]

APPEAL NO. 07F-06198

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 11:10 a.m., in Tampa, Florida. The petitioner was present. He was represented by his mother, [redacted] Present on behalf of the petitioner from [redacted] Health Care were [redacted] register nurse supervisor, and [redacted] register nurse. The respondent was represented by David Beaven, health program analyst. Witness for the Agency from Keystone Peer Review Organization (KePRO South) were [redacted], physician reviewer, and Mary Wheeler, manager of review operations.

ISSUE

The petitioner is appealing the respondent's denial of 155 hours and the designated hours of private duty nursing service as approved for 848 hours for the period of August 16, 2007 through October 14, 2007.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Denial Letter dated September 4, 2007. The nursing agency requested 1,003 for the petitioner based on the mother's flex work scheduled. Of the requested hours, 848 hours were approved and 155 hours were denied. The petitioner's mother is disputing how KePRO allocated the service hours approved.

1. The petitioner is two years of age and is a Medicaid recipient. The petitioner's care is medically complex. He was receiving private duty nursing 17 hours a day. The private duty nursing is provided by [redacted] Healthcare Services. [redacted] Healthcare Services, as the provider, submitted a request for 1003 hours of private duty nursing for the period of August 16, 2007 through October 14, 2007. The petitioner resides with his mother, the only parent in the home. The mother works in a restaurant and her hours change every week.

2. The Agency 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 hours worked by the mother in the previous week were:

Mondays	3:00pm to 12:00am
Tuesdays	11:00am to 12:00am
Wednesdays	3:00pm to 12:00am

Thursdays	8:00am to 7:00pm
Fridays	8:00am to 11:00pm
Saturdays	9:30am to 12:00am
Sundays	8:00am to 7:00pm

Based on the documentation, the physician consultant approved 848 hours for the period of August 16, 2007 through October 14, 2007. The hours approved were based on the work schedule indicated by [redacted] The 848 hours for the period of August 16, 2007 through October 14, 2007 were approved as follows:

Mondays	10 hours
Tuesdays	14 hours
Wednesdays	10 hours
Thursdays	17 hours
Fridays	17 hours
Saturdays	17 hours
Sundays	13 hours

2. A reconsideration was requested. The request was for the 848 for the period of August 16, 2007 through October 14, 2007 be "flex" hours as the mother works a flexible schedule that changes every week. For the reconsideration, the request was reviewed by a second, different, physician consultant. The physician consultant's response was that KePRO cannot authorize flex hours. The manager of review operation attested that KePRO does not have the authority to flex hours. The provider can submit the mother's work schedule every two weeks for modification of the decision.

3. The petitioner's mother is not disputing the 848 hours approved or the 155 hours denied for the period of August 16, 2007 through October 14, 2007. The 848 hours would be 98 hours a week 848 for the period of August 16, 2007 through October 14, 2007. She is disputing how the 98 hours were designated

by KePRO. She works in a restaurant and works the hours need by the restaurant. She was working 80 hours a week, but since approximately the time of the review period was demoted and is working 40 to 55 hours a week. The most hours she would work would be 55 hours. She is requesting that the 98 weeks hours be flexible so that she can work as much as she can when nursing care can be provided to her son. If the hours cannot be flexed, the better distribution of the hours would be better if the nursing was approved for the days she was most likely to work double shifts:

Mondays	10 hours
Tuesdays	10 hours
Wednesdays	10 hours
Thursdays	17 hours
Fridays	17 hours
Saturdays	17 hours
Sundays	17 hours

If the hours cannot be flexed or changed, she then disputes the denial of the 155 hours, as she would need those hours to cover days when she was working a double shift.

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...

I. As to the issue of the denial of 155 hours for the period of August 16, 2007 through October 14, 2007.

The request was for 1,003 hours. As the petitioner works a flexible weekly schedule that would be approximately 125 hours a week for the period of August 16, 2007 through October 14, 2007. The petitioner works 40 to 55 hours a week. The respondent approved 848 hours and denied 155 hours for the period of August 16, 2007 through October 14, 2007. The evidence as submitted did not demonstrate medical necessity for 1,003 hours for the period of August 16, 2007 through October 14, 2007. The respondent's action to deny 155 hours was within the rules of the Program.

II. As to the issue of flexing the approved hours and the allocation of the 848 hours approved for the period of August 16, 2007 through October 14, 2007.

The Home Health Services Coverage and Limitations Handbook set forth the content and limitation on approvals in Chapter 2 "Prior Authorization for Private Duty Nursing or Personal Care" (page 2-30):

> Content and Limitations on Approved Requests
>
> The approval of services is accessed via the Internet system and specifies:
> - Procedure code;
> - Units of service authorized;
> - Dates of service;
> - The discipline authorized to provide the service; and
> - The number of days for which the prior authorization is valid.

As medically necessity was not demonstrated for the 1,003 hours for the period of August 16, 2007 through October 14, 2007, the hearing officer reviewed the petitioner's request for flexible hours and the allocation of the 848 hours approved. Based on the documentation, the physician consultant approved 848 hours of private duty nursing for the period of August 16, 2007 through

October 14, 2007. The petitioner agrees with the 848 hours, if they were allocated to the days the petitioner needed the hours. The respondent did not submit any rule or policy that sets forth a requirement for specificity of hours approved for private duty nursing. The respondent statement that the hours must be specified was not supported by rule or policy. The PDN/PC Recipient Denial Letter dated September 4, 2007 does not specify any hours. Therefore, the respondent action to assign specific hours is not consistent with rule or policy. The petitioner appeal as to the assignment of hours is granted for 848 hours of private duty nursing for the period of August 16, 2007 through October 14, 2007. Any flexing of hours would need to be arranged between the petitioner and the nursing agency.

DECISION

This appeal is as follows.

1. As to the issue denial of 155 hours for the period of August 16, 2007 through October 14, 2007, the appeal is denied.

2. As to the issue of the designated hours of private duty nursing service as approved for 848 hours for the period of August 16, 2007 through October 14, 2007, the appeal is granted.

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

DONE and ORDERED this 7th 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: [redacted] Petitioner
District 7 ACCESS Cassandra Johnson

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

[redacted]

APPEAL NO. 07F-06509

PETITIONER,

Vs.
FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 St. Johns
UNIT: ICP

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Saint Augustine, Florida, at 10:25 a.m. on December 12, 2007. The petitioner was present and was assisted by her daughte[redacted] [redacted]and granddaughter[redacted] The respondent was represented by Jackie Haynes, ACCESS supervisor.

ISSUE

At issue was whether patient responsibility was correctly determined in the Institutional Care Program (ICP) of Medicaid. The petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner was approved for ICP coverage during the year 2007, but disavowed receipt of Department notices of case action informing as to patient

responsibility amount. The respondent agreed there might have been a notification problem.

2. Additionally, the respondent noted the patient responsibility was set too high, as the insurance payments were not correctly used to decrease patient responsibility.

3. Corrective action by the Department had not occurred prior to the hearing.

4. The hearing request was not withdrawn.

CONCLUSIONS OF LAW

Florida Administrative Code 65-2.060 (1), regarding evidence at administrative hearings for the Department, informs as follows:

> 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.

Because of this rule, the petitioner has the burden of proof and in order to prevail must meet such a burden. As the respondent's representative determined that notice may have been incorrectly issued and the respondent's representative confirmed that patient responsibility was calculated at an excessively high amount, it is evident the burden has not been met. However, as the hearing request was not withdrawn, a final order must be issued.

It is concluded, based upon declaration of the respondent's representative, that patient responsibility was too high. The respondent shall take whatever administrative action is needed to remedy the problem and shall use the correct address of the

petitioner for any correspondence sent to her. Any final disposition of case action would be appealable in customary administrative practice of the respondent.

DECISION

The appeal is granted and corrective action shall proceed.

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.

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

Copies Furnished To: [redacted], Petitioner
12 DPOES: Theola Henderson

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

[redacted]

APPEAL NO. 07F-06500

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 8:45 a.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by his mother [redacted] Also present was [redacted] administrator nurse practitioner from [redacted] Home Care, Inc. 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 Mary Wheeler, review operations manager.

ISSUE

At issue is the Agency's September 28, 2007 action of approving the petitioner's skilled home nursing services for 1,107 hours for September 19, 2007 to November 17, 2007. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, date of birth [redacted], is seven years old, and he is a Medicaid benefits recipient in Broward County, Florida. He receives skilled home nursing services from the [redacted] Pediatric Home Care, Inc. Included in the evidence is a copy of a Recipient Denial Letter, dated September 20, 2007, stating that 953 hours of skilled home nursing services were approved, and 283 hours were denied for him for September 19, 2007 to November 17, 2007.

Included in the evidence is a copy of a Recipient Reconsideration Denial Overturned notice, dated September 28, 2007. This notice informs the petitioner that upon reconsideration, 1,107 hours of skilled home nursing services were approved, and 129 hours were denied for September 19, 2007 to November 17, 2007. The notice explains that it was determined by Kepro that the medical care of the skilled home nursing services of 1,107 hours was determined to be medically necessary.

Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner, dated September 18, 2007, stating that the petitioner was diagnosed with chronic respiratory failure, other convulsions, anoxic brain damage, and infantile Cerebral Palsy, unspecified. He has developmental delay, functional limitations in endurance, ambulation, and speech. He has paralysis, and is incontinent in bowel and bladder. He uses a wheelchair, a pulse OX oximeter, a suction machine, a catheter, a feed pump, a nebulizer, and a gastrostomy tube. He requires oxygen, and is dependent on bronchodilators frequent suctioning.

Included in the evidence is a copy of a Kepro Synopsis of Case Report, concerning the reconsideration, dated September 28, 2007. This reconsideration was done by a

second Kepro physician consultant board certified in pediatrics, who did not issue the initial denial. This was done by Dr. Buzzeo, who took into consideration the petitioner's parents work schedules. The petitioner previously received skilled nursing services of 24 hours daily Monday through Friday, and 12 hours daily Saturday and Sunday.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. Fla. Admin. Code 59G-1.010 states in part:

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

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. The petitioner's skilled home nursing services was approved for 1,107 hours, and denied for 129 hours for the time period of September 19, 2007 to November 17, 2007. It was determined by Kepro that skilled home nursing services of 1,107 hours was medically necessary for the petitioner during that time.

The Agency's determination takes into account what is medically necessary for the petitioner, and his parent's availability to help care for him. The physician that testified at the hearing asserted the medical necessity of 1,107 hours of skilled home nursing care for the petitioner during that time. After careful consideration of the proper authorities and evidence, including the petitioner's diagnosis and condition, it is determined that the Agency's action of the skilled home nursing services, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 14th day of January 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Gail Wilk, Area 10 Medicaid Adm.

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

[redacted]

APPEAL NO. 07F-05523

PETITIONER,

Vs.

CASE NO. 1004916922

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 08 Charlotte
UNIT: 88634

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 15, 2007, at 9:45 a.m., in Port Charlotte, Florida. The petitioner was not present. She was represented by her guardian [redacted]. The respondent was represented by Debbie Sloan, economic self-sufficiency specialist. Present as a witness for the petitioner was her support coordinator with the Children's Home Society, Judy Munro.

ISSUE

At issue is the July 30, 2007 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program for the months of March, April, and May 2007.

FINDINGS OF FACT

1. On May 21, 2007, the petitioner filed a Request for Assistance to apply for benefits through the Institutional Care Program as she resided in a nursing facility. The respondent requested verification of the petitioner's assets.
2. The respondent determined that the petitioner had a timeshare and funds in a bank account. She has a guardian who became incapacitated in June 2007. At this point, the respondent considered the petitioner's funds in the bank account as unavailable along with the timeshare property. The unavailability was due to the fact that none of the petitioner's assets were available until a new guardian could be appointed.
3. On July 30, 2007, the respondent approved the petitioner for benefits through the Institutional Care Program beginning in June 2007. The respondent denied her application for the months of March, April, and May 2007 as the funds in her bank account were between $6,281.21 and $11,161.84 at the end of each of those months. The respondent determined that these amounts exceeded the $2,000 asset limit for the Institutional Care Program without even considering the value of the timeshare. Therefore, the respondent denied the petitioner's application for benefits for those months due to assets exceeding program limits.
4. The petitioner does not dispute the value of the bank accounts as presented by the respondent. The petitioner owed the nursing facility for the months of March, April, and May 2007 a total of $22,428.77. If part of

that bill had been paid, then her funds would have fallen below the $2,000 asset limit.

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.303 in part states

> Assets. (1) Specific policies concerning assets vary by program and are found in the program specific rule sections and codes of federal regulations. In general assets, liquid or non-liquid, are resources or items of value that are owned (singly or jointly) or considered owned by an individual who has access to the cash value upon disposition. Assets of each member of the SFU must be determined. A decision of whether each asset affects eligibility must be made. (2) Any individual who has the legal ability to dispose of an asset owns the asset...(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility on the factor of assets. Assets are considered available to an individual when the individual has unrestricted access to the funds. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for the individual's support and maintenance, even though the individual chooses not to do so...

Fla. Admin. Code 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant part:

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C.

Fla. Admin. Code 65A-1.716, Income and Resource Criteria, states in relevant part.

> (5) SSI-Related Program Standards.
> (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:

1. $2000 per individual.

The evidence establishes that the petitioner had funds in a bank account and owned a timeshare in the months of March, April, and May 2007. These funds exceeded the $2,000 asset limit for the Institutional Care Program. This is not disputed by the petitioner. However, the petitioner argues that these funds were owed to the nursing facility and should therefore be excluded. There is no provision for this consideration in the above-cited rules. Therefore, the respondent correctly determined that the petitioner did not qualify for the Institutional Care Program due to assets exceeding program limits.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of January 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
8 DPOES: Roseann Liriano
[redacted]

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

APPEAL NO. 07F-06626

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 21, 2007, at 1:36 p.m., in Tampa, Florida. The petitioner was present, telephonically. The respondent was represented by Ron Besalke, senior human services program specialist. Present as witness for the respondent was Donnette Waul-Santiango, senior human services program specialist. Present telephonically as witness for the respondent were Doug Harper, contract management overseer for ACHA; Kevin Murdy, manager, MMG Transportation; and Lisa Bacot, executive director for the Commission for the Transportation for the Disadvantaged. Michael McKenzie, Medicaid ombudsman, was observing.

The record was left open until December 31, 2007 for any additional evidence. As of December 31, 2007, no additional evidence was received. The record was closed on December 31, 2007.

ISSUE

The petitioner is appealing the denial of transportation on or about November 8, 2007.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient. The petitioner is disabled and weighs approximately 603 pounds. She cannot move her legs. She needs special transportation as she is too big for a regular van and she cannot move her legs. She needs transportation to for doctor appointments. On or about November 8, 2007, she requested transportation to a doctor appointment. She was just out of the hospital and needed a biopsy. She was verbally told no transportation was available and the only dates offered were in December 2007.

2. The respondent contract transportation for certain Medicaid recipient with the Florida Commission for Transportation for the Disadvantaged. In each county, the Commission enters into a sub-contract with a local transportation company. In Hillsborough County, transportation is sub-contracted to MMG Transportation.

3. The respondent's position is that MMG Transportation should have provided the transportation.

4. The contract management overseer attested that the trip was authorized. The petitioner was to receive the transportation. He cited the

Transportation Coverage, Limitation and Reimbursement Handbook, "Trip Limits" (pages 9-7). He opined that under the contract the only time a written referral is required is when the trip request is out of the areas. He opined that the commission does not have the authority to interpret policy.

5. The executive director of the commission attested that the sub-contractor followed the handbook directive. The transportation was denied on that day as the daily allocation was met. She cited the Transportation Coverage, Limitation and Reimbursement Handbook, "Documentation Requirements" (page 7-3). To have transportation when the daily allocation was already met, the petitioner would have needed to provide a letter of medical necessity from her physician. The executive director requested that the record be left open for additional evidence. The motion was granted to the extent that the executive director was a witness for the respondent. No additional evidence was received.

6. The MMG representative did not remember the date of the request only that it was sometime in November. The only dates available for transportation were in December has the daily trip limits for every other day in the month of November had been met. He opined that the petitioner either needed a doctor's note or could have selected a date in December. No written denial was given to the petitioner.

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 hearings

pursuant to Chapter 120.80 F.S. The Florida Administrative Code at 59G-4.330, "Transportation Services", indicates the handbook as promulgated into rule.

The petitioner requested transportation service on or about November 8, 2007. The respondent attested that the transportation was authorized. The respondent attested that the contract between the commission and the respondent only states that a doctor's note of medical necessity is only required when the trip is out of the area. The dispute appears to be a contract dispute. The hearing officer has no authority in contract disputes. As transportation service has been authorized, the hearing officer has no further jurisdiction in this issue.

DECISION

This appeal is dismissed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th 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: [redacted] Petitioner
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting

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

[redacted]

APPEAL NO. 07F-05796

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 4, 2008, at 3:50 p.m., in Tampa, Florida. The petitioner was not present. He was represented by his mother, [redacted] The respondent was represented by David Beaven, health care program analyst. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were [redacted] M.D., physician reviewer, and [redacted] R.N., nurse reviewer.

ISSUE

The petitioner is appealing the notices of September 7 and 15, 2007 for the respondent's action to deny 240 hours of private duty nursing for the period of September 2, 2007 through October 31, 2007. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Reconsideration - Denial Upheld notice on September 15, 2007. The notice informed the petitioner that for the requested 720 hours of private duty nursing for the period of September 2, 2007 through October 31, 2007, 240 hours were denied.

1. The petitioner care is medically complex. He was receiving private duty nursing private duty nursing twelve hours a day. The petitioner resides with his mother and grandparents. The mother is not working. The petitioner's sibling has left the home. There are no other children in the home. The mother has been trained in the petitioner's care. The grandparents do not participate in the petitioner's care.

2. The nursing agency requested 720 hours of private duty nursing for the petitioner for the period of September 2, 2007 through October 31, 2007. This request would be twelve hours a day of private duty nursing.

3. Prior authorization for private duty nursing is reviewed every 60 days. KePRO is the contract provider for the respondent for the prior authorization decisions for private duty nursing. The request for private duty nursing is reviewed by a nurse reviewer and a physician consultant.

4. The initial nurse reviewer screened the petitioner's request for private duty nursing using the Internal Focus Finding. The Internal Focus Finding provides information to KePRO of case identifiers and additional information regarding the petitioner. This information is generated to the computer for review by KePRO from the information entered by the petitioner's home health agency

via computer. The request was then referred to the board certified physician consultant.

5. The initial physician consultant determined was based on the information received from the nursing agency. The initial physician consultant determined that based the mother was capable of caring for the petitioner. A PDN/PC Recipient Denial Letter was sent to the petitioner on September 7, 2007. The notice informed the petitioner that for the requested 720 hours of private duty nursing for the period of September 2, 2007 through October 31, 2007, 480 hours was approved and 240 hours were denied.

6. The nursing agency requested a reconsideration. The reconsideration was reviewed by a second physician consultant. The reconsideration was denied for the 240 hours of private duty nursing. The respondent sent a PDN/PC Recipient Reconsideration - Denial Upheld notice on October 25, 2007.

7. The mother attested that even though she is not working, she is busy all the time making appointments and taking the petitioner to appointments. She needs the twelve hours of private duty nursing, as the extra hours are a help to her.

CONCLUSIONS OF LAW

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

Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code.

The Program is administered by the Agency for Health Care Administration.

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

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

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

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

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The denial is based on the availability of the mother. The mother is capable of caring for the petitioner. The parent is not working and has no other children in the home to care for. The mother attested that the hours are a help to her. The rule specifically states that the service must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. Based on the above cited authorities, the respondent's action to deny 240 hours of private duty nursing for the period of September 2, 2007 through October 31, 2007 was within the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th 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: [redacted], Petitioner
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting
Mary Wheeler, KePRO review manager

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

[redacted]

APPEALS NO. 07F-06202

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 29, 2007, at 9:45 a.m., in Lakeland, Florida. The petitioner was present. He was represented by his mother, [redacted] The agency was represented by Dena Gay, R.N., and David Beaven, program analyst. Present as a witness for the petitioner was [redacted] LPN. Present as witnesses for the agency telephonically from KePRO were Mary Wheeler, regional operations manager; and [redacted], M.D., physician reviewer.

ISSUE

1. The petitioner receives private duty nursing (PDN) services through his state plan Medicaid. The Agency for Health Care Administration contracts with Keystone Peer Review Organization (KePRO South) to perform the medical peer review for the Private Duty Nursing and Personal Care Prior

Authorization Program for Medicaid beneficiaries in the State of Florida. They review to determine "medical necessity" under the terms of the Florida Medicaid Program. On October 4, 2007, the petitioner filed a request for private duty nursing hours eight hours per day, Monday through Friday.

2. The petitioner is eight years old and has spastic cerebral palsy. He has seizures, microcephaly, GERD, and a gastronomy tube. His condition has remained stable the last few months. He receives home bound schooling, occupational and physical therapy. The petitioner receives nebulizer treatments and suctioning as needed.

3. The petitioner lives with his parents, and two siblings, ages 6 and 13. His father is not currently working but goes out looking for work. The mother volunteers at her church every morning until noon.

4. On October 7, 2007 a physician reviewer noted that:

   Mom is healthy now. Hoyer lift at home. Parents are trained in pt's care. The siblings should be in school during the requested hrs. Dad is currently not employed though is looking for job. I would deny this request as parents can provide the necessary care." The physician reviewer issued a denial letter for the requested private duty nursing hours.

5. On October 8, 2007, the petitioner submitted the following note:

   Requesting reconsideration of hours. Mom stated that the client has a tremendous amount of spasms, and is total care. He is on Advair for respiratory problems ad accumulation of phlegm due to the fact that the patient is unable to swallow so he requires constant suctions. She also stated that he is restless during the night. Mom is looking forward to going back to work during the day from 8 am to 2 pm, Monday through Friday, as soon as the agency calls her back to work. Dad is still seaching for work. Mom is up

during the night off and on with the client and runs errands during the day while nurse is present and she also assist the nurse to and from any therapy because client can't be transported alone due to constant suctioning. Thank you.

6. On October 9, 2007, a second KePRO physician reviewer conducted the reconsideration. He determined that both parents were available at different parts of the day to care for the child independently. If and when either parent obtains employment, a new request for PDN hours could be submitted. The reviewer found that the clinical and social information which was provided did not support the level of care for PDN services. A denial of the reconsideration request was issued on October 10, 2007.

7. The mother indicated that the petitioner needs lifting 6-8 times in an eight hour shift. He requires 5-6 diaper changes and 24 hour suctioning. He has muscle spasms that can last 15-20 seconds. The father does not normally feed the petitioner.

CONCLUSIONS OF LAW

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

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

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The Florida Administrative Code at 59G-4.290(2)(f) discusses Skilled Services and states in relevant part:

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

The Home Health Services Coverages and Limitations Handbook states in relevant part on pages 2-15 and 2-16:

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

Medicaid reimburses private duty nursing services for recipients under the age of 21 who:
- Have complex medical problems; and
- Require more individual care than can be provided through a home health nurse visit.

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

Private Duty Nursing Requirements

Private duty nursing services must be:
- Ordered by the attending physician;
- Documented as medically necessary;
- Provided by a registered nurse or a licensed practical nurse;
- Consistent with the physician approved plan of care; and
- Authorized by the Medicaid service authorization nurse.

Parental Responsibility

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

Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver. Medicaid does not reimburse private duty nursing for respite care. Examples are parent or caregiver recreation, socialization, and volunteer activities.

The evidence establishes that the petitioner requested PDN hours. The number of PDN hours approved is determined through the peer review process by a Kepro physician reviewer. The request under review was for eight hours of PDN services five days per week. The original request was denied as was the request for reconsideration. The petitioner's parents are not working. The father looks for work and the mother volunteers at her church. However, both are available for the child's care. They could alternate their activities while still providing for his care. The evidence supports that the private duty nursing hours are more for the convenience of the parents than for the medical needs of the

child. Therefore, the agency correctly denied the hours requested due to lack of "medical necessity" for the child.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 14th day of January 2008, in Tallahassee, Florida.

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

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

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

[redacted]

APPEAL NO. 07F-06499

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 09 Palm Beach
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 17, 2008, at 8:18 a.m., in [redacted] Florida. The petitioner was not present. Representing the petitioner was her mothe[redacted] [redacted] Representing the respondent was [redacted] management analyst, Agency for Health Care Administration (AHCA). Appearing as witnesses, telephonically at their request, were [redacted] M.D., physician reviewer KePro; and [redacted] registered nurse, KePro.

ISSUE

At issue is whether the respondent was correct in reducing private duty nursing hours (PDN) from 12 hours per day Saturday and Sunday to 8 hours per day. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a nine year old (DOB [redacted] recipient of Medicaid services. She is diagnosed with chronic respiratory failure, convulsions, and other dyspnea and respiratory abnormalities. She is on a ventilator, has a trach, and is fed through a g-tube. She requires assistance with all her activities of daily living (ADL). Her medications include Topamax, Klonopin, Lamictal, Valium, Valporic acid, Pulmicort, Albuterol, Diastat, Motrin, and Tylenol.
2. As part of the eligibility determination process for services, medical progress reports are forwarded to KePro for review. KePro is the organization contracted by AHCA to perform these reviews.
3. KePro reviewed the submitted reports September 21, 2007. On October 7, 2007 KePro denied the total PDN hours for Saturday and Sunday because the mother was home on the weekends.
4. Subsequently, a reconsideration was submitted October 9, 2007. On October 14, 2007 the physician reviewer authorized 8 hours each Saturday and Sunday, reducing the total by 4 hours each day.
5. The petitioner has been receiving 12 hours daily of PDN for at least the past 4.5 years. There are no other family members that can assist the mother.
6. The mother has been attempting to obtain additional Medicaid benefits through the Waiver Program but has yet to have these authorized. She presents that her daughter's condition is worsening.

7. In this regard on October 16, 2007 requests were submitted by the Provider (Maxim) that because the child's condition is worsening it is recommended that 24 per day care should be given. KePro had requested additional medical and social information that has yet to be forthcoming.
8. This request for additional hours came subsequent to the original submission for a hearing.

CONCLUSIONS OF LAW

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

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

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

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

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care,

be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

Home Health Services Coverage and Limitations Handbook July 2007 Covered Services, Limitations, and Exclusions states in part:

Private Duty Nursing Definition

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

Who Can Receive Private Duty Nursing

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

Have complex medical problems; and

Require more individual care than can be provided through a home health nurse visit.

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

Private Duty Nursing Requirements

Private duty nursing services must be:

Ordered by the attending physician;

Documented as medically necessary;

Provided by a registered nurse or a licensed practical nurse;

Consistent with the physician approved plan of care; and

Prior authorized before services are provided.

Parental Responsibility

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

Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.

Medicaid does not reimburse private duty nursing for respite care. Examples are parent or caregiver recreation, socialization, and volunteer activities.

Authorization Process

Private duty nursing services are authorized by the Medicaid peer review organization if the services are determined to be medically necessary.

Private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child's condition improves.

Prior Authorization

All private duty nursing services must be prior authorized by the Medicaid peer review organization prior to the delivery of services.

In this instant case and pursuant to the requirements of the Handbook, the parent is responsible to the greatest degree in the care of her child. The mother testified that she is capable of caring for her daughter.

Although she is employed full time, she is available to administer care on the weekends. In reconsideration KePro has re-authorized 8 hours of PDN care each Saturday and Sunday.

This may initially be difficult but it is within parameters of the parental responsibility.

DECISION

The appeal is denied. The respondent's action is affirmed. As noted the petitioner has submitted additional documents that are requesting even more hours. KePro requires more medical and social information before it will make a judgment on the request.

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 24th day of January 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Mark Pickering, Area 9 Medicaid Adm.
David King

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

[redacted]

APPEAL NO. 07F-05816

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 30, 2007, at 11:38 a.m., in [redacted] Florida. The petitioner was present. He was represented by her mother, [redacted] Witnesses for the petitioner from [redacted] Health Care were [redacted] L.P.N., [redacted] clinical supervisor, and [redacted] L.P.N. Observing was [redacted] Health Care case manager. The respondent was represented by [redacted] health care program analyst and [redacted] nurse specialist. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were [redacted] M.D., physician reviewer. [redacted], R.N., KePRO manager of review operations was observing.

ISSUE

The petitioner is appealing the notice of September 19, 2007 for the respondent's action to deny 160 hours of private duty nursing for the period of September 3, 2007 through November 1, 2007. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Denial Letter on September 19, 2007. The notice informed the petitioner that for the requested 920 hours of private duty nursing for the period of September 3, 2007 through November 1, 2007, 160 hours were denied.

1. The petitioner is two years old with the development of a one year old baby. The petitioner care is medically complex. He was receiving 1,080 hours private duty nursing private duty nursing for the period ending September 2, 2007. The petitioner resides with his mother. The mother works as a school teacher.

2. The nursing agency requested 1,080 hours of private duty nursing for the petitioner for the period of September 3, 2007 through November 1, 2007. The request was on the basis that mother works Monday through Friday and is required to go to occasional attends required workshops on weekends. This request would be eighteen hours a day of private duty nursing.

3. Prior authorization for private duty nursing is reviewed every 60 days. KePRO is the contract provider for the respondent for the prior authorization

decisions for private duty nursing. The request for private duty nursing is reviewed by a nurse reviewer and a physician consultant.

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

5. The initial physician consultant determined was based on the information received from the nursing agency. The hours requested were from 7:00 a.m. to 5:00 p.m. and 11:00 p.m. to 7:00 a.m., seven days a week. The initial physician consultant determined that the mother was capable of caring for the petitioner on weekends. From the hours requested, the denial was for the hours of 7:00 a.m. to 5:00 p.m. on Saturday and Sundays. A PDN/PC Recipient Denial Letter was sent to the petitioner on September 16, 2007. The notice informed the petitioner that for the requested 1,080 hours of private duty nursing for the period of September 3, 2007 through November 1, 2007, 920 hours was approved and 160 hours were denied.

6. The nursing agency did not request a reconsideration and did not provide any additional information. As a Fair Hearing was requested, KePRO did a reconsideration. The reconsideration was denied.

7. The petitioner's mother attested that she is required to attend some workshops on some Saturdays from 8:00 a.m. to 3:00 p.m. to maintain her employment and other workshops are for personal growth. The mother did not indicate the frequency of the workshops were or the location of the workshops. During the week, she works until 3:30 p.m., cares for the petitioner from 5:00 pm. to 11:00 p.m. and sleeps and cares for herself from 11:00 p.m. to 7:00 a.m. She uses the nursing hours that she is not attending workshops on weekends to take care of the home and shop. She only has six "sick days" at work and cannot miss work when a nurse does not come to the home. She uses her sick days to take the petitioner to the doctor. The petitioner requires constant, total care and monitoring. Both the petitioner and the mother had surgery in October 2007. The petitioner had stent placement in October 2007. The stent was placed to build an airway. The mother was not specific as to the nature of her surgery.

8. Both of the [redacted] nurses attested that the petitioner cannot be left alone and that his care is intensive. He requires G-tube feeding six times a day and suctioning every two hours. The petitioner had stent placement in October 2007. The stent was placed to build an airway. The petitioner pulls out his trach tube. Prior to the stent placement, the petitioner would only have 60 seconds to get trach replace before he would stop breathing. With the stent, he has five minutes to get the trach replaced. The petitioner is immuno-compromised with frequent infections that require visits to the emergency room. His last visit was September 6, 2007.

CONCLUSIONS OF LAW

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

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

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

> itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

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

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

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The amount of private duty nursing the respondent authorized in order that the mother's participation in providing care for the petitioner to the fullest extent possible was a denial of the 7:00 a.m. to 5:00 p.m. hours on Saturday and Sunday. The petitioner appealed the denial as the mother is required to attend workshops on some Saturday, the petitioner had surgery and the mother had surgery. The mother was not specific as to the frequency or the dates of the specific workshops or if the workshops were in town or out of town. The evidence did not demonstrate that the mother was unavailable to provide care on Sunday. The mother provided no specifics as to her surgery. The petitioner's surgery was for stent placement. There was no evidence that either surgery affected the petitioner's care.

The respondent met the burden of proof that medical necessity was demonstrated for 920 hours of private duty nursing. The respondent's action to deny 160 hours of private duty nursing for the period of September 3, 2007 through November 1, 2007 was within the rules of the Program.

DECISION

This appeal is denied for the period of September 3, 2007 through November 1, 2007.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th 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: [redacted] Petitioner
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 07F-06454

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 03 Suwannee
UNIT: 88674

CASE NO. 1240836961

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on December 19, 2007, at 2:35 p.m., in [redacted] Florida. The petitioner was not present. Present representing the petitioner was his wife, [redacted] The respondent was represented by [redacted], ACCESS supervisor. Present as a witness for the respondent was [redacted], ACCESS processor.

The hearing was scheduled for December 11, 2007. However, at the request of the petitioner a continuance was granted.

As stipulated during the hearing, the record was held open for seven days to allow the petitioner the opportunity to submit additional evidence which has been received and entered into evidence as the Petitioner's Exhibit 1.

ISSUE

The petitioner is appealing the respondent's action to decrease the community spouse income allowance effective December 2007.

FINDINGS OF FACT

1. The petitioner is a resident of [redacted] Health Care Center which is a skilled nursing facility. The petitioner is married and his wife is living in the community. Therefore, she was considered to be a community spouse for Institutional Care Program purposes.

2. The petitioner's income was Social Security of $765, VA compensation of $712 and a pension of $917.55. The petitioner's total income was $2,394.55. His wife's income was Social Security Disability benefits of $1,353 and a pension of $81.53. Her total income was $1,434.53. The petitioner's income exceeded the Institutional Care Program's income standard of $1,869. However, he established an income trust which was being funded monthly. Therefore, he was determined eligible to receive Institutional Care Program benefits as the monthly amount deposited into the income trust reduced his income below the Institutional Care Program's income standard.

3. The petitioner's wife submitted an application for the redetermination of the petitioner's eligibility for Institutional Care Program benefits. She listed her shelter expenses as rent of $400 per month and also listed a utility expense. To determine the income allocated to meet the petitioner's wife's needs, the respondent subtracted 30 percent of the monthly minimum maintenance income allowance of $1,712, or $514, from the shelter cost of $598 which included rent of $400 and the current standard food stamp utility allowance of $198. The balance of $84 was the excess shelter. The monthly minimum maintenance income allowance of $1,712 was added to the excess

shelter which resulted in a total of $1,796 which was the allowable shelter deduction. The wife's total income of $1,434.53 was subtracted from the total allowable shelter deduction. The balance of $361.47 was the amount of the petitioner's income that was to be allocated to meet the needs of his wife or the community spouse income allowance effective December 2007. The community spouse income allowance and the $35 personal needs allowance were subtracted from the petitioner's income of $2,394.55. The balance of $1,998.08 was the patient responsibility effective December 2007.

4. Prior to December 2007, the community spouse income allowance was $402 which was based on the wife's shelter expenses of $598 and her previous Social Security Disability income of $1,310. The respondent determined that the pension that the petitioner's wife was receiving was erroneously excluded and should have been included in the calculation of the community spouse income allowance.

5. On November 6, 2007, the respondent notified the petitioner that the community spouse income allowance would be $361.47 effective December 2007.

6. During the hearing, the petitioner's wife stated that as part of her rental agreement and in addition to the $400 rental payment she was required to pay annually the homeowner's insurance of approximately $643 and the property taxes of approximately $884 on the mobile home that she was renting. The respondent was not aware of the rental agreement that included the wife's obligation to pay the cost of homeowner's insurance and property taxes. According to the wife, the nursing facility where her husband resides completed the application and she was not aware that all of her shelter expenses were not included on the application.

7. Subsequent to the hearing, the hearing officer received a copy of the rental agreement (Petitioner's Exhibit 1) between the petitioner's wife and [redacted] owner, dated October 26, 2002. The rental agreement states that the wife agreed to pay rent of $400 per month and insurance and taxes annually on the property where she resided.

8. The petitioner's wife has monthly expenses that include the cost of cable television, automobile insurance, maintenance and repairs, medical expenses, burial contract payments, church contributions and the cost of food. The respondent did not include these expenses in determining the community spouse income allowance as deductions for those expenses were not allowed in the Institutional Care Program.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.7141 in part states:

> SSI-Related Medicaid Post Eligibility Treatment of Income.
> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income".
>
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
>
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance...
>
> (d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses.
>
> (e) For community Hospice cases, a spousal allowance equal to the SSI Federal Benefit Rate (FBR) minus the spouse's own monthly income shall be deducted from the individual's income. If the individual has a spouse and a dependent child(ren) they are entitled to a portion of the

individual's income equal to the Temporary Cash Assistance consolidated need standard (CNS) minus the spouse and dependent's income. For CNS criteria, refer to subsection 65A-1.716(1), F.A.C.

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

Fla. Admin. Code 65A-1.716(5) in part states:

(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: MMIA × 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.

4. Food Stamp Standard Utility Allowance: $198.

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.

Fla. Integrated Pub. Policy Manual, passage 2640.0117 in part states:

Patient Responsibility Computation (MSSI)
The following policy applies to ICP, institutionalized MEDS ...:
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. Refer to 2640.0118 for information regarding the personal needs allowance.
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 (refer to 2640.0123) for the following programs:
1. Institutional Care Programs, (including institutionalized MEDS and institutionalized Hospice) - the month of admission to and discharge from a nursing facility,
2. Assisted Living Waiver - the month of admission to and discharge from an ALF,
3. PACE and Long-Term Care Diversion - the month of admission or discharge from a nursing home facility or from an assisted living facility.
Step 4 - Deduct uncovered medical expenses as discussed in passages 2640.0125.01 through 2640.0125.04.
The balance is the amount of the patient responsibility.

Fla. Integrated Pub. Policy Manual, passage 2640.0119.01 in part states:

Community Spouse Income Allowance (MSSI)
The following policy applies to the ICP, institutionalized MEDS, institutionalized Hospice, Long Term Care Diversion, PACE, and the Assisted Living Waiver Programs. When an institutionalized individual has a community spouse whose gross income is less than the state's minimum monthly maintenance income allowance (MMMIA) plus the CS excess shelter expense costs, a portion of the individual's income may be allocated to meet the needs of his community spouse.

Fla. Integrated Pub. Policy Manual, passage 2640.0119.02 in part states:

Community Spouse's Monthly Income Allowance (MSSI)
A community spouse's monthly income allowance depends on the amount of monthly income available to the community spouse and the amount of excess shelter costs the community spouse must pay.
The actual community spouse monthly income allowance is equal to how much the state's MMMIA plus the community spouse's excess shelter costs exceed the community spouse's income.

Fla. Integrated Pub. Policy Manual, passage 2640.0119.03 in part states:

Formula for Community Spouse Income Allowance (MSSI)
The following is the formula used to determine the community spouse's income allowance:

(State's MMMIA + community spouse's excess shelter costs) - (the community spouse's total gross income) = (the community spouse's income allowance.)
The community spouse's income allowance is the total amount that can be allotted to the community spouse from the institutionalized individual.
The state's MMMIA plus CS excess shelter cost cannot exceed the state's cap on CS income allowance (see Appendix A-9).
The institutionalized individual's personal needs allowance and deduction for therapeutic wages is deducted prior to deducting the community spouse's income allowance.

Fla. Integrated Pub. Policy Manual, passage 2640.0119.04 in part states:

Determining Community Spouse's Excess Shelter Costs (MSSI)
The following steps are used to determine the community spouse's excess shelter costs:
Step 1 - Obtain verification of the community spouse's monthly assistance group expenses if questionable. Allowed expenses are limited to rent or mortgage payment (including principal and interest), taxes, insurance (homeowners or renters), maintenance charges if a condominium and mandatory homeowner's association fees. Do not include expenses paid by someone other than the community spouse. Add all of these expenses.
Step 2 - To the total obtained above, add the current food stamp standard utility disregard (refer to Appendix A-3.1) if the community spouse pays utility bills. Allowed utilities are limited to water, sewage, gas, and electric.
Step 3 - To determine what portion of the total shelter costs is excess, subtract 30% of the state's income allowance, from the total costs. The difference is the community spouse's excess shelter costs.

Fla. Integrated Pub. Policy Manual, Appendix A-9 set forth the minimum monthly maintenance income allowance of $1,712 effective July 2007.

Fla. Admin. Code 65-2.056 in part states:

Basis of Hearings.

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

The Findings of Fact show that in calculating the community spouse income allowance, the respondent must include the community spouse's total income. Therefore, the respondent was correct to include the wife's pension and Social Security Disability income in calculating the community spouse income allowance that was effective December 2007.

The findings showed that at the time of the redetermination of eligibility, the petitioner's wife, as part of her rental agreement, had the obligation to pay the cost of homeowner's insurance and property taxes. At the time of the redetermination, the respondent was not aware of the rental agreement and of the wife's obligation to pay the cost of homeowner's insurance and property taxes. However, in accordance with Fla. Admin Code 65-2.056(3) hearings are considered de novo hearings, in that, either party may present new or additional evidence not previously considered by the respondent in making its decision. The above rules, allow the cost of homeowner's insurance and property taxes to be included as a shelter cost in the calculation of the community spouse income allowance. These are shelter related expenses that the community spouse incurs. Therefore, the respondent is to give the her the opportunity to verify the amount of her payments for the homeowner's insurance and property taxes. Upon receipt of the verification, said shelter expenses are to be included in the calculation of the community spouse income allowance effective December 2007. Additionally, the respondent is to include the revised community spouse income allowance in calculating the petitioner's patient responsibility effective December 2007.

The community spouse has monthly expenses that include the cost cable television, automobile insurance, maintenance and repairs, medical expenses, burial

contract payments, church contributions and the cost of food. The above rules do not list these as expenses that can be included in determining the community spouse income allowance. The only expenses allowed by the above rules in determining the community spouse income allowance are shelter related expenses. Therefore, the respondent was correct not to include the above expenses in the calculation of the community spouse income allowance.

DECISION

The appeal is granted as set forth in the conclusions.

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 24th day of January, 2008, in Tallahassee, Florida.

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

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 07F-05845

CASE NO. 1181619947

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Pasco
UNIT: 88333

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 25, 2007, at 1:04 p.m., in [redacted] Florida. The petitioner was not present. The petitioner was represented by his wife, [redacted]. The respondent was represented by [redacted] economic specialist supervisor.

ISSUE

The petitioner is appealing the notice of September 25, 2007 for the respondent's action to determine the patient responsibility at $2,272.36 and the spousal diversion at $1,822. The petitioner is requesting an additional $245.36 diversion to the spouse to meet the spouse's expenses and the petitioner's excess medical expenses.

FINDINGS OF FACT

1. The petitioner reapplied for Institutional Care Program benefits. The reapplication was a passive review, in that the respondent called the petitioner for an interview. The petitioner's gross monthly income is $4,129.36. The income is $3,010.36 in an annuity pension and $1,119 in Social Security Administration benefits.

2. The respondent reviewed the reapplication. The budget was computed for the maintenance need allowance. The shelter costs and the minimum monthly maintenance allowance (MMMIA) exceeded the allowable shelter deduction of $2,541. The amount of the allowable shelter deduction of $2,541 was used to subtract the spouse's income of $719 to determine a community spouse income allowance of $1,822. The petitioner's income $4,129.36 less the community spouse income allowance of $1,822 resulted in a patient responsibility of $2,272.36. The respondent approved for the Institutional Care Program and Medicaid. The respondent did not give a deduction in the petitioner's for the medical insurance premium or excess medical expenses.

3. The petitioner's wife indicated that in addition to her household expenses, car expenses and medical bills she was paying medical and dental bills for the petitioner.

The spouse's shelter expenses are $521.21 monthly mortgage, $505.65 monthly land lease, $779 yearly home owner's insurance and $103.20 yearly home taxes. The increase in the home owner's insurance was recent. The spouse also incurs expenses for home repairs, appliance repair, car insurance,

gas for the car, repairs for the car, utilities, tree trimming, termite inspection, food and personal needs.

The petitioner's dental expenses are $2,144. The spouse is paying $100 a month on the current $1,200 dental bill. She is paying $50 a month toward the $9,420.14 balance for expenses incurred at the last nursing home the petitioner was in. She is paying was she can each month to a collection agency for medical expenses incurred by the petitioner in 2002.

CONCLUSIONS OF LAW

To review the petitioner's request to decrease the patient responsibility and increase the spousal diversion, the hearing officer explored an increase in the community spouse allowance and the amount of patient responsibility.

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 shelter expenses exceeded the allowable shelter deduction 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 are not exceptional expenses. The spouse's household, medical and personal expenses have not met the two step test. The community spouse income allowance in and of itself cannot be increased.

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

The Florida Administrative Code at 65A-1.714 explains the SSI-Related Medicaid Post-Eligibility Treatment of Income:

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or ALWHCBS, 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.
> (b) Single veterans or surviving spouses with no dependents residing in medical institutions who receive a reduced VA Improved Pension of $90, or less, are entitled to keep their reduced VA pension payment and shall have $35 of their income protected for their personal need allowance.
> (c) If the individual earns therapeutic wages an additional amount of income equal to one-half of the monthly therapeutic wages, up to $111, shall be protected for personal need. This protection is in addition to the $35 personal need allowance.
> (d) Individuals who elect hospice services have an amount of their monthly income equal to the federal poverty level protected as their personal need allowance unless they are a resident of a medical institution, in which case $35 of their income is protected for their personal need.
> (e) The department applies the formula and policies in 42 U.S.C. § 1396r-5 to compute the community spouse income allowance after the institutionalized individual is determined eligible for institutional care benefits. The standards used are in Rule 65A-1.716(5)(c), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses.
> (f) For community hospice cases, a spousal allowance equal to the SSI FBR minus the spouse's own monthly income shall be deducted from the individual's income.
> (g) For ICP, income may be protected for the first and last months of eligibility if the individual's income for that month is obligated to directly pay for their cost of food or shelter outside of the facility...

In addition, 42 U.S.C. § 1396a provides that:

> with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver,...there shall be taken into account 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, and
> (ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

These code provisions are further iterated in 42 C.F.R. §435.725. The regulation 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.

Based on the above listed authorities, the hearing officer concludes that the petitioner can receive a deduction for medical expenses that are not reimbursable in determining his patient responsibility to the nursing facility. The

Economic Self-Sufficiency Policy sets forth which uncovered medical expenses are deductible in passage 2640.0125.01 "Uncovered Medical Expenses (MSSI)":

> Policies found in passages 2640.0125.01 through 2640.0125.05 apply to the ICP, ICP MEDS, ICP Hospice, Community Hospice, Long-Term Care Diversion Waiver Program, the Assisted Living Waiver Program, and PACE.
> When an individual incurs medical expenses that are not Medicaid compensable and not subject to payment by a third party, the cost of these uncovered medical expenses must be deducted from the individual's income when determining his patient responsibility. To be deducted, the medical expense only needs to be incurred, not necessarily paid.
> Uncovered medical expenses will be averaged and projected over a prospective period of, generally, no more than six-months.
> 1. The following types and amounts of medical expenses may be deducted from an individual's income available for patient responsibility. The actual amount of health insurance (other than Medicare) payments an individual is responsible for paying. This includes premiums, deductibles, and coinsurance charges;
> 2. The actual amount (if reasonable) incurred for medical services or items that are recognized under state law and medically necessary.
> A medical expense deduction is not budgeted when:
> 1. Medical expenses are paid by someone other than the recipient or other than someone acting on behalf of the recipient using the recipient's funds.
> 2. Payments are made to someone other than the provider.
> 3. The medical expense is for nursing facility services, including those incurred during a penalty period...

The petitioner's wife is paying each month $100 towards the petitioner's current dental bill, $15 to a collection agency for past medical bills in 2002 and $50 a month for a past nursing home facility debt in 2003. The petitioner is entitled to $100 deduction in his patient responsibility for the payment of a current dental bill. The policy sets forth that a medical expense deduction is not budgeted when the payments are made to someone other than the provider or the medical expense is for nursing facility services. Therefore, the petitioner is

not entitled to a deduction for the $15 to a collection agency for past medical bills in 2002 and $50 a month for a past nursing home facility debt in 2003.

DECISION

This appeal is granted in part, to the extent of decreasing the patient responsibility by the $100 paid for dental expenses each month.

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: [redacted], Petitioner
Roseann Liriano, Suncoast Region

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 07F-06998

CASE NO. 1248063104

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 3, 2008, at 1:15 p.m., in [redacted], Florida. The petitioner was not present but was represented by her son, [redacted], via speakerphone. The Department was represented by [redacted], economic self-sufficiency specialist II.

ISSUE

The petitioner's representative is appealing what he believes to be a Department action to seek recovery of an overpayment in public assistance benefits, specifically Institutional Care Program(ICP) and Medicaid benefits. In addition the petitioner is appealing the Department's action of October 22, 2007 to terminate ICP and Medicaid benefits. The Department bears the burden of proof.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving ICP and Medicaid benefits. The Department determined that the petitioner was not eligible for benefits under the ICP Medicaid program because her income exceeded allowable program benefits. The petitioner was to deposit her income into an Irrevocable Income Trust. The petitioner's representative indicated that due to a misunderstanding, the income was not deposited into the Income Trust.

2. On October 22, 2007, the Department advised the petitioner that her ICP Medicaid benefits would be terminated effective October 31, 2007. The Department acknowledged that benefits have been restored effective November 2007 as the petitioner began to adequately fund the irrevocable Income Trust. As a result, there has been no loss of benefits to the petitioner.

3. On December 7, 2007, the Department notified the petitioner that a discrepancy was discovered in her case and requested that she contact the Department by December 17, 2007 to verify information it had received. In addition, the Notice of Discrepancy indicated that her case was being referred to the Benefit Recovery Program Unit because the Department believes she may have received an overpayment in public assistance benefits because the Department did not take timely action to cancel her case. As of the hearing date, the benefit recovery unit had not determined whether or not the petitioner had received an overpayment in benefits and has taken no action to establish an overpayment claim.

CONCLUSIONS OF LAW

Florida Administrative Code 65-2.056:

> Basis of Hearings. The hearing officer shall include consideration of: (1) Any agency action, or failure to act with reasonable promptness, on a claim of financial assistance, social services, medical assistance, or Food Stamp Program benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.

Florida Administrative Code 65-2.047, Rejection of Hearing Request, states:

> A hearing request may only be rejected or dismissed by the hearing officer.

The Findings of Fact show that the Department has restored the ICP and Medicaid termination and that the petitioner's ICP Medicaid was reinstated effective November 2007, which was the effective date of the termination. Therefore, the issue of the ICP termination is considered to be moot.

Further, the Findings show that the Department has not taken action to establish a claim against the petitioner for an overpayment in program benefits. The Department has only made a referral to the Benefit Recovery Program Unit for a possible overpayment. It is premature to address an overpayment, as a claim has not been established. Therefore, there is no basis for the petitioner's appeal as related to an overpayment. If the Department should establish a claim against the petitioner and issue written notification, the issue would then be ripe for appeal.

DECISION

The appeals are denied as both moot and not yet ripe for appeal.

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.

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

Copies Furnished To: [redacted] Petitioner
1 DPOES: Jan Blauvelt
[redacted]

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

[redacted]
PETITIONER,

Vs.

[redacted]
RESPONDENT.
_____/

APPEAL NO. 07N-00200

FINAL ORDER

Pursuant to notice, an administrative hearing was convened at 9:15 a.m. on December 20, 2007 at the [redacted] before the undersigned. The petitioner was not present but was represented by [redacted], manager of Long Term Care Ombudsman Council in the area. The respondent was represented by [redacted] administrator, with testimony available from [redacted], business office manager.

ISSUE

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

FINDINGS OF FACT

1. The petitioner was admitted to the facility from hospital care several times over the past year, beginning March 7, 2007. Need for nursing care is undisputed.

2. At time of most recent admission, as shown in the September 2007 billing record there was a remaining "balance forward" of $7,011.95, shown in Respondent's Exhibit 2. On October 4, 2007, the billing statement, including anticipated charges for October, showed the amount due as $12,591.65. The amount increased monthly, and as of date of hearing, amount due was $28,098.74. This is undisputed.

3. Application for Medicaid likely had occurred, but was not approved. Respondent's Exhibit 3 reflects denial status, but the concern was not thoroughly addressed due to hearsay and relevance factors.

4. On November 6, 2007, Nursing Home Transfer and Discharge Notice was issued to the petitioner with location for discharge shown as a health care center in a nearby county [redacted] Notice was Respondent's Exhibit 1 and was challenged.

5. The Office of Appeal Hearings directed an Agency for Health Care Administration survey be conducted. It may have been conducted, but as of date of hearing, results had not been sent to the undersigned and there is no survey to enter into evidence.

6. The petitioner would prefer to remain at the [redacted]

7. The respondent will not discharge the petitioner to an unsafe location, but does not wish to retain the petitioner in the current status of payment (alleged nonpayment).

8. There may be some family problems or lack of follow through with regard to Medicaid eligibility, but the petitioner has not been declared incompetent and does not have a legal guardian. Medicaid status or lack of it would not be addressed through the nursing home discharge hearing process, but there is a Medicaid (Institutional Care

Program-ICP) hearing process also available through the Department of Children and Families.

CONCLUSIONS OF LAW

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

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
> ...
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.
> ...
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
> ...
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State....

It is concluded that the facility appropriately issued billing statements and notified proper parties of charges. Inadequate payment has occurred following reasonable and appropriate notice to pay. Despite the preference of the petitioner, and the difficulties of the situation, burden of proof has been met by the respondent. Intent to discharge has been justified.

DECISION

The appeal is denied and discharge intent is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th day of January 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
[redacted] Mngr Agency for Health Care Administration
[redacted]e, LTCO Manager

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

[redacted]

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

APPEAL NO. 07N-00187

CASE NO.

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 4, 2007 at 10:50 a.m., in Estero, Florida. The petitioner was not present. He was represented telephonically by his son and guardian, [redacted] The facility was represented by [redacted] executive director. Present, as a witness for the facility was [redacted] social services director. Present, as an observer was [redacted]

ISSUE

At issue is the August 4, 2006 notice from the facility proposing to discharge the petitioner for failure to pay for services at the facility. The facility has the burden of proof.

FINDINGS OF FACT

1. On September 29, 2007, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner. The notice indicated that the facility proposed discharging the petitioner on October 28, 2007. The facility proposed discharging the petitioner due to his failure to pay his bill at the facility following reasonable and appropriate notice to pay.
2. The petitioner entered the nursing facility on February 16, 2007. His bill was covered under Medicare until July 1, 2007. He was approved for Medicaid benefits through the Institutional Care Program beginning September 1, 2007. The balance on his bill is $13,179.63 mostly for the period of July 1, 2007 through August 31, 2007.
3. The facility sent a monthly bill to the son notifying him of the charges and balance on his father's account. The business office spoke with the representative on several occasions regarding the balance. The representative did not dispute the charges or balance presented by the facility. However, the representative would not state whether he would pay the balance on his father's bill or not.
4. The facility located several facilities that would accept the petitioner as a resident.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255. Matters that are considered at this type of hearing are the decisions by the facilities to discharge patients. Federal

regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that he would be discharged from the nursing facility in accordance with the Code of Federal Regulations at 42 CFR § 483.12(a):

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

The petitioner was aware that there is an outstanding debt to the facility. The petitioner's guardian does not dispute the charges or balance due on the account. The facility established that the petitioner failed to pay the balance following notices to do so. Therefore, the facility may proceed with the proposed discharge action due to the petitioner's failure to pay his bill at the facility.

DECISION

This appeal is denied. The facility'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 First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The party must either pay the court fees required by law or seek an order of indigency to waive those fees.

The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

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

in Tallahassee, Florida.

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

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

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

[redacted] PETITIONER,

APPEAL NO. 07N-00182

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened at 2:10 p.m. on December 13, 2007 in the [redacted]. The petitioner represented herself with assistance from ombudsman staff, [redacted] and manager, [redacted] The respondent was represented by [redacted] administrator, with testimony available from [redacted] business office manager; [redacted] risk manager; and [redacted] social services director.

ISSUE

At issue was whether intent to discharge was correct based upon failure to pay for services after reasonable and appropriate notice to pay. Ombudsman staff also raised question as to discharge location. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner has been a resident of the nursing facility since July 26, 2007, following discharge from a hospital. She has health impairments. She requires catheter

and colostomy care and controlled medications. She is competent and does not have a legal guardian.

2. She was approved for Medicaid Institutional Care Program by the Department of Children and Families. This program involves a patient responsibility. As a Medicaid recipient, almost all available funds would be earmarked for care at the nursing facility and would be used to pay for services received at the nursing facility.

3. The petitioner receives $1700 monthly Railroad Retirement pension benefit from her husband's past employment. She does not use that pension money to pay the nursing facility. Instead, she is reserving those funds toward an anticipated residence for discharge and for payment on other bills.

4. The respondent issued billing statements to the petitioner and as of September 30, 2007, the amount owed was $4,470.96, shown in the billing statement attached to the Nursing Home Transfer and Discharge Notice (Respondent's Exhibit 1). As of date of hearing, the amount owed was $8,428.51 (Respondent's Exhibit 2), with advance billing for the month. Reason for discharge was "bill for services...not been paid after reasonable and appropriate notice to pay."

5. The respondent issued the discharge notice on October 2, 2007 and reflected location for discharge as "... [redacted] in Jacksonville. Her daughter presently lives at that location, which is a mobile home. The petitioner described that location as in some type of foreclosure, and with an eviction notice issued. Documentary evidence to support such was not introduced. When facility staff conducted discharge review before issuance of the discharge notice, the [redacted] was reviewed and appeared viable. "[redacted], DO Physician/Designee" signed discharge notice.

6. At direction of the undersigned, an Agency for Health Care Administration review was conducted. Regulatory compliance was found (Hearing Officer Exhibit 1).

7. The petitioner does not dispute nonpayment. She was concerned about her other bills and acquisition of another residence or public housing. She declared "I have no place to go" (Petitioner's Exhibit 1). The ombudsman staff were similarly concerned.

8. Facility staff noted that unsafe discharge location is not permitted by regulations and if eviction from [redacted] were factually confirmed, then another location would be developed.

CONCLUSIONS OF LAW

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

> § 483.12 **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
> (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid
> ...
> (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. ...

> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
>
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
> ...
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:...
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State;
> (v) The name, address and telephone number of the State long term care ombudsman;
> ...
> (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.

Based upon findings, it is concluded that significant underpayment has occurred following reasonable and appropriate notice to pay. It is evident that underpayment occurred during an extended period. Under regulations, adequate payment for continuing stay at a nursing facility is required. It is concluded that reasonable and appropriate notice to pay was followed by insufficient payment for services rendered.

Additionally, while the [redacted] location may be of some concern, there was no evidentiary basis to determine that location was nonviable. With an appropriate medical provider declaring validity of the discharge, no error can be found in this element. However, facility staff noted that discharge to an unsafe location is not permissible and all efforts would be made to ensure regulatory compliance. Discharge has been adequately justified as set forth in notice of October 2, 2007.

DECISION

The appeal is denied and the discharge notice 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 3rd day of January 2007, in Tallahassee, Florida.

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

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

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

[redacted]

PETITIONER,

APPEAL NO. 07N-00185

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on December 4, 2007, at 2:35 p.m., at [redacted] in Daytona Beach, Florida. The petitioner was present, but was represented by her sister, [redacted] ombudsman, Long-Term Care Ombudsman Program, Department of Elder Affairs, was also present. [redacted] nursing home administrator, represented the respondent. Present, as witnesses for the respondent were [redacted] director of nursing, [redacted] unit manager, and [redacted] social services director.

The record was left open in order for the respondent to have the opportunity to submit a discharge notice signed by a physician. It was received and the record was closed.

ISSUE

The respondent will have the burden to prove by a clear and convincing evidence that the petitioner's discharge in the notice dated January 8, 2007 is in accordance with the requirements of Code of Federal Regulation 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 was admitted to [redacted] on July 18, 2002. Her diagnosis includes depression, schizophrenia, diabetes, GI bleed, hypertension, and obesity. She is still in residence there pending the outcome of this hearing. Upon admission, the petitioner was informed of the facility's smoking policy.

2. The respondent entered into evidence a typed summary, portions of the medical records, Progress Notes, alleging smoking incidents by the petitioner, as the Respondent's Composite Exhibit 2. When the petitioner first entered the nursing facility, she had no restrictions on smoking. As time went by, she required supervision when smoking. After she burned her clothes, she was still supervised and she was given a smoking apron. Notes on March 2, 2007 state: "Resident has been caught with lighters in her possessions several times in the last couple weeks and observed in the courtyard smoking unsupervised". She was counseled by the nurse for unsafe smoking.

3. On April 30, 2007, Progress Notes shows that the petitioner had a small wound on her left thumb caused by hot ashes falling from a cigarette, and she also had an area on her left forearm. The two areas could have happened at different times because of the healing stages. The petitioner admitted to the nurse that she was burned from the

"hot fire" from her cigarette. On May 1, 2007, a meeting was held with the nurse, director of nursing, and the petitioner's sister to discuss noncompliance with the smoking rules and safety issue. Chantix was prescribed to aid with the smoking cessation. She was still noncompliant on May 23, 2007.

4. The petitioner's family fully supported the smoking cessation plan. On July 12, 2007, the petitioner was found with cigarettes, and again on August 5, 2007. The doctor had given orders that she was "not to smoke" on August 24, 2007. On October 24, 2007, she was observed smoking in the courtyard, and she was placed on one to one supervision.

5. The Smoking Safety Data Collection and Assessment, dated August 24, 2007, notes that the petitioner's family does not want her to smoke, and that it was unsafe for her to smoke. Another assessment dated November 27, 2007, shows she was non-compliant with smoking rules because of a life safety risk (Respondent's Exhibit 3).

6. On October 12, 2007, the petitioner was given a 30-day Nursing Home Transfer and Discharge Notice. Her sister signed it on that day. On December 4, 2007, the respondent generated another discharge notice that included a physician's signature and doctor's order, as the first notice did not. The reason was "Your needs cannot be met in this facility." (Respondent's Exhibits 1 & 4).

7. The petitioner's family asked for a patch to assist her while she quit smoking. They do not want her to smoke. She did not get the patch. The respondent attests that Chantix is better than the patch and gets the same results. The petitioner wants to smoke. Her representative believes she has not been smoking in the building and will not burn someone or start a fire.

8. Discharge planning included the names of four nursing facilities. Neither the petitioner nor her family could agree on one facility. The discharge location cited on the discharge notice was the residence of the petitioner's sister.

CONCLUSIONS OF LAW

Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Additionally, transfer and discharge is addressed at 42 C.F.R. § 483.12 stating 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;...
>
> (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...

Based on all evidence and testimony presented, it is concluded the current facility cannot adequately meet the security or personal welfare needs of the petitioner, as described in the notice. The petitioner has on many occasions failed to comply with the measures in place to ensure her safety and the safety of others. Once discharge planning has been completed and an adequate facility has been found, the respondent may proceed with the discharge of the petitioner in accordance with the requirements set forth by the Agency for Health Care Administration.

DECISION

The appeal is denied as the facility's action to discharge the petitioner is correct and in accordance with federal regulations. The facility may proceed with the discharge as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 10th day of January 2008,

in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To: [redacted] Petitioner

[redacted], Respondent

Agency for Health Care Administration

[redacted]

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

[redacted]

APPEAL NO. 07N-00192

PETITIONER,

Vs.

Administrator [redacted],

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on December 12, 2007, at 2:50 p.m., at the [redacted], in Daytona Beach, Florida. The petitioner was not present. Her daughter-in-law, [redacted] represented her. In attendance for the respondent was [redacted], business office manager, [redacted] managing member, [redacted] bookkeeper, and [redacted], social worker director.

ISSUE

The respondent has the burden to prove by clear and convincing evidence that the petitioner's discharge notice dated November 1, 2007, is in accordance with the requirements of 42 C.F.R. § 483.12(a):

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

FINDINGS OF FACT

1. The petitioner received a Nursing Home Transfer and Discharge Notice on November 1, 2007. The notice informed the petitioner of the facility's intent to discharge her citing, "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay" (Respondent's Exhibit 1). She is residing in the facility pending the outcome of this hearing.

2. The petitioner was admitted to the facility around February 24, 2004. She incurred expenses for her stay there. The Respondent's Exhibit 2 is a spreadsheet that shows the patient responsibility beginning September 1, 2005, the amount of her Social Security checks, pension checks, and other payments received by the facility, through November 2006. The Respondent's Exhibit 3 is monthly statements, with the last statement dated November 27, 2007. The petitioner has an outstanding obligation to the nursing home for $4623.64 as of November 27, 2007. She incurred $15059.48 in expenses and paid a total of $10442.56, leaving a corrected balance of $4616.92 outstanding.

3. In December 2005, the petitioner's daughter-in-law verbally agreed to pay the nursing facility $50 per month as a payment on an old balance. She agreed to send the petitioner's pension check and Social Security benefits to the facility each month. The pension stopped in August 2007, but the facility only received three pension checks as payment for the petitioner's care prior to that. It received a check in January, April, and October 2006. The respondent received three $50 checks, received in January, March, and April 2006. The facility did not receive a Social Security check in December 2005.

The petitioner's patient responsibility for payments to the facility changed from $1030.78 to $1060.78 in January 2006.

4. The petitioner wants to stay in the respondent's facility. Her daughter-in-law believes it will be detrimental to move her to another facility. The petitioner's representative stipulates that she did not make more than three $50 payments or send more than three pension checks. She believes she overpaid the balance owed from when the petitioner was on private pay status, but did not have any evidence to support her position. She received bills and on occasion received part of someone else's bill with her mother-in-law's bill. She understands that the facility wants the money it is owed, and will pay $50 a month towards the bill, but states the nursing facility now wants $200 a month to clear up the outstanding balance, and she cannot agree to that amount.

CONCLUSIONS OF LAW

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

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

The facility has given the petitioner 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. 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 petitioner's treating physician and in accordance with applicable Agency for Health Care Administration requirements.

DECISION

This appeal is denied. The respondent may proceed with the discharge as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29th day of January, 2008, in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To: [redacted] Petitioner

[redacted], Respondent

Agency for Health Care Administration