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

APPEAL NO. 08F-05574

PETITIONER,

Vs.

CASE NO. 1281345164

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 08 Lee
UNIT: 88806

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 14, 2008, at 1:05 p.m., in Ft. Myers, Florida. The petitioner was not present. She was represented by her attorney, Present as a witness for the petitioner telephonically was attorney and Medicaid expert; and vice-president of Employees Life Company. The respondent was represented by Eugenie Rehak, Regional Chief Legal Counsel. Present witnesses for the respondent were Marilyn Mofford, senior human services program specialist; Raymond Muraida, operations management consultant 1; Yesid Hernandez, Access supervisor; and Irene Jordan, Access worker. Present to assist vas his legal assistant.

Both parties were allowed 30 days to submit proposed final orders or memorandum of law. A proposed final order was received from the respondent on November 25, 2008. A memorandum of law was received from the petitioner.

On December 1, 2008, the petitioner submitted another memorandum of law responding to the petitioner's proposed final order.

ISSUE

At issue is the July 29, 2008 action by the respondent denying the petitioner's application for Institutional Care Program benefits for the period of March 11, 2008 through July 26, 2008 due to the imposition of an improper transfer of assets creating a penalty period.

FINDINGS OF FACT

1. On March 11, 2008, the petitioner filed a Request for Assistance to apply for benefits through the Institutional Care Program. The petitioner was 90 years old. The petitioner's attorney-in-fact (her daughter-in-law) purchased a whole life insurance policy with a terminal illness benefit rider. The insurance policy in question is a whole life policy where a terminal illness rider was added. The policy was purchased for $48,000 on February 11, 2008. The terminal illness rider specifies that the insurance company will pay 75% of the face amount of the policy and reduces the policy face amount accordingly from the due date of the first monthly payment. There are 75 guaranteed equal payments of $482.40; the first such payment becoming due one month from the effective date of the policy. This leaves 25% of the value as a residual death benefit ($12,061). The rider further specifies that the cash values of the policy are irrevocably assigned to the insurance agency to cover the benefits of the policy and the rider. The beneficiaries of the policy upon the death of the

applicant are her son and daughter-in-law. At the death of the insured the beneficiaries can commute the remaining payments. The commutation shall be calculated using a discount rate of 6% interest.

2. The respondent was not familiar with a single premium whole life insurance policy which paid to the insured prior to death. They initially analyzed the purchase according to annuity criteria to qualify the purchase as an allowable transfer for fair compensation. On April 23, 2008, the respondent denied the application and imposed an improper transfer of assets penalty effective February 2008. The notice allowed the petitioner 10 days (until May 5, 2008) to rebut this decision.
3. The petitioner disagreed with the respondent's action treating the purchase (insurance policy) according to annuity policy. The petitioner testified that this was a life insurance policy and the respondent should apply the policies that evaluate life insurance to this purchase.
4. After a review by the policy experts with the agency, the respondent reversed their position that the purchase should be analyzed according to annuity policy. They reviewed the purchase pursuant to life insurance policy criteria.
5. The petitioner transferred $48,000 cash to purchase the life insurance policy (an asset) within the 36 month of the application for benefits. The life insurance company provided proof that the policy had no cash surrender value, could not be assigned, and was irrevocable.

6. The respondent determined that the applicant had a life expectancy of 53.16 months. The life insurance terminal illness rider provided a monthly benefit of $482.40. The respondent multiplied the monthly amount by 53 to equal $25,567.20. This represents the amount that the petitioner would be expected to receive in her lifetime and was considered fair compensation by the respondent. The remaining amount is $22,432.80 ($48,000 - $25,567.20).

7. On July 29, 2008, the respondent notified the petitioner that her application for Institutional Care Program benefits were approved beginning July 15, 2008. The period of March 11, 2008 through July 14, 2008 was a penalty period due to the improper transfer of an asset. The respondent calculated the penalty period by dividing the uncompensated value of $22,432.80 (rounded to $22,433) by $5,000 resulting in a 4.486 or 4 month and 14 days penalty period.

8. On October 9, 2008, the respondent determined that they did not calculate the penalty period correctly. They determined that the penalty period should have been March 11, 2008 through July 25, 2008. Her eligibility for benefits through the Institutional Care Program should have started on July 26, 2008. The respondent mailed a corrected notice to the petitioner.

11. Both parties entered into the following stipulated facts:

    1. The parties stipulate that the insurance in question is the sole reason for the denial of benefits to .

    2. The parties further stipulate the policy issued by the EMPLOYEES LIFE is a whole life policy, guaranteed issue,

with a terminal illness rider.

3. The parties further stipulate that this policy is not an annuity and should not be reviewed by the case worker using the annuity rules.

4. The policy was duly approved by the FLORIDA DEPT. OF INSURANCE.

CONCLUSIONS OF LAW

The transfer of resources and fair compensation rules are set forth in the Florida Administrative Code at 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria":

> (3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing facility care services, institutional hospice or HCBS waiver services. The department will mail a notice to individuals who report a transfer for less than fair market value (Form CF-ES 2264, Feb 2007, Notice of Determination of Assets (Or Income) Transfer, incorporated herein by reference), advising of the opportunity to rebut the presumption and of the opportunity to request and support a claim of undue hardship per subparagraph (c)5. below. If the department determines the individual is eligible for Medicaid on all other factors of eligibility except the transfer, the individual will be approved for general Medicaid services (not long-term care services) and advised of their penalty period (Form 2358, Feb 2007, Medicaid Transfer Disposition Notice, incorporated herein by reference.) The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.
>
> (a) The department follows the policy for transfer of assets mandated by 42 U.S.C. § § 1396p and 1396r-5. Transfer policies apply to the transfer of income and resources...
>
> 1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or

a disabled individual under age 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.

2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life expectancy tables noted in paragraph (b) above), it is not considered to be established for the sole benefit of the indicated individual and any potential exemption from penalty or consideration for eligibility purposes is void...

(g) For transfers made on or after November 1, 2007, periods of ineligibility begin with the later of the following dates: (1) the day the individual is eligible for medical assistance under the state plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period; or (2) the first day of the month in which the individual transfers the asset; or (3) the first day following the end of an existing penalty period. The department shall not round down, or otherwise disregard, any fractional period of ineligibility of the penalty period but will calculate the period down to the day. There is no limit on the period of ineligibility. Once the penalty period is imposed, it will continue although the individual may no longer meet all factors of eligibility and may no longer qualify for Medicaid long-term care benefits.

The evidence establishes that the attorney in fact (daughter-in-law) for the petitioner bought a life insurance policy for $48,240 one month before applying for benefits through the Institutional Care Program. The insurance policy had a terminal illness rider that pays a benefit to the petitioner of $482.40 monthly. The insurance policy does not have any cash value.

The petitioner argues that the money was used to purchase a life insurance policy that is irrevocable, has a $0 cash value, and is approved by the Department of Insurance. The petitioner claims that the petitioner received fair

compensation due to the death benefit purchased and the value of the monthly benefit that would be considered as income. There is no provision prohibiting the petitioner from purchasing a life insurance policy. Once purchased the petitioner argues that the respondent should only consider the cash value of the policy and should not proceed to a determination of whether an illegal transfer occurred. According to the petitioner the respondent did not establish or argue that the life insurance policy was not purchased for less than "fair market value." Therefore, the policy would not cause the petitioner to exceed the $2,000 asset limit of the Institutional Care Program.

The respondent does not dispute the value of the life insurance policy. However, the respondent reviews assets, asset conversion and disposition under transfer of asset policy when it occurs within the 36 month look-back period. The transfer would make the petitioner eligible on assets so the respondent considered whether it was an allowable transfer. To make that determination, they looked at whether the petitioner would receive fair compensation for the transfer within her lifetime. Since she would not receive fair compensation in her lifetime by their calculation, a transfer penalty was applied and the petitioner suffered a period of ineligibility

The above-cited code requires the respondent to look-back 36 months at any transfer of an asset for less than fair compensation. This is to determine if the transfer occurred to obtain Medicaid eligibility. The code specifies that one way of looking at whether the compensation was "fair" was to look at whether the person (or their representative) who transferred the asset would receive fair

compensation within their "lifetime." To accomplish this calculation the respondent commonly uses the Period of Life Table as set forth in Rule 65A-1.716, F.A.C. (Life Expectancy Tables). Therefore, the respondent correctly determined that the petitioner received less than fair compensation for the transfer when they multiplied her life expectance of 53.16 months by the monthly insurance benefit of $482.40 to set her compensation as $25,567.20.

The petitioner appears to have confused the fair market value of an insurance policy with the respondent's fair compensation in a lifetime policy. The respondent never asserted that the policy was worth less than fair market value for an insurance policy. The hearing officer agrees that the respondent is required to look at fair compensation for the transfer of an asset from one form to another. According to the above-cited code, when fair compensation was not received, the transfer was not allowable and a penalty period must be imposed. Therefore, the respondent acted correctly.

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 27th day of January, 2009,

in Tallahassee, Florida.

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

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

APPEAL NO. 08F-07225

PETITIONER,

Vs.

CASE NO. 1288377436

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on November 19, 2008, at 1:05 p.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was not present, but was represented at the hearing by attorney. Also present on behalf of the petitioner was the petitioner's wife, The Department was representative by Oneida Gamboa, economic self sufficiency specialist II. The hearing was left open for one additional day in order for the Department to submit additional information. The hearing was left open for seven additional days in order for the petitioner to submit Findings of Fact and Conclusions of Law. Additional information was submitted by each party within the perspective time frames allotted.

ISSUE

At issue is the petitioner's request for an increase in the community spouse's income allowance that is diverted from the petitioner's patient responsibility ICP (Institutional Care Program) payment made to the nursing home. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a resident of a nursing home and receives ICP benefits. His wife lives in the community and is known to the Department as the community spouse. The petitioner's patient responsibility is $673.48, as of November 2008. The income diverted to the community spouse from the petitioner's income as an allowance is $1,164.27. The community spouse's income alone is $601.

2. The facts were not disputed in this case. The Department has a process to determine the petitioner's patient responsibility and the community spouse's allowance. The community spouse's "allowance" is a diversion of the petitioner's income to the community spouse.

3. Department Exhibit 1, contains a copy of the Department's Institutional budget sheet and a copy of the Department's institutional allowance worksheet for the petitioner. This Exhibit also contains a copy of the Department's uncovered medical expense worksheet. All of the above "copies" indicate the Department's budget process.

4. The community spouse pays $96.40 a month for her Medicare Part B insurance premium. She pays an AARP health insurance supplement premium of $209.75 and an AARP prescription drug premium of $27 a month. Additionally, she claims to pay $40 out of pocket prescription drug cost of about $40 a month. These added together total

$373.15. These costs are not included in the Department's process for the diversion allowance for the community spouse. This amount is what the petitioner is requesting for this hearing officer to consider as part of the community spouse's "allowance" to be increased.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.716(5) 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.

Fla. Admin. Code 65A-1.712 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.
>
> (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.

As shown in the Findings of Fact, the Department determined the petitioner's patient responsibility is $673.48 and the community spouse's allowance from the petitioner's income is $1,164.27. The Department provided copies of this determination as part of their evidence. All of the facts of this case concerning the budget process and income are not in dispute. The Rule cited above allows the hearing officer the ability to adjust these figures.

The petitioner's representative argued that the community spouses medical costs as outlined in the Findings of Fact, should be allowed and considered to adjust the petitioner's patient responsibility downward, thus allowing the community spouse to receive an increased allowance. The petitioner's representative argued that as the petitioner has various and severe medical problems; she must pay for her medical insurances or incur much larger medical costs.

After considering the evidence, the Florida Administrative Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer concludes the Department's action to set petitioner's patient responsibility as $673.48 and set the community spouse's allowance from the petitioner's income at $1,164.27, remains correct. The petitioner's request for the adjustment, do not meet the exceptional circumstances or unavoidable costs for the hearing officer to override the Department decision.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk,

Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the 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 20th day of January, 2009,

in Tallahassee, Florida.

Robert Akel

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

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

APPEAL NO. 08F-07776
08F-07777

PETITIONER,

Vs.

CASE NO. 1292239808

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Sarasota
UNIT: 883CF

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on December 12, 2008, at 1:29 p.m., in Venice, Florida. The petitioner is now deceased. The deceased petitioner's interests were represented by her husband, also testified. The respondent was represented by Mary Jane Stafford, supervisor in the ACCESS Program.

ISSUE

At issue is the respondent action of November 10, 2008 to deny Institutional Care Program (ICP) Medicaid benefits for the months of August and September 2008 based on excess counted income. Specifically, the respondent asserts that an income trust created in August 2008 was not funded to permit ICP eligibility.

FINDINGS OF FACT

1. The petitioner transferred from an adult living facility to a nursing facility on August 15, 2008. The petitioner remained in the nursing facility until her decease on September 22, 2008. The petitioner's husband lives in the community.
2. On August 27, 2008, the petitioner's attorney applied for ICP benefits for the petitioner. The petitioner's income of $1,173 monthly Social Security and a pension check of $2,452 were listed on this application. The petitioner had total income of $3,625 monthly for August and September 2008.
3. On August 29, 2008, the respondent sent the petitioner a verification list of items needed to process the ICP application. The petitioner received this list. One of the items on the list was proof of qualified trust. There was no verbal communication between the respondent and the petitioner's husband or attorney of verifications needed in August 2008.
4. On August 7, 2008, prior to the application of August 27, 2008, the petitioner's attorney created income trust documentation. The respondent received this income trust documentation on August 27, 2008. There is no evidence that the respondent completed the approval process through their legal process to determine if the trust is a qualified trust. The petitioner did not establish a bank account to deposit funds into the trust account. The respondent had no verbal or

written communication with the petitioner's husband or the petitioner's attorney on the amount needed to fund the trust.

5. On October 8, 2008, the respondent was advised that the petitioner deceased on September 22, 2008. On November 7, 2008, the respondent advised the petitioner's attorney that ICP benefits could not be approved because a trust account had not been established, nor funded. On November 10, 2008, the respondent sent notice that ICP benefits had been denied because needed information was not received. Specifically, the respondent asserts that the trust account needed to be established and funded in a sufficient amount to create ICP eligibility.

6. The respondent processed the application without an interview. The respondent contacted the petitioner's attorney later in November 2008 to advise that ICP eligibility could not be established for August and September 2008. The only communication from the respondent to the petitioner occurred in writing in August 2008 until the attorney was contacted in November 2008.

CONCLUSIONS OF LAW

The Florida Administrative Code (F.A.C.) 65A-1.713 **SSI-Related Medicaid Income Eligibility Criteria** states in part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.

F.A.C. 65A-1.702 **Special Provisions** states in part:

(15) Trusts.

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

The Respondent's interpretive FLORIDA Integrated Public Assistance Policy Manual, passage 1840.0110 Income Trusts (MSSI) states:

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

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

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

it is irrevocable;

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

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

The above-cited F.A.C. rule shows that countable income may not exceed 300% of the federal benefit rate to be eligible for ICP benefits. This amount is

interpreted as $1,869 effective during the months at issue, per Attachment 8 of the respondent's interpretive manual. This amount has increased to $2,022 effective January 2009, per Attachment 9 of the respondent manual. The petitioner's total $3,625 income exceeded this maximum income amount for ICP eligibility.

F.A.C. Rule 65A-1.713 permits the establishment of a qualified income trust to potentially create ICP eligibility by reducing countable income to an amount below the income standard. A qualified income trust was created by the petitioner's attorney on August 7, 2008, and received by the respondent on August 27, 2008. However, an ICP applicant must also fund the trust account by an amount sufficient to reduce countable income below the income standard. The petitioner did not establish an income trust account so that sufficient funding of the account could occur, to reduce income below the $1,869 income limit.

A decision by the Fourth District Court of Appeal (DCA) (**Forman v. DCF**, 956 So.2d 477 (2007)) is similar to this appeal and addresses the respondent's requirement to advise ICP applicants, in part as follows:

> where, as here, a caseworker is presented with specific and revealing information regarding the applicant's eligibility for benefits, that caseworker has an affirmative duty under 45 CFR 206.10(a)(2)(i) to inform that applicant at least orally of the conditions relevant to her eligibility.

The respondent received information on all the petitioner's income sources in August 2008 when she applied for ICP benefits. This income information is specific enough to reveal the need to establish an income trust,

and the amount needed to fund the trust below the income limit. Therefore, the respondent had an affirmative duty to advise the petitioner in August 2008 of the federal benefit rate to be eligible for ICP benefits. With that information, the petitioner could determine the correct monthly amount to put in the trust account.

The Respondent ACCESS Customer Service Center defines ICP cases in need of an income trust as a case that requires an interview. The rationale for the policy is that cases that have an income trust have a greater tendency to be error prone. While a face-to-face interview is not a requirement, the respondent must conduct at least a directed interview (Access Customer Service Center Guide, page 7). The Guide further states that the interview should focus on areas that are likely to be error prone.

The Respondent's interpretive FLORIDA Integrated Public Assistance Policy Manual, passage 1840.0110 Income Trusts (MSSI) states:

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

In accordance with this policy, the petitioner should have received a directed interview. During that interview the petitioner should have been informed of :

- the requirements of an income trust;
- the federal benefit rate to be eligible for ICP benefits;

- the need for the trust to be funded; and
- to fund the trust immediately and not wait for approval of the trust from the respondent.

While the respondent is not responsible for providing the amount the trust should be funded, it was necessary to advise that the trust account needed to be established and should be funded as soon as possible and that eligibility would commence from the time the trust was executed and funded.

The petitioner had advance knowledge of the need to establish an income trust. However, the petitioner was not advised of the federal benefit rate to be eligible for ICP benefits, the need for the trust to be funded, and the need not to wait for approval of the trust before funding the trust account. Since the petitioner was not informed of these requirements of the income trust, the denial of ICP benefits for August 2008 and September 2008 must be reversed. The respondent is ordered to redetermine ICP eligibility on relevant factors other than income for the months at issue, August and September 2008.

DECISION

The appeal is granted. The respondent's action to deny benefits based upon income is denied. The respondent is ordered to redetermine ICP eligibility for the months of August and September 2008 on factors other than income. It is not known whether or not the petitioner will be eligible for ICP benefits on factors other than income.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 26th day of January, 2009,

in Tallahassee, Florida.

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

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

PETITIONER,

Vs.

APPEAL NO. 08F-07097

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 03 Bradford
UNIT: 88521

CASE NO. 1249842620

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on December 9, 2008, at 11:00 a.m., in Starke, Florida. The petitioner was not present. Present representing the petitioner was his wife,

The Department was represented by Marlene Brown, economic self sufficiency specialist II and Amanda Williams, economic self sufficiency specialist I.

ISSUE

At issue is whether the Department correctly denied the petitioner's request for Institutional Care Program benefits for the months of June 2008 and July 2008 based on excess income.

FINDINGS OF FACT

1. On August 1, 2008, the petitioner filed an application for Institutional Care Program (ICP) benefits. The petitioner was a resident of a nursing home in Starke,

Florida. At the time of the application, the petitioner's gross monthly income was Social Security Disability benefits of $1,920 and a pension of $571. The petitioner's total gross monthly income was $2,491. The petitioner's total gross monthly income exceeded the income standard for the ICP of $1,911 for an individual. Therefore, the petitioner was not eligible to receive ICP benefits unless he established an income trust and funded the trust each month.

2. On January 4, 2008, the petitioner established an income trust. The trust was funded on August 28, 2008 and a deposit of $585 was made into the income trust on that date. There were no deposits made into the income trust during the months of June 2008 and July 2008. The Department determined that the petitioner was not eligible to receive ICP benefits for the month of June 2008 and July 2008 because his income exceeded the ICP income standard.

3. On September 9, 2008, the petitioner's request for ICP benefits for June 2008 and July 2008 was denied based on excess income.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.702(15) "Trusts" in part states:

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

(b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36-month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual.

Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.

(c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income.

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

SSI-Related Medicaid Income Eligibility Criteria.

(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(15), F.A.C. ... (4)(b) For institutional care...the department applies the following methodology in determining eligibility: 1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month.

Fla. Integrated Pub. Policy Manual Appendix A-9 sets forth the ICP income limit for an individual at $1,911 effective January 2008. Appendix A-10 sets forth the federal benefit rate at $637. Three hundred percent of the federal benefit rate at the time of the application at issue was $1,911.

Fla. Integrated Pub. Policy Manual Section 1840.0110 in part states:

Income Trusts (MSSI)

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

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

1. it is established on or after 10/01/93 for the benefit of the individual;
2. it is irrevocable;
3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and
4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The eligibility specialist must forward all income trusts to their Region or Circuit Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A-22.1, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.

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

The above authorities provide for the establishment of an income trust by an Institutional Care Program applicant in order to reduce monthly income below the State income limitations. The income trust must be funded monthly in order to reduce the monthly income below the State income limitations. The Findings of Fact show that the income trust was established on January 4, 2008. However, the income trust was not funded in the months of June 2008 or July 2008. The above authority explains that the

individual must make the deposit each month that eligibility is requested. Therefore, the petitioner's total income was available to be counted in the eligibility determination process for June 2008 and July 2008. As the total gross income of $2,491 exceeded the Department's income limitation of $1,911, the petitioner was not eligible to receive Institutional Care Program benefits for the months of June 2008 or July 2008. Therefore, the Department correctly denied Institutional Care Program benefits for those months.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 20th day of January, 2009, in Tallahassee, Florida.

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

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

APPEAL NO. 08F-07644

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 22, 2009, at 10:35 a.m., in Lake Worth, Florida. The petitioner was not present but was represented by her grandmother,

Representing the respondent was David King, management analyst, Agency for Health Care Administration (AHCA). Appearing as witnesses were: Sharon Garrison, registered nurse (RN), AHCA; Edna Clifton, operations manager, RN, Keystone Peer review Organization (KePro); and R. Mittal, M.D., medical consultant, for KePro.

ISSUE

At issue is whether the respondent was correct in reducing private duty nursing (PDN) hours from 20 hours each day Saturday and Sunday to 8 hours

each day based upon medical necessity. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a six year old (DOB 11-12-02) recipient of Medicaid services. She is diagnosed with Huntington's Chorea, has medical complexities and a G-tube for feeding.
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. Prior to the most recent review, the petitioner had been receiving PDN Monday through Friday at 24 hours per day and 20 hours each Saturday and Sunday.
4. KePro reviewed the submitted reports in October 2008 and determined, October 24, 2008, that the Saturday and Sunday hours should be reduced from 20 to 8 hours each day. Notice was given and also the right for a reconsideration.
5. A reconsideration was done and, on October 30, 3008, the Saturday and Sunday hours would now be reduced from 20 to 13. Thus, there would be a loss of 7 hours each day.
6. The respondent explains that the grandmother is trained and does not work on the weekends. PDN services "are authorized to supplement care provide by the parents and caregivers".

7. The grandmother explains that she was never formally trained. On one occasion when she was caring for the petitioner the nurse arrived and told her that she was not performing something properly. When told what to do, this was considered training.

8. Presently the grandmother is on worker's compensation and cannot lift the petitioner when needed. This information has been forwarded to KePro for evaluation.

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 Covered Services, Limitations and Exclusions

Handbook July 2008 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.

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.

In this instant case, the respondent has the burden of proof when reducing benefits. The grandmother has testified that she had not received training. The respondent has not provided any evidence that there was any proper training to care for a medically complex child.

Further, it has been the experience of this hearing officer that when the respondent is seeking to reduce PDN benefits, it is in the best interest of the petitioner and/or the caregiver(s) that the reduction be done gradually. That is, reduce the hours by two or four initially in order that it can be determined that the caregiver is capable of performing the necessary tasks.

The initial request to reduce the Saturday and Sunday hours from 20 to 8 each day is too excessive. The reconsideration that took it from 20 to 13 each day is also too excessive. It would have been better to reduce it from 20 to 16 at the most, preferably from 20 to 18.

DECISION

The appeal is granted. The PDN hours will remain at 20 each day, Saturday and Sunday. The respondent will insure that the grandmother is properly trained in providing the necessary services for the petitioner.

It is not until that is done that the reduction in hours can be entertained.

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 27th day of January, 2009,

in Tallahassee, Florida.

Melvyn Littman

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

Copies Furnished

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

[redacted]

APPEAL NO. 08F-07455

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on December 16, 2008, at 2:24 p.m., in New Port Richey, Florida. The infant petitioner was not present but was represented by his mother, who also testified. Kathy Sizak-Freeman, registered nurse specialist with the Agency For Health Care Administration (AHCA), represented the respondent and testified.

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

ISSUE

At issue is the respondent's decision of October 24, 2008 to terminate private duty nursing (PDN) hours paid by Medicaid. The respondent previously

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

FINDINGS OF FACT

1. The petitioner is one of six children all born at 29 weeks gestation on September 1, 2007. A five year-old sister also lives in the home. The petitioner and all his siblings lives with and receives care from his mother. The petitioner's father also lives in the home.
2. The petitioner's father works from 3:00 a.m. until noon seven days weekly in a self-employment business. The petitioner's mother and caretaker do not work outside the home. However, the petitioner's mother assists with paperwork in the self-employment business.
3. The petitioner received PDN 12 hours daily seven days weekly prior to the termination action at issue. On October 24, 2008, the respondent sent notice to petitioner that all PDN hours for the petitioner had terminated, based on the respondent conclusion of no medical necessity. The termination action was upheld by the respondent upon request for reconsideration on October 31, 2008. The petitioner seeks to retain the prior 12 hour daily PDN services for the reviewing period of October 24, 2008 to April 21, 2009.
4. As of the date of hearing, two nurses were in the home at night, and there was one nurse in the daytime for the all the sextuplets. The petitioner received PDN hours from 8:00 p.m. to 8:00 a.m. before the intended action to terminate the PDN hours at issue.

5. Even though the petitioner's health has drastically improved, the petitioner's pediatrician requests continued nursing care through the night to monitor his respiratory status. The petitioner is not on an apnea monitor and has no nightly upper respiratory intervention. The petitioner has not had recent upper respiratory problems except for an upper respiratory infection. The petitioner receives Albuterol by an inhaler on an as needed basis. The petitioner had not been hospitalized in the last 60 days.
6. The petitioner has diagnoses to include prematurity, retinopathy of prematurity, and patent forame. Patent forame is a low pressure small opening in the upper chamber of the heart. Dr. Buzzeo opines that most children grow out of this condition.
7. The petitioner is on no medical devices. He receives regular baby food by mouth. The petitioner receives myilicon for gastric pain, albuterol for wheezing and bottom paste for diaper rash.
8. The respondent contracts with Kepro physicians to make a medical necessity determination for the requested PDN hours at issue. The Kepro physicians make medical necessity determinations based on the clinical and social information supplied them by the nursing provider. Based on this information, the Kepro physician determined the petitioner no longer meets medical necessity criteria for PDN hours. The Kepro reviewing physician, Dr. Robert Buzzeo, testified at the hearing. Dr. Buzzeo opines that the petitioner's upper

respiratory condition does not warrant the need for private duty nursing services at night as requested.

9. The petitioner's mother is on Prozac and Xanax due to conditions of post-partum depression and anxiety. The petitioner's mother complains of an unsteady gait as a side effect of the medication. However, the evidence does not show that the petitioner's mother and caretaker is unable to provide for the petitioner's needs.

CONCLUSIONS OF LAW

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

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

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

The petitioner's treating physician opines that PDN services remain necessary at night to monitor the petitioner's respiratory status. This opinion of the treating physician was given considerable and substantial weight to evaluate the medical necessity of PDN services. The evidence shows that it would be helpful to continue nursing care hours to monitor the petitioner's respiratory status. However, the "medical necessity" definition sets a higher standard of medically necessity to those services that are necessary to "protect life, significant illness or disability, or to alleviate severe pain."

The evidence shows that the petitioner's overall condition has drastically improved, per the treating physician. While it is evident that the petitioner would benefit from upper respiratory monitoring, it must be concluded whether this risk rises to a level of requiring private duty nursing services to monitor such. The petitioner's current respiratory condition does not suggest that this risk rises to the defined medical necessity for continued PDN services at night. Therefore, there is good cause to conclude that Dr. Buzzeo's testimony on the lack of defined medical necessity for continued PDN hours overcomes the customary weight given the treating physician's opinion on the request for PDN hours.

petitioner's treating physician or on the reconsideration requests. The conservative measures had not been completed and the diagnostic test (laparoscopy) had not been done. The reviewing physician needed the results of a laparoscopy before determining whether a complete abdominal hysterectomy met the Medicaid medically necessary standards. Based on the above findings and controlling authorities, it is concluded that the respondent correctly denied the petitioner's request for prior authorization for inpatient hospital services for a complete abdominal hysterectomy, as medical necessity was not demonstrated.

The petitioner may wish to pursue the laparoscopy and if a problem is detected, she can then have her physician make a new request for prior authorization for inpatient hospital services, if needed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of February, 2009,

in Tallahassee, Florida.

Morris Zamboca

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

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

APPEAL NO. 08F-07131

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 2, 2008, at 10:47 a.m., in Tampa, Florida. The petitioner was not present. He was represented by his mother, Present on behalf of the mother from was licensed practical nurse. The respondent was represented by David Beaven, program analyst. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Rakesh Mittal, M.D., physician reviewer, and Edna Clifton, operations manager.

ISSUE

The petitioner is appealing the notices of October 8 and 16, 2008 for the respondent's action to deny 78 hours of private duty nursing for the period of October 8, 2008 through April 5, 2009. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner care is medically complex. He was receiving ten hours a day of private duty nursing. He attends Prescribed Pediatric Extended Care (PPEC) Monday through Friday from 8:00 a .m. to 5:00 p.m. and Saturday from 9:00 a.m. to 4:00 p.m. The petitioner resides with grandmother and grandfather. The grandmother attested that she has adopted the child. (The hearing officer will refer to the parents as grandmother and grandfather as indicated by the provider in documentation sent to the respondent) The grandmother is working. The grandmother is capable of providing care for the petitioner. The grandfather is not working and has medical problems. The petitioner does not have any siblings residing in the home.

2. The nursing agency (provider) requested 1,800 hours of private duty nursing for the petitioner for the period of October 8, 2008 through April 5, 2009. The agency requested ten hours a day of private duty nursing from 9:00 p.m. to 7:00 a.m. The provider reported that the grandmother was working and her hours vary. The provider indicated that the grandmother's typical schedule was Monday 9:00 a.m. to 6:00 p.m., Tuesday 7:00 a.m. to 5:00 p.m., Wednesday from 4:00 p.m., and off on Thursday and Friday.

3. Prior authorization for private duty nursing is reviewed every 180 days. KePRO is the contract provider for the respondent for the prior authorization decisions for private duty nursing. The request for private duty nursing is reviewed by a nurse reviewer and a physician consultant.

4. 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 decided that based on the information reported by the provider, the days the grandmother worked (Monday, Tuesday and Wednesday) were approved for 10 hours a days and the days she was off (Thursday and Friday) were approved for 9 hours a day. A PDN/PC Recipient Denial Letter was sent to the petitioner on October 8, 2008. The notice informed the petitioner that for the requested 1,800 hours of private duty nursing for the period of October 8, 2008 through April 5, 2008, 1,696 hours was approved and 104 hours were denied.

6. The nursing agency requested a reconsideration. The reconsideration was reviewed by a second physician consultant. The provided informed the respondent that Thursday was the day the grandmother would work at her new job. The second physician consultant determined that additional hours were necessary as the grandmother started a new job. The physician consultant recommended approval for the hours of from 9:00 p.m. to 10:00 p.m. on Thursday. The hour from 9:00 p.m. to 10:00 p.m. on Friday, Saturday and Sunday night would continue to be denied. The respondent sent a PDN/PC Recipient Reconsideration - Denial Upheld notice on October 16, 2008. The

notice informed the petitioner that for the requested 1,800 hours of private duty nursing for the period of October 8, 2008 through April 5, 2008, 1,722 hours was approved and 78 hours were denied.

7. The licensed practical nurse attested that the hours submitted were the hours reported by the petitioner as the hours she worked the two weeks before the October 10, 2008 request. The grandmother attested as follows. She is working at her regular job Monday 10:00 a.m. to 6:30 p.m., Tuesday 10:00 a.m. to 6:30 p.m., Wednesday 2:00 p.m. to 10:30 p.m., Thursday 2:00 p.m. to 10:30 p.m. and Sunday either 8:00 a.m. to 4:30 p.m. or 6:00 a.m. to 2:30 p.m. She had been working that schedule for months. She started her part-time job after the October 10, 2008 request. She works at the part-time job on Friday from 9:00 a.m. to 2:00 p.m. She is off on Saturdays. The petitioner has medical problems and needs surgery. She is taking the petitioner, herself and her husband to doctor appointments. Her husband and family help her with the petitioner's care.

8. The physician reviewer stated that the hours attested to by the petitioner were not the same as reported by the provider. He attested that the hours the grandmother worked would impact the decision; however, he was unwilling to make any further reconsideration. The respondent indicated that the petitioner may request any additional hours or services for changes that occur, such as the grandmother requiring surgery.

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 by the respondent was based on the hours the grandmother worked as reported by the provider. The physician consultants recommended that the hour from 9:00 p.m. to 10:00 p.m. on Friday, Saturday and Sunday night would be denied. The hearing officer must give deference to the opinion of a physician. However as the hours reported to the respondent in making their decision were not the same hours attested to by the petitioner and the physician consultant attested that the hours worked would impact the decision, the hearing officer is making the decision based on the hours reported by the petitioner.

The hours of private duty nursing that the respondent denied were 9:00 p.m. to 10:00 p.m. Friday, Saturday and Sunday from October 8, 2008 through April 5, 2009. On Fridays, the petitioner works her part-time job from 9:00 a.m. to 2:00 p.m. and the petitioner attends PPEC from 8:00 a.m. to 5:00 p.m. On Saturdays, the petitioner is off and the petitioner attends PPEC from 9:00 a.m. to 4:00 p.m. On Sundays, the petitioner works from 8:00 a.m. to 4:30 p.m. Based on the hours reported by the petitioner, she is home during the

hours of 9:00 p.m. to 10:00 p.m. Friday, Saturday and Sunday. The evidence does not support a finding of medical necessity for ten hours a day of private duty nursing on Friday, Saturday and Sunday. Medical necessity was demonstrated for 10 hours a day Monday through Thursday and 9 hours a day Friday through Sunday. Based on the above cited authorities, the respondent's action to approve 1,722 hours and deny 78 hours of private duty nursing for the period of October 8, 2008 through April 5, 2008 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 16th day of January, 2009,

in Tallahassee, Florida.

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

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

APPEAL NO. 08F-07796

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 19, 2008, at 11:11 a.m., in St. Petersburg, Florida. The petitioner was present. Present on behalf of the petitioner was his friend, The respondent was represented by Linda Thompson, senior program specialist. Katherine Sisek-Freeman, registered nurse specialist, was observing. Witnesses for the respondent from the Bureau of Managed Care who appeared by telephone were Laura Rumph, unit manger, and Cathy Wilson, registered nurse consultant. Witnesses for the respondent from the Amerigroup who appeared by telephone were Toni Mitchell, M.D., regional medical director; Vickie Deloatch, quality manager; Mitch Wright, director of regulatory service, and Hannanh Kurish, nurse case manager.

ISSUE

The petitioner is appealing notices for the respondent's action to deny his prescription for Ensure.

FINDINGS OF FACT

1. The petitioner is a Medicaid eligible individual. The petitioner requested Ensure for additional nutrition. Three years ago, he had dentures that resulted in painful sores on his gums and in his mouth. He had trouble chewing. He took pain medication for three years. The petitioner attested that he is gaining some weight and is eating a somewhat regular soft diet.

2. The request was made by the petitioner treating physician for two cans of Ensure a day. The prescription was written on August 26, 2008. The diagnosis was difficulty in chewing and dentures.

3. Requests for Ensure are considered an enteral nutrition product. As an enteral supply the item would be considered durable medical equipment. Prior authorization for Ensure is done by Amerigroup, a contract provider for the respondent. Amerigroup reviewed the request. Amerigroup gave prior authorization for the petitioner's request for Ensure for thirteen months. The regional medical director opined that thirteen months was sufficient time to address the petitioner's dental issues. On September 2, 2008, Amerigroup denied the petitioner request for Ensure, as the request did not meet the criteria as a sole source of nutrition. On September 10, 2008, a letter of denial was sent to the petitioner's treating physician by Amerigroup's regional medical director.

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 Administrative Code at 59G-4.070, "Durable Medical Equipment and Supplies" incorporates the handbook into rule:

> (1) This rule applies to all durable medical equipment and supply providers enrolled in the Medicaid program.
> (2) All durable medical equipment and supply providers enrolled in the Medicaid program must comply with the Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, April 1998, incorporated by reference...

Enteral feeding formula policy is set forth in the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook (June 2005):

> Enteral Nutrition Products
> Florida Medicaid covers commercially prepared enteral products when the criteria listed below are met...
> Medicaid does not cover enteral products for patients who are institutionalized (Plan 200).
> Medicaid does not cover enteral products for weight reduction, bodybuilding, athletic performance, enhancement, anorexia, or bulimia.
> **Patients age 21 and older:**
> Standard 1 – 2 kcal/ml products are covered if product is the patient's sole source of nutrition. Patient must have documented diagnosis of a barrier to ingestion, digestion, and/or absorption of regular food, or a diagnosis of renal failure or hepatic failure.

The petitioner is eating a somewhat regular soft diet. The Ensure is not the petitioner's sole source of nutrition. The petitioner does not have a

documented diagnosis of a barrier to ingestion, digestion, and/or absorption of regular food, or a diagnosis of renal failure or hepatic failure. Based upon the above cited authorities, the respondent's action to deny the petitioner's request for Ensure is 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 16th day of January, 2008,

in Tallahassee, Florida.

Linda Jo Nicholson

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

Copies Furnished T

Further, it is not evident that the petitioner's mother and caregiver can not provide needed care to the petitioner, even though she has certain health issues and many responsibilities in her home. The language of the cited "Home Health Services Coverage and Limitations Handbook," on page 2-15, shows that parents and caregivers must participate in care "to the fullest extent possible," as in the following excerpt:

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

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

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

DONE AND ORDERED this 20th day of January, 2009,

in Tallahassee, Florida.

Jim Travis

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

Copies Furnished

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

APPEAL NO. 08F-07454

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on December 16, 2008, at 3:09 p.m., in New Port Richey, Florida. The infant petitioner was not present but was represented by his mother, who also testified. Kathy Sizak-Freeman, registered nurse specialist with the Agency For Health Care Administration (AHCA), represented the respondent and testified.

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

ISSUE

At issue is the respondent's decision of October 24, 2008 to terminate private duty nursing (PDN) hours paid by Medicaid. The respondent previously

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

FINDINGS OF FACT

1. The petitioner is one of six children all born at 29 weeks gestation on September 1, 2007. A five year-old sister also lives in the home. The petitioner and all his siblings lives with and receives care from her mother. The petitioner's father also lives in the home.
2. The petitioner's father works from 3:00 a.m. until noon seven days weekly in a self-employment business. The petitioner's mother and caretaker does not work outside the home. However, the petitioner's mother assists with paperwork in the self-employment business.
3. The petitioner received PDN 12 hours daily seven days weekly prior to the termination action at issue. On October 24, 2008, the respondent sent notice to petitioner that all PDN hours for the petitioner had terminated, based on the respondent conclusion of no medical necessity. The termination action was upheld by the respondent upon request for reconsideration on October 31, 2008. The petitioner seeks to retain the prior 12 hour daily PDN services for the reviewing period of October 24, 2008 to April 21, 2009.
4. As of the date of hearing, two nurses were in the home at night, and there was one nurse in the daytime for the all the sextuplets. The petitioner received PDN hours from 8:00 a.m. to 8:00 p.m. before the intended action to terminate the PDN hours at issue.

5. Even though the petitioner's health has drastically improved, the petitioner's pediatrician requests continued nursing care through the night to monitor her respiratory status. The petitioner is subject to upper respiratory infection. The petitioner is not on an apnea monitor, is on no respiratory medications, and has no nightly upper respiratory intervention. The petitioner has not had recent upper respiratory problems except for an upper respiratory infection. The petitioner has not been in the hospital in the last 60 days.
6. The petitioner has diagnoses to include prematurity, retinopathy of prematurity, patent forame, and respiratory distress syndrome.
7. The petitioner is on no medical devices. She receives regular baby food by mouth. The petitioner receives mylicon for gastric pain, bottom paste for diaper rash, and motrin or tylenol for pain, as needed.
8. The respondent contracts with Kepro physicians to make a medical necessity determination for the requested PDN hours at issue. The Kepro physicians make medical necessity determinations based on the clinical and social information supplied them by the nursing provider. Based on this information, the Kepro physician determined the petitioner no longer meets medical necessity criteria for PDN hours. The Kepro reviewing physician, Dr. Robert Buzzeo, testified at the hearing. Dr. Buzzeo opines that the petitioner's risk for upper

respiratory infection does not warrant the need for private duty nursing services at night as requested.

9. The petitioner's mother has a diagnosed condition of post-partum depression and panic attacks. The petitioner's mother is concerned about her ability to administer medications to all six infants appropriately. However, the evidence does not show that the petitioner's mother and caretaker is unable to provide for the petitioner's needs.

CONCLUSIONS OF LAW

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

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

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

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

The petitioner's treating physician opines that PDN services remain necessary at night to monitor the petitioner's respiratory status. This opinion of the treating physician was given considerable and substantial weight to evaluate the medical necessity of PDN services. The evidence shows that it would be helpful to continue nursing care hours to monitor the petitioner's respiratory status. However, the "medical necessity" definition sets a higher standard of medically necessity to those services that are necessary to "protect life, significant illness or disability, or to alleviate severe pain."

The evidence shows that the petitioner's overall condition has drastically improved, per the treating physician. While it is evident that the petitioner would benefit from upper respiratory monitoring, it must be concluded whether this risk rises to a level of requiring private duty nursing services to monitor such. The petitioner's current respiratory condition does not suggest that this risk rises to the defined medical necessity for continued PDN services at night. Therefore, there is good cause to conclude that Dr. Buzzeo's testimony on the lack of

defined medical necessity for continued PDN hours overcomes the customary weight given the treating physician's opinion on the request for PDN hours.

Further, it is not evident that the petitioner's mother and caregiver can not provide needed care to the petitioner, even though she has certain health issues and many responsibilities in her home. The language of the cited "Home Health Services Coverage and Limitations Handbook," on page 2-15, shows that parents and caregivers must participate in care "to the fullest extent possible," as in the following excerpt:

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

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

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 20th day of January, 2009,

in Tallahassee, Florida.

Jim Travis

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

Copies Furnished T

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

APPEAL NO. 08F-05729

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on November 6, 2008, at 3:25 p.m., in New Port Richey, Florida. The petitioner was not present but was represented by his mother, who also testified. Kathy Sizak-Freeman, registered nurse specialist with the Agency For Health Care Administration (AHCA), represented the respondent and testified.

registered nurse and director of clinical services with appeared as a witness for the petitioner.

Two persons with Kepro appeared as witnesses for the respondent by telephone: Edna Clifton, operations manager, and Dr. Rakesh Mittal, pediatrician and physician reviewer.

ISSUE

At issue is the respondent's decision of August 18, 2008 to reduce private duty nursing (PDN) hours paid by Medicaid. The respondent previously paid for 24 hours daily, seven days (24/7) weekly PDN. The respondent reduces PDN by four hours on both Saturday and Sundays, from 3:00 to 7:00 p.m. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is now twenty years old and was born on [redacted]. He has no siblings in the home. The petitioner lives with and receives care from his 58 year-old mother. There is no father in the home.
2. The petitioner's mother is a high school teacher. She puts in approximate 16 hour days during the week working as a teacher of gifted, second language and special learning disabilities students. Some hours are spent after class grading papers at the school because the petitioner's need for care distracts. The petitioner's mother has a private business doing resumes on weekends for variable hours, between 12 and 16 weekend hours daily, per testimony.
3. Prior to August 18, 2008, the petitioner received 24/7 hours daily PDN. On August 18, 2008, the respondent reduced PDN hours by 208 hours quarterly. The petitioner requested to continue prior approved 24/7 PDN hours in this hearing request dated August 28, 2008. Upon reconsideration on September 23, 2008, quarterly PDN hours were to be reduced by 168 hours quarterly. However, the respondent re-approved

24/7 PDN hours through October 2, 2008 after a hospitalization in August 2008. Since October 2, 2008, the respondent reduced PDN hours by four hours, on Saturdays and Sundays only. The respondent believes the petitioner's mother can provide needed services to the petitioner from 3:00 p.m. to 7:00 p.m. on weekends. The petitioner seeks to retain the prior 24/7 PDN services for the reviewing period that ends February 25, 2009.

4. The petitioner is a medically complex individual with many diagnoses to include: cerebral palsy, spastic quadriplegia, seizure disorder, RSDS, scoliosis, non-ambulatory, asthma, sleep apnea, and history of gastric issues. The petitioner had colonoscopies performed in late 2007 and spring 2008 to attempt to remove large fecal impactions. The petitioner underwent abdominal surgery on August 8, 2008 to remove a bezoar. After this recent surgery, the petitioner remained in the hospital for three weeks due to pulmonary complications.

5. The petitioner receives continuous feeding through a gastrostomy tube (GT). The petitioner requires preparation and feeding through this GT. The petitioner is not verbal and is incontinent of bowel and bladder. The petitioner receives continuous oxygen therapy and monitoring. The petitioner needs catherization about three times weekly. The petitioner has hand splints, foot orthotics and uses a thoracic lumbar sacral orthotic. The petitioner has an implanted baclofen pump which is refilled every three months.

6. Dr. is the petitioner's treating neurologist. In his letter of October 13, 2008, Dr. opines the petitioner to continue to need 24 hour daily nursing care by trained nurses to decrease the number of hospital admissions. Dr. opines that the patient must be monitored for occasional absence seizures and tremors, as well as signs or symptoms of pain and discomfort. This neurologist opines that the Baclophen pump must be checked for correct operation. Further, he opines that the petitioner's breathing must be monitored.

7. Dr, is the petitioner's treating gastroenterologist. In his letter of October 10, 2008, Dr. notes that the petitioner had two to three emesis episodes per week at night while using bi-pap. The petitioner has had occasional daytime emesis with little or no warning that vomiting is eminent. Nursing staff have positioned and suctioned the petitioner to prevent aspiration. Dr. opines the petitioner to need continued 24/7 skilled nursing to prevent nausea and aspiration to avoid hospitalization. Further, nurses continue to administer medications.

8. Dr. is another treating physician. In his letter of October 1, 2008, Dr. also opines the petitioner to need continued 24/7 care by full trained experienced registered nurses, or specially trained licensed practical nurses. Dr. opines that the petitioner will require frequent and prolonged hospitalizations if nursing hours are reduced.

9. The respondent contracts with Kepro physicians to make a medical necessity determination for the requested PDN hours at issue. The Kepro physicians make medical necessity determinations based on the clinical and social information supplied them by the nursing provider. Based on this information, the Kepro physician determined those PDN hours can be reduced by four hours on Saturdays and Sundays. The Kepro reviewing physician, Dr. Rakesh Mittal, testified at the hearing. Dr. Rittal believes that the petitioner's mother is able to provide care to the petitioner from 3:00 p.m. to 7:00 p.m. on Saturdays and Sundays.
10. The petitioner's mother has not had any medical training. However, the petitioner's mother has infrequently provided care to the petitioner when nurses were not available. The petitioner's mother has pain in her upper back and has a recent diagnosis of chronic fatigue syndrome. The petitioner requires much preparation for sleeping from 3:00 p.m. to 7:00 p.m., per testimony. The petitioner's mother may fall asleep during this time due to exhaustion, per testimony.

CONCLUSIONS OF LAW

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

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

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the contracted Kepro reviewing physician recommends the reduction of ongoing nursing services based on his evaluation of the petitioner's needs. The Kepro physician opines that the petitioner's caregiver is able and required to provide care to the petitioner for four hours daily on weekends.

The opinion of the treating physicians must be given considerable and substantial weight to evaluate the medical necessity of the reduction of the PDN services at issue. There must be a conclusion of good cause to overcome the customary weight given the treating physician's opinion on the continued need for 24/7 nursing care. In this appeal, three different treating physicians opine that it is necessary to retain continued 24/7 nursing care to reduce hospital care.

This treating opinion evidence consistently shows the medical need of continuous care and monitoring of the medically complex petitioner by fully trained nurses. The petitioner's mother is not such trained nurse. The cumulative medical evidence shows that the petitioner has medical conditions that meet the high standard of defined medically necessity for continued 24/7 nursing care in order to "protect life, significant illness or disability, or to alleviate severe pain." The opposing cumulative respondent medical opinion does not show good cause to overcome the customary weight of the treating opinion evidence.

The language of the cited "Home Health Services Coverage and Limitations Handbook," on page 2-15, shows that parents and caregivers must participate in care "to the fullest extent possible," as in the following excerpt:

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

The cumulative evidence does not show that the petitioner has the medical knowledge necessary to provide all of the petitioner's care needs. Further, the petitioner's caregiver has health issues and work schedule conflicts that preclude her current ability to provide care to the petitioner during the hours at issue. In sum, it is not concluded that the respondent has met its burden to justify the reduction of the PDN hours at issue.

DECISION

This appeal is granted. The respondent is ordered to continue approve 24/7 PDN hours.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 6th day of January, 2009, in Tallahassee, Florida.

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

Copies Furnished

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

APPEAL NO. 08F-07564

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 2, 2008, at 9:22 a.m., in Tampa, Florida. The petitioner was not present. He was represented by his mother, Present on behalf of the petitioner from (the petitioner's nursing agency) was egistered nurse. The respondent was represented by David Beaven, program analyst. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Rakesh Mittal, M.D., physician reviewer, and Edna Clifton, operations manager.

ISSUE

The petitioner is appealing the notices of September 25, 2008, October 7, 2008 and October 20, 2008 for the respondent's action to deny 180 hours of private duty nursing for the period of September 1, 2008 through February 27, 2008. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner care is medically complex. She was receiving private duty nursing. The petitioner is tube fed every four hours: 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., 10:00 p.m., and 2:00 a.m. The petitioner attends school with a nurse Monday through Friday from 8:00 a.m. to 3:00 p.m. The petitioner resides with her mother, her 17 year old sibling and the sibling's child who is nine months old. The petitioner's mother works from 8:00 a.m. to 3:00 p.m. The mother provides care for the petitioner when the private duty nurses are not scheduled.

2. The nursing agency requested 2,889 hours of private duty nursing for the petitioner for the period of September 1, 2008 through February 27, 2008. The hours of private duty nursing requested were Monday through Thursday 7:00 a.m. to 4:00 p.m. and 10:00 p.m. to 7:00 a.m., Friday 7:00 a.m. to 3:00 p.m. and 10:00 p.m. to 7:00 a.m., Saturday 7:00 a.m. to 12:00 p.m. and 10:00 p.m. to 7:00 a.m. and Sunday 10:00 p.m. to 7:00 a.m.

3. Prior authorization for private duty nursing is reviewed every 180 days. KePRO is the contract provider for the respondent for the prior authorization decisions for private duty nursing. The request for private duty nursing is reviewed by a nurse reviewer and a physician consultant.

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 "...reduce night hours to usual 8 hr (11P-7A). Approve remaining hours". A PDN/PC Recipient Denial Letter was sent to the petitioner on September 25, 2008. The notice informed the petitioner that for the 2,889 hours of private duty nursing requested, 2,709 hours was approved and 180 hours were denied for the period of September 1, 2008 through February 27, 2008.

6. The nursing agency requested a reconsideration. The reconsideration was reviewed by a second physician consultant. The physician reviewer opined that the mother was capable of performing the care, the grandchild should be asleep by 10:00 p.m. and the 17 year old sibling was capable of caring for herself or assisting the mother. For the reconsideration for the requested 2,889 hours of private duty nursing, 2,709 hours were approved and 180 hours were denied for the period of September 1, 2008 through February 27, 2008. The respondent sent a PDN/PC Recipient Reconsideration - Denial Upheld notice on October 7, 2008.

7. Another reconsideration was completed and reviewed by a different physician consultant. For the second reconsideration for the requested 2,889, 2,709 hours were approved and 180 hours were denied for the period of

September 1, 2008 through February 27, 2008. The respondent sent a PDN/PC Recipient Reconsideration - Denial Upheld notice on October 20, 2008.

8. The physician review recommended that the tube feeding hours be changed to 11:00 p.m., 3:00 a.m. and 7:00 a.m. or that the mother provide the feeding at 10:00 p.m.

9. The mother attested as follows. From 4:00 p.m. to 10:00 p.m., she is caring for the petitioner. When she is caring for the petitioner, the petitioner has her tube feeding at 6:00 p.m. The petitioner's feeding takes an hour. Someone must stay with the petitioner during the entire feeding for tracheotomy care and monitoring aspiration. At 7:00 a.m., the petitioner gets ready for school. The mother opined that if she started the petitioner's feeding one hour later at 7:00 a.m. the petitioner would have no time to get ready to be at school and she would have no to time to get ready for work. The petitioner's mother concern is that she needs to care for her other daughter who is 17 years old and her grandchild and could not provide this care if she was feeding the petitioner at 10:00 p.m.

10. The nurse attested that the petitioner needs to be in bed at 10:00 p.m. The nurse does more than just the feeding for the petitioner at 10:00 p.m. The nurse performs tracheotomy care, places pulse oxygen meter and other treatments. The petitioner needs to be kept on schedule and get adequate rest for school. The last few weeks, the petitioner has been sick, vomiting, losing weight, running a fever and at risk for aspiration. The respondent was made aware of these changes.

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 petitioner's mother is capable of caring for the petitioner. The petitioner's mother does the petitioner's feeding and care at 6:00 p.m. The hearing officer must give deference to the medical opinion of a physician. The expert found that the mother was capable of providing care the petitioner's care from 10:00 p.m. to 11:00 p.m. No evidence was submitted to the mother was unable to care for the child from 10:00 p.m. to 11:00 p.m. Based on the above cited authorities, the respondent's action to deny 108 hours of private duty nursing for the period of September 1, 2008 through February 27, 2008 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 16th day of January, 2009,

in Tallahassee, Florida.

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

Copies Furnished

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

APPEAL NO. 08F-08033

PETITIONER,

Vs.

CASE NO. 1007463007

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 10 Broward
UNIT: 88139

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 18, 2008, at 9:30 a.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by case manager from the Florida. The respondent was represented by Jacqueline Pusley, Florida Access specialist.

ISSUE

At issue is the Department's November 17, 2008, action of denying the petitioner's October 7, 2008 Institutional Care Program Medicaid application, due to not providing the Department with proof of identification, and United States citizenship. The petitioner has the burden of proof.

FINDINGS OF FACT

1. Included in the evidence is a copy of a Notice Of Case Action form dated November 17, 2008, stating that the petitioner's October 7, 2008 Institutional Care Program (ICP) Medicaid application was denied because the Department did not receive information needed to process the case.

2. The reason for the ICP Medicaid application denial was that the Department was not provided with the petitioner's proof of identification, and U.S. citizenship.

3. According to the parties at the hearing, there were previous applications for the petitioner for ICP Medicaid benefits. They were denied due to the petitioner not providing the Department with proof of identification, and U.S. citizenship.

4. Included in the evidence is a copy of an Appointment Notice/Request for Information form dated October 15, 2008. On this form, the petitioner's representative is being requested to provide the Department with proof of citizenship, and a copy of a photo identification by the deadline of October 27, 2008.

5. Included in the evidence are copies of Appointment Notice/Request for Information forms from the petitioner's previous ICP Medicaid applications that are dated April 8, 2008, July 17, 2008, and September 3, 2008. The petitioner's representative was requested to provide the Department with information, including proof of citizenship, and a photo identification for the petitioner.

6. As with the October 7, 2008 ICP Medicaid application, all of the previous ICP Medicaid applications were denied because the petitioner did not provide the Department with proof of identification, and U.S. citizenship.

7. According to the petitioner's representative at the hearing, the petitioner was in the nursing home from February 2008 to April 2008. She is requesting Institutional Care Program Medicaid benefits for that time period.

8. According to the petitioner's representative, the petitioner was homeless previous to the time that he was in the nursing home. When he left the facility in April 2008, he moved to Georgia to live with relatives.

CONCLUSIONS OF LAW

In the Medicaid Program, in accordance with Fla. Admin. Code 65A-1.205(1):

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

The Public Assistance Policy Manual at 1440.0400 and 1440.0103 explain that in order to get Medicaid benefits, the individual's proof of identification and U.S. citizenship must be documented. In the eligibility process, certain information must be verified and documented. The eligibility specialist must obtain the facts of the situation of the individual. The petitioner's Institutional Care Program Medicaid application was denied because the Department was not provided with proof of his identification, and U.S. citizenship. This was requested on a October 15, 2008 Request for Information form, with a deadline of October 27, 2008.

The petitioner's representative argued that the Department did not help the petitioner with getting proof of his identification, and U.S. citizenship. According to the respondent's representative, she spoke to the petitioner's representative, and even on the

previous applications, she spoke to her about getting this information. She explained that if the petitioner's representative gets at least a picture of the petitioner for a photo identification, then something might be done to start the process of getting the identification, and the proof of citizenship that is needed to determine his ICP Medicaid benefits eligibility.

The petitioner's representative submitted into evidence copies some of the petitioner's medical records from when he was in the Imperial Point Medicaid Center, and she argued that doctors identified the petitioner. According to the respondent's representative, these medical records are not sufficient documentation for proof of the petitioner's identification, and U.S. citizenship. After careful consideration, it is determined that the Department's action to deny the petitioner's Institutional Care Program Medicaid application, due to not providing proof of identification, and U.S. citizenship, is upheld.

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 16th day of January, 2009,

in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished

opinion that given the new information he would see no problem in approving the night hours of 10 pm to 3 am. Based on evidence presented the appeal is granted.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11th day of February, 2009, 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: [redacted]

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

[redacted]

APPEAL NO. 08N-0230

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on December 30, 2008, at 12:05 p.m., in Miami, Florida. The petitioner was present and represented himself at the hearing. Representing the facility was , nursing home administrator. Present as witnesses for the respondent were acility physician; social worker; and , social worker.

ISSUE

At issue is whether or not the facility's action of November 24, 2008 to discharge the petitioner is an appropriate action, based upon the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because, "Your health has improved sufficiently so that you no longer need the services provided by

this facility." The nursing home has the burden of proof to establish that the discharge action is consistent with federal regulations.

FINDINGS OF FACT

1. The petitioner is a resident of Miami-Dade County. The petitioner was admitted to the facility on November 29, 2006 after a hospital discharge and complications with diabetes and hypertension. The petitioner is seen by the facility's physician.
2. The petitioner had a previous discharge notice issued and a hearing was conducted. In September 2008 the undersigned hearing officer ruled against the petitioner, however the facility did not discharge the petitioner but opted to have him stay until a stomach problem was resolved. The petitioner's treating physician stated that there was no longer a concern with the petitioner's stomach.
3. On November 29, 2008, the facility's physician authorized the facility to initiate the discharge process for the petitioner, as he was found medically ready for discharge.
4. A Notice of Discharge was issued to the petitioner with an intended discharge date of December 25, 2008. The petitioner filed for an appeal of that action.
5. At the hearing the physician stated that the petitioner is completely independent in his activities of daily living and has improved where he is able to live in the community and does not need the services of a skilled care facility. The petitioner can continue to receive medical care in the community. The

physician states that from a medical standpoint, the petitioner has improved sufficiently where he can be discharged.

CONCLUSIONS OF LAW

42 C.F.R. § 483.12 Admission, transfer and discharge rights states in part:

> (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 plants or not. (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- (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident ... (iii) Include in the notice the items described in paragraph (a)(6) of this section. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for the transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; ...

The petitioner states that he feels that the physician's statements were correct.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The notice, as required, noted the reason for the discharge as "your health has improved sufficiently so that you no longer need the services provided by this facility."

The hearing officer finds that the petitioner presented no medical evidence or testimony to contradict the medical opinion presented by the facility's physician, in fact, he agreed with him. The notice issued by the facility provided a location, to which the

petitioner was to be discharged and therefore, all requirements were found to have been met by the nursing facility.

DECISION

The appeal is denied. Pursuant to 42 C.F.R. § 483.12(7), the "facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of January, 2009, 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:

[redacted]

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

APPEAL NO. 08N-00209

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice an administrative hearing was convened at the nursing facility on January 7, 2009 at 11:00 a.m. The petitioner represented himself and administrator, represented the respondent. Ombudsman was present on behalf of the petitioner. Present to testify on behalf of the respondent were director of nursing, and social service director.

ISSUE

At issue was whether or not intent to discharge based on safety endangerment was correct. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner has resided at the facility for several years, following a stroke and hospitalization at the end of 2005.

2. He is lucid, alert, oriented, and capable of speaking for himself. He has physical problems and uses an electric wheelchair but can use some of his extremities with limited range of motion. He also has emotional problems and recognizes that he has "an anger problem." In the past several years he has had thirteen roommates, he frequently does not get along with his roommates, and he has repeatedly voiced his distress to them and in front of them. He acknowledged he had verbally threatened roommates, but had never actually committed violence on any of them.

3. He has seen a psychiatrist and a psychologist and takes medications of Ativan and Zoloft under psychiatric orders. In his opinion he has not seen a psychiatrist in about six months, but both the psychiatrist and psychologist are on staff at the facility and are available as requested, and the medications are currently ongoing. Thus, it is found that he is and has been under psychiatric care. Respondent's Exhibit 6 showed psychiatric notes of late December 2008 and early January 2009. Medication dosage has been increased.

4. On October 14, 2008 he had an altercation with his then roommate and threatened verbally to place a television set in a body cavity of the roommate. Law enforcement was called and responded and an abuse registry was contacted with a report filed. The petitioner did not commit words to action, but the words were threatening and the roommate was frightened and was then relocated within the facility.

5. According to both the petitioner and the respondent, there were repeated threats made to other patients over the years and several other patients

were intimidated by his words. The petitioner alleged he would not have taken any physical action. Documentation of verbal intimidation is in the nursing home records. Family members of other patients have complained about threats.

6. The petitioner was offered a private room at this facility, but such a change would be more costly and would involve different caregivers. He has declined that option.

7. On November 10, 2008, following the roommate/television incident, the facility issued Nursing Home Transfer and Discharge Notice saying, "safety of other individuals in this facility is endangered..." Location for discharge was a smaller facility in the county with transfer planned in 30 days. Respondent's Exhibit 1 was the discharge notice including doctor's confirmation of "psychosocial behaviors...verbal threats...poses a threat...safety risk to other residents with decreased physical and cognitive abilities who would be unable to protect themselves..."

8. The facility to which discharge is planned is smaller than the current location.

CONCLUSIONS OF LAW

Regulations at 42 C.F.R. § 483.12 address nursing facility **Admission, transfer and discharge rights** for residents, in relevant part as follows:

> (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--

(iii) The safety of individuals in the facility is endangered;
(iv) The health of individuals in the facility would otherwise be endangered;

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

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

(5) Timing of the notice.
(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice may be made as soon as practicable before transfer or discharge when--
(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section...

The petitioner argued he would not have committed words to action, and evidence established no physical injury has yet been caused by the petitioner. However, he clearly and self-admittedly has a significant anger control problem. This has caused other people to be intimidated and fearful on repeated occasions. Roommates have been moved because of his intimidating verbal behaviors. While medication is taken as prescribed, it has not eliminated the

angry and intimidating words. Though the petitioner might not actually inflict harm on the fragile people with whom he lives, those profoundly impaired people cannot be expected to know that his words would not be followed by dangerous actions. His impairments are not prima facie proof of his inability to inflict harm. To the contrary, he has apparent mobility and capability, although to a limited extent.

In final analysis, it is concluded that the facility has an obligation to protect all the fragile and impaired individuals who reside there. The petitioner's repeated threats create an endangering environment for others. Despite his disclaimers of violent intent, the verbal behaviors are more threatening than is generally acceptable. Other residents should not have to tolerate a fearful environment and they should not have to worry or fear the possibility that words could escalate to violent actions. Thus, it is concluded that the discharge intent is reasonable due to safety endangerment of others in the facility.

DECISION

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

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

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

DONE and ORDERED this 29th day of January, 2009, 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

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

[redacted]

APPEAL NO. 08N-0212

PETITIONER,

Vs.

[redacted],

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on December 30, 2008, at 12:20 p.m., in Miami, Florida. The petitioner was present and represented himself at the hearing. Present at the hearing was ombudsman. Representing the facility was nursing home administrator. Present as witnesses for the respondent were: facility physician; social worker; and social worker. served as translator. The Rule was invoked by the ombudsman, no objections were made.

ISSUE

At issue is whether or not the facility's action of November 18, 2008 to discharge the petitioner is an appropriate action, based upon the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because, "Your health has improved sufficiently so that you no longer need the services provided by

this facility." The nursing home has the burden of proof to establish that the discharge action is consistent with federal regulations.

FINDINGS OF FACT

1. The petitioner (age 57) is a resident of Miami-Dade County. The petitioner was admitted to the facility in March 2005 after a knee amputation and complications with diabetes. The petitioner uses a prosthesis and is seen by the facility's physician.
2. On November 18, 2008, the facility's physician authorized the facility to initiate the discharge process for the petitioner, as he was found medically ready for discharge.
3. A Notice of Discharge was issued to the petitioner with an intended discharge date of December 19, 2008. The petitioner filed for an appeal of that action on November 18, 2008.
4. At the hearing the physician stated that the petitioner is completely independent in his activities of daily living. He is ambulatory, can administer his own medication and does not require skilled nursing services.
5. The petitioner did have vision problems, but had a bi-lateral lens implant and currently his vision is "good."
6. The physician states that the petitioner is able to live in the community and can continue to receive follow up medical care from the community and Jackson Memorial Hospital's adult living facility (ALF). He states that from a medical standpoint, the petitioner has improved sufficiently where he no longer requires the services of the facility.

CONCLUSIONS OF LAW

42 C.F.R. § 483.12 Admission, transfer and discharge rights states in part:

> (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 plants or not. (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- (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident ... (iii) Include in the notice the items described in paragraph (a)(6) of this section. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for the transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; ...

The petitioner states that he agrees with the physician that he is medically ready. However, he states that he still has a problem with his vision and he does not feel safe when he would have to occasionally inject himself with insulin. The petitioner also feels that he needs assistance when showering, because he has to remove the prosthesis and sit in a chair. Additionally, he states that he has family but not in this state and would not like to return to his country (Honduras).

The physician argues that the petitioner is not on insulin at the moment, he is medically independent, he can read labels and he can have medical follow-up in the community.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The notice, as

required, noted the reason for the discharge as "your health has improved sufficiently so that you no longer need the services provided by this facility."

The hearing officer finds that the petitioner presented no medical evidence or testimony to contradict the medical opinion presented by the facility's physician. The notice issued by the facility provided a location, to which the petitioner was to be discharged and therefore, all requirements were found to have been met by the nursing facility.

DECISION

The appeal is denied. Pursuant to 42 C.F.R. § 483.12(7), the "facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of January, 2009,

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: [redacted]

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

APPEAL NO. 08N-00227

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 16, 2009, at Center, at 8:19 a.m., in , Florida. The petitioner was present. The petitioner was represented by his wife, The respondent was represented by administrator. Witness for the respondent was , business office manager. ombudsman, was observing.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of November 17, 2008 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 has been a resident of the facility since 2002. The facility has sent the petitioner billing statements each month he has resided in the facility. The petitioner had has an outstanding obligation to the nursing home since October 2006. The facility and the petitioner entered into an agreement in which the facility wrote off the balance to encourage future monthly payment in full by the petitioner of his patient responsibility. After entering into the agreement, the petitioner has not paid his patient responsibility each month. The amount of the current outstanding balance as of December 31, 2008 is $9,423. If the facility had written off a part of the petitioner's outstanding balance, the outstanding balance would have been $18,177.88 as of December 31, 2008.

2. The respondent sent the petitioner notification on November 17, 2008 advising him of the facility's decision to discharge the petitioner on December 30, 2008. The basis of that discharge was that there had been lack of payment of his bill for services and after reasonable and appropriate notice the financial situation had not been resolved. The notice advised that he would be discharged to his wife. The petitioner's wife is a nurse.

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 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 billed the petitioner each month. The facility had written off almost half of the petitioner's outstanding balance to assist the petitioner in meeting his monthly obligation. Since the action of the facility to write off the petitioner's outstanding balance, the petitioner has not paid his monthly patient responsibility and has incurred further outstanding obligations to the facility. The facility has given the petitioner and his family reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial arrangement 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 26th day of January, 2009,

in Tallahassee, Florida.

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

Copies Furnished T

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

APPEAL NO. 08N-00214

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on January 16, 2009, at 2:30 p.m. at the and Florida. The petitioner was not present but was duly represented by her son-in-law, The respondent was represented by administrator, with testimony available from: social services assistant; social services director; business office manager; RN, director of nursing; and regional accounts 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 initially admitted to the nursing facility in January 2007. At that time, she signed an agreement for care noting, among other items, that she "may be removed" from the facility if she "...failed to pay for or have paid under Medicare or Medicaid a stay at the facility..." Respondent's Exhibit 7 is the contract signed by the petitioner and the nursing facility staff.

2. For several months, payments were provided under Medicare while the petitioner needed skilled nursing service and therapies. As of July 2007, she continued in therapy. By June 2008, need for care was custodial rather than skilled. Insurance coverage was exhausted. For a time, facility staff thought there would be a Veterans' Administration (VA) ChampVA reimbursement. That did not happen.

3. About $70,000 of care and services, for approximately one year, were resolved through "write-off" by the facility. Facility staff mistakenly thought VA insurance or assistance would be forthcoming and "write-off" was deemed a permissible resolution, shown in Respondent's Exhibit 4.

4. In addition to "write-off" of the $70,000+/-, private payments for care were made through September 2008.

5. In September 2008 the petitioner was hospitalized. She was readmitted to the nursing facility after hospitalization.

6. During October 2008, the respondent was concerned that adequate payment might not occur because there was no payer source indicated. The petitioner was making payments only from Social Security checks. Testimony

was that Social Security benefits were over $700 monthly, but Respondent's Exhibits 2 and 3 indicate the figure was actually $678. In any case, the petitioner also receives a VA pension but that VA pension was not used to pay for care.

7. As of October 31, 2008, skilled nursing and rehabilitative therapy were no longer in place. The petitioner again received custodial care. Basic daily cost was approximately $195 (Respondent's Exhibit 2).

8. Following the September 2008 readmission, facility staff made many contacts with the family to facilitate payment and to encourage Medicaid application for the Institutional Care Program (ICP). These efforts are reflected in Respondent's Exhibits 4-6. Bills and statements of balance due were issued.

9. Medicaid application was not filed, and had not been filed as of date of hearing. The family hesitated to have the petitioner become a "ward of the state" or receive "welfare." The petitioner does not have a legal guardian and there is no indication of how/why she would become a ward of the state.

10. On November 12, 2008, the respondent issued Nursing Home Transfer and Discharge Notice (Respondent's Exhibit 1) citing reason as "bill for services at this facility has not been paid after reasonable and appropriate notice to pay." At time of Discharge Notice, amount owed was more than $3,000, and as of hearing date, more than $10,000 was owed.

11. The family understanding was that VA should assist with costs of care and VA assistance has been sought (Petitioner's Exhibit 2). The family understanding, gleaned from the petitioner's now deceased husband, was that VA would provide for the petitioner.

12. The does not have a VA contract to provide care and it is not a VA facility. As of hearing date, there was no indication that VA payments would be achieved for care expenses.

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....

While agreeing with the essence of the respondent's presentation and sequence of events, the petitioner's representative hoped that Veterans' Administration (VA) might assist with payment. No evidence established this as

a viable option and the facility is not a VA facility. If some type of aid and attendant service or payment is provided through VA in future, evidence did not establish that full payment would be achieved that way. Moreover, the VA pension that the petitioner has been receiving throughout this period has not been used to help with the costs of care.

It is concluded that inadequate payment has occurred following reasonable and appropriate notice to pay. Serious delinquency exists. On that merit, discharge is appropriate. Despite preferences of the petitioner, and difficulties of the situation, the respondent has met burden of proof. Intent to discharge has been justified as set forth due to insufficient payment for care and services rendered.

DECISION

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

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the 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 30th day of January, 2009, 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]

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

APPEAL NO. 08N-00203

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to Notice, an administrative hearing was convened before the undersigned hearing officer on January 7, 2009, at 8:15 a.m., in Florida. The petitioner was present. Representing the petitioner were her children, and Representing the respondent was , administrator. Appearing as witnesses were , director of nursing; , registered nurse and risk manager; and director of social services.

ISSUE

At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to transfer the

petitioner because her "needs cannot be met in this facility". The nursing home has the burden of proof.

FINDINGS OF FACT

1. The petitioner is presently a resident of the home. She has been a resident since August 2006.
2. On October 30, 2008 the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner and/or her representative with an effective transfer date of November 30, 2008. The Notice indicated the reason for transfer as "your needs cannot be met in this facility".
3. The petitioner's medical condition is dementia. As such, she will often wander from the facility. The facility has concerns about her safety.
4. The facility has a WanderGuard system whereby they attach a bracelet on a resident to monitor their whereabouts. The resident has removed the bracelets on several occasions.
5. The respondent has provided medical documentation to support their concerns. First, M.D. signed a medical order on behalf of the staff physician Dr. ndicating that the petitioner should be "discharged to a secure dementia unit". This was signed October 29, 2008, and was attached to the Discharge Notice.
6. Second, on October 31, 2008, a Psychiatric Follow-Up Report was signed by Dr. ., M.D. This report concluded that the

petitioner "will be benefited from [a] skilled nursing facility with [a] restricted unit".

7. Lastly, the State of Florida Department of Elder Affairs evaluated the petitioner November 12, 2008. The cover FAX letter to the facility with the evaluation noted that "due to her behavioral issues and wandering, a secured, locked facility is recommended".
8. Overall, the respondent explains that it can no longer have staff monitor the petitioner 24 hours per day, 7 days per week. Because they are not equipped for this, they are seeking the transfer.
9. The children do not deny that their mother will wander. They are, however, opposed to a "lock down" dementia unit.
10. Their mother can perform most of her activities of daily living (ADL). They explain that a better security system than the WanderGuard would be more effective in monitoring her movements.
11. The children would like to have their mother in the mother's home if the State would provide someone to keep watch of her activities.
12. Lastly, there was no additional medical documentation provided that would rebut the findings of the physicians as noted above.

CONCLUSIONS OF LAW

42 C.F.R. § 483.12 Admission, transfer, and discharge rights states in part:

(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--

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

(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....

(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....

Pursuant to federal guidelines, the nursing facility issued a Nursing Home Transfer and Discharge Notice to the petitioner and/or her representative October 30, 2008. , administrator, signed this Notice. Also, as

required, Dr. M.D., signed a discharge order. By signing the order the physician, in effect, concurred with the facility's reason for discharge.

The Notice, as required, indicated the reason for discharge as "your needs cannot be met in this facility". The effective date of transfer was given as November 30, 2008. The location to which the petitioner was to be discharged was given as Florida.

All requirements have been met by the nursing facility. No contradictory medical evidence was provided that would give this hearing officer concern as to whether or not the petitioner's condition warranted transfer.

DECISION

The appeal is denied. Pursuant to 42 C.F.R. § 483.12(7), the "facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility".

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of January, 2009,

in Tallahassee, Florida.

Melvyn Littman

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

Copies Furnished 1

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

APPEAL NO. 08N-00197

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 7, 2009 at 11:20 a.m., at the respondent nursing facility. The petitioner was present and represented herself. The respondent was represented by the facility administrator, Present as witnesses for the respondent were , financial specialist, social worker and licensed practitioner nurse (LPN) unit manager.

ISSUE

At issue is whether the petitioner can be discharged from the respondent facility because the petitioner's health has improved sufficiently so that facility services are no longer needed. The respondent has the burden of proof at a clear and convincing level.

FINDINGS OF FACT

1. The petitioner has been residing at the facility since July 30, 2008. Prior to entering the facility, the petitioner was living alone in a home she owns in the community. The petitioner's date of birth is December 19, 1958, the petitioner is age 50.
2. The petitioner has been diagnosed with diabetes, hypertension, morbid obesity, depression, peripheral vascular disease (blood flow restriction caused by narrowing of blood vessels) and conjunctivitis (commonly known as pink eye). One document in the petitioner's file indicates that she had a stroke. The facility believes this is an error as that impairment is not listed anywhere else in the record. The petitioner did not recall having a stroke, but does stipulate to the other aforementioned impairments. The petitioner was approved for "temporary nursing facility" (Respondent's Composite Exhibit 2) care to treat her depression and inability to independently complete all the activities of daily living. The facility's clinical records show the petitioner received psychotherapy and the drug Zoloft to treat her depression. The facility's records show clinical assistance was provided to educate the petitioner on the activities of daily living; the petitioner's progress has been such that she is now able to independently perform all the activities of daily living.
3. On October 17, 2008, the petitioner was given written notice that she was being discharged effective November 17, 2008 because her

health had improved so that she no longer needed skilled nursing care. The facility's treating physician completed a discharge order; the facility proposes discharging the petitioner to her home.

4. Both parties stipulate that the petitioner independently performs all her activities of daily living. The petitioner is able to toilet, shower, dress, groom and feed herself. The facility does administer the petitioner's medications and a facility staff member is in the room during showering. The facility explained that these measures are taken in accordance with facility policies and not because the petitioner is unable to take her medications or shower alone.
5. The petitioner admitted that she does not require skilled nursing care 24 hours per day. However, the petitioner believes she still needs an unspecified amount of skilled care due to weakness in her right hand, incontinence and because she is confused about when and in what amounts her medication should be taken. The petitioner would like to remain in the facility.
6. The petitioner's right hand was examined and x-rayed; the results show no broken bones or tissue damage. The petitioner's report of incontinence was diagnosed as bladder spasms for which the petitioner has been prescribed medication. At her own discretion, the petitioner has begun wearing adult diapers which she can change without assistance. The facility was unaware of the petitioner's confusion regarding her medications. The facility explained that

medication management education is included in the facility's discharge planning. The facility believes the petitioner's presenting symptoms do not require skilled nursing care and can be treated in the community with the assistance of a home health care service. The facility asserted that its position is independently supported by the Department of Children and Families October 2008 denial (Respondent's Composite Exhibit 2) of the petitioner's application for Institutional Care Program (ICP) assistance. The Department's notice explains the ICP denial decision was based, in part, on the petitioner not meeting the level of care requirement.

CONCLUSIONS OF LAW

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

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

(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-

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

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;
(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge 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. The documentation must be made by-
(i) The resident's physician when transfer or discharge is necessary under paragraph (a) (2) (i) or paragraph (a) (2) (ii) of this section; and
(ii) A physician when transfer or discharge is necessary under paragraph (a) (2) (iv) of this section.
(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
(ii) Record the reasons in the resident's clinical record; and
(iii) Include in the notice the items described in paragraph (a) (6) of this section.
(5). Timing of the notice. (i) Except when specified in paragraph (a) (5) (ii) of this section, the notice of transfer or discharge required under paragraph (a) (4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice may be made as soon as practicable before transfer or discharge when--
(A) the safety of individuals in the facility would be endangered under paragraph (a) (2) (iii) of this section;...
(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...

The legal authority cited above specifies the conditions that must exist for a Medicaid or Medicare facility to discharge a resident.

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

> The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing office

The facility wishes to discharge the petitioner. The legal authority cited above makes it clear the facility holds the burden of proof at the level of clear and convincing. The fact that the petitioner no longer requires 24 hour a day skilled nursing care is undisputed. The facility has proven that the petitioner can independently complete all the activities of daily living. The facility's treating physician signed a discharge order for the petitioner; no rebuttal expert medical opinion was submitted by the petitioner. The petitioner's reported incontinence and weakness in the right hand do not prevent the petitioner from completing the activities of daily living and do not require skilled nursing care. The petitioner's confusion regarding managing her medications will be addressed during the facility's discharge planning.

After carefully reviewing all the evidence, the undersigned hearing officer concluded that the facility met its burden by presenting evidence which proves that the petitioner no longer requires skilled nursing care.

DECISION

The appeal is denied. The facility may proceed with the discharge in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the 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 23rd day of January, 2009,

in Tallahassee, Florida.

Leslie Green

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

Copies Furnished To

[redacted]

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

APPEAL NO. 08F-08048

PETITIONER,

Vs.

CASE NO. 1020029684

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 10 Broward
UNIT: ICP

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 18, 2008, at 10:10 a.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by case manager from the The respondent was represented by Jacqueline Pughsley, Florida Access specialist.

ISSUE

At issue is the Department's October 2, 2008 action of denying the petitioner's September 10, 2008 Institutional Care Program Medicaid benefits application, due to not receiving information needed to process the case. The petitioner has the burden of proof.

FINDINGS OF FACT

1. Included in the evidence is a copy of a Notice Of Case Action form that is dated October 2, 2008, stating that the petitioner's September 10, 2008 Institutional Care

Program (ICP) Medicaid benefits application was denied, due to the Department not receiving information needed to process the case.

2. According to the respondent's representative at the hearing, the ICP Medicaid benefits application was denied because the Department did not receive proof of identity, and U.S. citizenship for the petitioner.

3. According to the petitioner's representative, the petitioner has been in the facility since August 2008. As of the time of the hearing, he was still there. She is seeking ICP Medicaid benefits for him from August 2008, and ongoing.

4. The parties asserted at the hearing that the petitioner receives SSI benefits. According to the respondent's representative, receipt of SSI benefits is sufficient to prove identification and U.S. citizenship, therefore she agreed to have the application approved for the ICP Medicaid benefits.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.712 explains Institutional Care Program Medicaid coverage. The Department denied the petitioner's ICP Medicaid benefits application due to not receiving proof of his identity, and U.S. citizenship. The petitioner is seeking ICP Medicaid benefits to pay for his stay at a nursing home from August 2008, and ongoing. The respondent's representative agreed at the hearing to have the application approved for the ICP Medicaid benefits. The Department is ordered to promptly process this case, and should be copied in all correspondence concerning this matter.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 16th day of January, 2009,

in Tallahassee, Florida.

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

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

APPEAL NO. 08F-07729

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 11, 2008, at 8:45 a.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by her father,

The respondent was represented by Ken Hamlin, program operations administrator. Present on the telephone from Kepro was Dr. Robert Buzzeo, and Edna Clifton, review operations manager.

ISSUE

At issue is the Agency's November 12, 2008 action of approving the petitioner's skilled home nursing services for 528 hours, and denying 1,716 hours for October 2, 2008 to March 30, 2009. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, date of birth June 15, 2008, was six months old as of the time of the hearing. She is a Medicaid benefits recipient in Broward County Florida.

2. Included in the evidence is a copy of a Recipient Denial Letter dated October 21, 2008, stating that 504 hours of skilled home nursing services were approved, and 1,740 hours were denied for the petitioner for October 2, 2008 to March 30, 2009.

3. Included in the evidence is a copy of a Reconsideration Denial Overturned Letter dated November 12, 2008. This notice informs the petitioner that upon reconsideration, 528 hours of skilled home nursing services were approved, and 1,716 hours were denied for the petitioner for October 2, 2008 to March 30, 2009.

4. The notices sent to the petitioner explained that it was determined by Kepro that the medical care of the private duty nursing services of 528 hours was determined to be medically necessary.

5. Included in the evidence is a copy of a Kepro Internal Focus Review Finding Report on the petitioner dated October 17, 2008, stating that the petitioner's father works, her mother does not work outside of the home, and that they also have a one year old son. The petitioner's diagnosis was that she was born prematurely, has apnea, RDS, PDA, and anemia.

6. Included in the evidence is a copy of a Kepro Synopsis Of Case Report, stating that skilled home nursing services was approved for the petitioner for 24 hours per day for the first 7 days, and then the hours would change to 12 hours per day for 3 weeks, from 7:00 p.m. to 7:00 a.m. Then upon reconsideration, the approval was for 24 hours per day for the first 7 days, and then the hours would change to 12 hours per day for 4 weeks,

from 7:00 p.m. to 7:00 a.m. It was requested for the petitioner that she would receive 12 hours per day of skilled home nursing services for 7:00 p.m. to 7:a.m. for the entire certification period through March 30, 2009, after the initial 24 hours requested for the first 7 days.

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. Skilled home nursing services of 528 hours were approved, and 1,716 hours were denied for the petitioner for October 2, 2008 to March 30, 2009. This determination took into account the petitioner's condition, and her father's work hours with her mother not working, as reported by the nursing service to Kepro. The physician that testified at the hearing agrees with this determination. After careful consideration, it is determined that the Agency's action to approve skilled home nursing services of 528 hours, and deny 1,716 hours for the petitioner for October 2, 2008 to March 30, 2009, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of January 2009,

in Tallahassee, Florida.

Stuart Imberman

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

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

APPEAL NO. 08F-06749

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 19, 2008, at 11:07 a.m., in Florida. The petitioner was present. She was represented by her grandmother and grandfather, The respondent was represented by David Beavin, program analyst. Present as a witness for the petitioner was Maribel Conn, behavior assistant. Present as a witness for the agency telephonically was Jody Winter, physical therapist.

ISSUE

At issue is the November 12, 2008 action by the agency denying the petitioner's request for motorized wheelchair.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient. On September 5, 2008, the Durable Medical Equipment (DME) provider submitted a request for Medicaid to pay for a motorized wheelchair. This was a prior authorization request that is reviewed by a Medicaid representative in the agency's central office in Tallahassee.
2. The petitioner had been using a Quicken 220 motorized wheelchair. She had the wheelchair for four and a half years. On June 26, 2008 the wheelchair disappeared after a trip to Walmart. On that date, the petitioner, her grandmother, and her behavior assistant traveled to Walmart to shop. The wheelchair was attached to a platform on her grandmother's pickup truck. It could not be seen when looking back from the driver's seat. The wheelchair was attached by four straps to the platform. Three bungee chords kept a cover over the chair. The wheelchair weighed approximately 375 pounds.
3. It started to rain heavily when the grandmother pulled into the parking lot so they remained in the truck. At one point, the grandmother got out and loosened two of the platform cords when it appeared that he rain was going to stop. However, it did not stop. They left Walmart and traveled the two miles back home.
4. When they reached home, the grandmother discovered that the wheelchair was no longer on the platform. She quickly retraced the trip back to Walmart but could not find the wheelchair. The grandmother

asked Walmart to review their video surveillance and filed a police report. The police responded immediately. A copy of the police report was accepted as Petitioner's Exhibit 1. The report referred to the incident as "lost or stolen property". The police could not find the chair and the video tape of the parking lot was not working properly.

5. The petitioner obtained a physical assessment of her wheelchair needs on July 10, 2008. The DME provider completed the necessary forms to request a new customized power wheelchair for forwarded them to the prior authorization reviewer on September 5, 2008.

6. On November 12, 2008, the Medicaid reviewer determined that the petitioner was only entitled to a replacement wheelchair every five years unless it was stolen or destroyed. The reviewer wrote that "Medicaid does not replace equipment in instances of misuse, abuse, neglect, loss, or wrongful disposition of equipment by the recipient, the recipient's caregiver(s), or the provider." The reviewer referred to the police report where the officer recorded:

> Upon my arrival I made contact with the reporting person who advised she did not secure her motorized wheelchair to her vehicle (2003 grey in color Ford pick up Florida Handicap Tag before driving. advised when she arrived at her residence the wheelchair had fallen off its platform.
> An attempt to locate the wheelchair was conducted in the Walmart parking lot with negative results.

7. The Medicaid reviewer explained that:

The model provided weighs 115 pounds and the batteries required weigh 54 pounds each, so the total equipment is a minimum of 223 pounds. This amount of weight falling off the back of a vehicle should have been felt by the passengers inside the vehicle. The failure to adequately secure a power wheelchair to her vehicle is a clear incident of neglect and the recipient is not eligible for a replacement chair.

8. On November 12, 2008, the petitioner was notified that Medicaid would not replace the motorized wheelchair. She would have to wait until April 2009 when her five years expired. At that time she could request a new chair.

CONCLUSIONS OF LAW

The Medicaid Program only provides for medical services that are defined as being "medically necessary," or of "medical necessity" as set forth in the Florida Administrative Code Rule 59G-1.010(166)(a). The care, goods or services must meet the conditions as follows:

> (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 Florida Administrative Code Rule section 59G-4.070 states in part:

(1) This rule applies to all durable medical equipment and supply providers enrolled in the Medicaid program.

(2) All durable medical equipment and supply providers enrolled in the Medicaid program must comply with the Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, April 1998, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, HCFA 1500 and EPSDT 221, incorporated by reference in Rule 59G-5.020, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

The Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, dated July 2008 page 2-90, states in part:

Service Requirements

Medicaid will reimburse for a wheelchair when the recipient is non-ambulatory or has severely limited mobility and it is medically documented that a wheelchair is medically necessary to accommodate the recipient's physical characteristics.

Medicaid will reimburse and provide maintenance for only one wheelchair (regardless of type) or power operated vehicle (POV) procedure code per recipient, per maximum limit period, as stated in the DME and Medical Supply Services Provider Fee Schedule.

The following types of wheelchairs and POVs devices require prior authorization:

- Customized manual wheelchairs,
- Customized power wheelchairs,

- Non-custom power wheelchairs,
- Motorized scooters (POV), and
- Power Conversion kits.

Note: See the DME and Medical Supply Services Provider Fee Schedules for the maximum limits.

This handbook, page 2-27, continues and states in part:

Limitations for Replacement of Equipment

Medicaid will not replace equipment in cases of misuse, abuse, neglect, loss, or wrongful disposition of equipment by the recipient, the recipient's caregiver(s), or the provider.
At a minimum, examples of equipment misuse, abuse, neglect, loss or wrongful disposition by the recipient, the recipient's caregiver, or the provider include the following:

- Failure to clean and maintain the equipment as recommended by the equipment manufacturer; and
- Failure to store the equipment in a secure and covered area when not in use.

If equipment is stolen or destroyed in a fire, the provider must obtain, in a timely manner, a completed police or insurance report that describes the specific medical equipment that was stolen or destroyed. The police or insurance report must be submitted with the prior authorization request, if the item requires prior authorization, or to the recipient's area Medicaid office with the claim for reimbursement, if the item does not require prior authorization.

The respondent agrees that the petitioner meets "medical necessity" for a motorized wheelchair. They dispute whether the old wheelchair is eligible for replacement before the expiration of the five year period. The evidence establishes that the petitioner's wheelchair came off of the back of the truck. A search ensued and a police investigation immediately followed. The wheelchair was not found. The evidence establishes that it was likely stolen after falling off the back of the truck.

The police report and testimony by the petitioner's grandmother establishes that she loosened two of the straps on the wheelchair. She did not tighten the straps before traveling with the chair. This is the likely cause for the loss of the chair. The above-cited handbook is clear that in "cases of misuse, abuse, neglect, loss, or wrongful disposition of equipment by the recipient, the recipient's caregiver(s), or the provider Medicaid will not replace the chair." The evidence establishes that the chair was first "lost" and then "stolen". Since the chair was first "lost" due to the neglect of the caretaker, the agency correctly determined that the chair could not be replaced by Medicaid.

DECISION

This appeal is granted. The agency's action denying payment for a motorized wheelchair is reversed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of January, 2009,

in Tallahassee, Florida.

Terry Oberhausen
Hearing Officer
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850-488-1429

Copies Furnished To