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JUL 24 2007
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-02863

PETITIONER,

Vs.

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

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 18, 2007, at 9:34 a.m., at the Caleb Service Center, in Miami, Florida. The petitioner was present, but was represented at the hearing by her mother Also present on behalf of the petitioner was her sister

The Agency was represented by Erica Woodard, registered nurse specialist, Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the agency was Teresa Ashey, review operations supervisor from KePRO.

ISSUE

At issue is the Agency's action of April 27, 2007, to deny the petitioner eight hours of Home Health Aide (HHA) services of 180 hours requested, for the period of April 4,

2007 through June 2, 2007, because the medical care as described to them is not medically necessary. The Agency has the burden of proof.

FINDINGS OF FACT

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

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the respondent. The Prior Authorization Process was completed for the petitioner by KePRO.

3. On April 26, 2007, the provider, s, requested 180 hours of HHA services, four hours daily, Monday through Friday. Because only 172 hours were needed for the certification, eight hours were denied due to provider miscalculation of hours.

4. During the reconsideration process, the provider informed KePRO that the petitioner's mother was previously working part-time, but now works from 8:00 a.m. to 5:00 p.m., Monday thru Saturday, and that she is the only caregiver. The provider notes that Home Health Aide needed to assist the petitioner with personal care and activities of daily living. The provider requested four additional hours of HHA services on weekends also.

5. On June 6, 2007, based on the new information provided, KePRO approved four additional hours on Saturdays, for a total of 304, but denied four hours requested for

Sundays. KePRO noted that there was no clinical or social explanation for HHA assistance on Sundays.

6. The petitioner's representative agrees with this decision. She explained that she requested the hearing because she thought that the HHA service had been cancelled.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.901(14) **Definitions** states in part:

> "Medicaid agency" or "agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

Fla. Stat. ch. 409.901(4) **Home Health Care Services** states in part:

> The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.

Fla. Admin. Code 59G-1.010, which applies to the Florida Medicaid Program 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.

Fla. Admin. Code 59G-4 **Home Health Services** states in part:

> (1) This rule applies to all home health agencies licensed under Chapter 400, Part IV, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.
> (2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.
> (3) When terminating, reducing, or denying private duty nursing or personal care services, Medicaid will provide written notification to the recipient or the recipient's legal guardian. The notice will provide information and instructions regarding the recipient's right to request a hearing.

The respondent, through KePRO, took action on April 27, 2007, to deny the petitioner eight hours of home health aide services of 180 hours requested, for the period of April 4, 2007 through June 2, 2007. This decision was based on the information as provided by the petitioner's service provider and the petitioner's medical necessity need of the request for the service.

During the reconsideration process, KePRO approved 304 hours but denied four hours of HHA service. The petitioner's representative agreed with this stipulation.

After considering the evidence, the Fla. Admin. Code and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the respondent's action.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

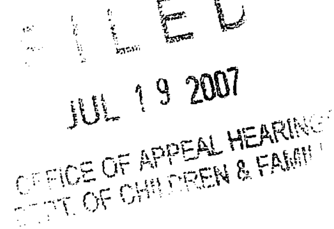
DONE and ORDERED this 24th day of July, 2007,

in Tallahassee, Florida.

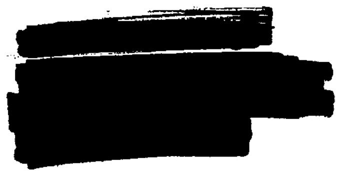
Alfredo Fernandez
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

Claudia Treadwell, Nursing Consultant



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



APPEAL NO. 07F-03343

PETITIONER,

Vs.

CASE NO. 1248468643

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Santa Rosa
UNIT: BRP

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 20, 2007, at 9:40 a.m., in Pensacola, Florida. The petitioner was not present but was represented by his granddaughter, ██████████. The Department was represented by Kendra Parker, economic self-sufficiency specialist I and Candy Norman, supervisor, Benefit Recovery Program.

ISSUE

The petitioner is appealing the Department's action of May 23, 2007 to establish an overpayment claim of $2,817 in the Medicaid program that occurred for the month of October 2006 due to agency error. The Department bears the burden of proof.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner resided of [redacted] Nursing Home. The petitioner filed an application for Institutional Care Program (ICP) and Medicaid benefits for the month of October 2006 and ongoing. At the time of the application, the petitioner's total income consisting of Defense Finance and Accounting Services (DFAS) annuity of $835 and Social Security benefits of $1,205 exceeded the income standard for the ICP program of $1,809. Therefore, he was not eligible to receive ICP benefits unless he established an irrevocable Medicaid income trust and funded the trust each month.

2. On October 30, 2006, the petitioner's representative closed the petitioner's money market account [redacted] at Suntrust Bank in the amount of $2,077.66 and funded an irrevocable Medicaid income trust with the proceeds of that closure. The petitioner deposited an additional $100 to the income trust for a total of $2,177.66 on October 30, 2006.

3. The petitioner executed the trust document and submitted it to the Department. The Department sent the trust document to its district legal counsel for review and approval on December 11, 2006. The income trust document was approved by the Department's district legal counsel and the Department approved ICP and Medicaid benefits effective October 2006.

The petitioner's income was $2,128.09. The petitioner funded the Income Trust account with an initial deposit of $2,177.66 on October 30, 2006. The petitioner

deposited the income to the income trust in order to reduce his countable income to within the program income standard. The income outside the trust is considered countable income. The total countable income was less than $749 which is the ICP-MEDS income limit.

A tier one monitoring was completed on January 25, 2007. As a result of the case review, the Department determined that it erred when it approved ICP and Medicaid for October 2006 because it incorrectly determined the petitioner's assets for that month. The Department determined that assets consisted of the Suntrust money market account [redacted] of $2,077.66 and a Suntrust checking account [redacted] with a balance of $3,243.83 as of October 30, 2006. The total asset balance exceeded allowable asset limit. As a result of the Department's error, a referral was made to the Benefit Recovery Program.

At the hearing, it was determined that the money market account balance on October 30, 2006 was zero. The Department further acknowledged that it did not subtract direct deposited income from the checking account [redacted] Evidence presented by the respondent indicated that the balance should have been $2,048.54 after subtracting direct deposited income of $1,205.18 and interest income of $.09 paid on October 24, 2006 (Respondent Exhibit 8). The correct total countable resources were $2,048.54.

CONCLUSIONS OF LAW

20 C.F.R. §416.1201 in part states:

> Resources; general. (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

The Department's online integrated policy manual, 165-22, section 1840.0205 sets forth the maximum asset limitation in the ICP-MEDS program as $5,000.

> Total countable assets for an individual or a couple must not exceed $2,000 or $3,000 respectively.
>
> Exceptions to these asset limits include the following:
> 4. for ICP, PACE, and Hospice individuals (admitted to an institution on or after September 30, 1989) and for Assisted Living Waiver (ALW) individuals...with community spouses, the individual's assets must not exceed $2,000...For ICP-MEDS, the asset limit cannot exceed $5,000 for the institutionalized individual...

The Department's online integrated policy manual 1840.0110 Income Trusts, includes ICP-MEDS as one of the programs that uses income trust policy.

> 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-9 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. ...
>
> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month is which the income is received to reduce their countable income (the income outside the trust) to within the program income standard...

Eligibility Standards for SSI-Related Programs at Appendix-9 of the Department's online integrated policy manual sets forth the Income limit for an individual as $749 for the ICP-MEDS program and the Asset limit for an individual as $5,000 for ICP-MEDS program.

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

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month.

The Findings of Fact show that the petitioner's income exceeded ICP program eligibility limits. The Findings also show that the petitioner executed and funded a qualified Irrevocable Medicaid Income Trust account on October 30, 2006 with sufficient income to reduce countable income outside the trust. The countable income outside the trust was less than the MEDS-AD/ICP-MEDS income limit for an individual of $749. Therefore, the petitioner met the income standards for ICP-MEDS program. The Findings further show that the petitioner's countable asset, in the form of a checking account, was less than the MEDS-ICP asset limit of $5,000 for the month at issue. Therefore, the undersigned authority concludes the petitioner was eligible for ICP-MEDS program benefits and that the Department erred in its action to establish an overpayment claim for Medicaid benefits in October 2006.

DECISION

The appeal is granted. The Department is to void the overpayment claim in the Medicaid program for October 2006.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of July, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
1 DPOES: Jan Blauvelt
Elwood Barninger
Candy Norman

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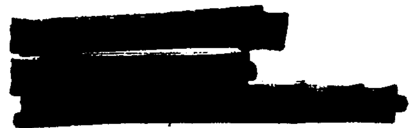
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 07F-02913

PETITIONER,

Vs.

CASE NO. 1022194828

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
DISTRICT: 02 Washington
UNIT: 88115

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 13, 2007, at 1:30 p.m., in Bonifay, Florida. The petitioner was not present but was represented by her daughter and power of attorney, [redacted]. The Department was represented by Nancy Riley, supervisor, Access Florida.

ISSUE

The petitioner is appealing the Department's action of March 25, 2007 to deny Institutional Care Program (ICP) benefits for the months of January and February 2007 because asset value exceeds program eligibility limits. The Petitioner bears the burden of proof.

FINDINGS OF FACT

Prior to the action under appeal, the petitioner resided in an assisted living center. On November 22, 2006, she was admitted to the [redacted] Rehabilitation and

Convalescent Care Nursing Center (WCCC) located in [redacted] Florida. An application for ICP was filed on behalf of the petitioner by the social work department of the nursing facility on November 29, 2006. On January 5, 2007, the application was denied because the petitioner did not verify unearned income.

A second application was filed by the social work department on February 7, 2007 requesting retroactive ICP coverage from November 2006 and ongoing. The petitioner's daughter was not in direct contact with the respondent but supplied all requested information to the social worker representing her mother. During the application process, the petitioner's income was being deposited to her bank account and no patient responsibility was paid to the nursing facility. As a result, the petitioner's bank account balance accumulated and exceeded the asset value for the ICP program. The assets at issue consisted of savings at Regions Bank, savings at Tyndall Federal Credit Union and checking at Tyndall Federal Credit Union and a preneed burial contract. The respondent did not present evidence to show the value of the preneed burial contract or whether or not it was irrevocable.

The petitioner's income was Social Security of $816 (net), Department of Finance and Accounting Services (DFAS) of $636 (net) and interest on her bank accounts. The total net income was approximately $1,452. Based on the income reported, the Department determined the appropriate asset limit for ICP benefits to be $2,000.

The Department received statements from the Tyndall Federal Credit Union (CU) and Regions bank showing direct deposited income into the credit union savings

account. For the month of January, the Department counted $312.59 in the Regions checking, $36.97 in the credit union savings and $3,010.81 in the credit union checking account. For February 2007, the Department counted $160.58 in the Regions account, $37 in the credit union savings and $4,510.01 in the checking account. The Department determined the petitioner's assets to exceed the allowable asset limit for the months of January and February 2007 and denied ICP benefits for those months. The Department acknowledged that it counted the balances shown on the bank accounts without first subtracting direct deposited income. Therefore, the balances used did not accurately reflect assets.

At the hearing, the respondent reviewed the bank statements and determined that the countable resources for January 2007 were as follows. The Regions checking account balance in January should have been $207.26 after allowing for cancelled checks. The Tyndall Federal Credit Union savings account balance should have been $36.94 and the checking account balance should have been $1,511.94. The total asset for January 2007 was $1,756.14.

The countable resources for February 2007 were as follows. The Regions checking account balance was $101.52. The Tyndall Federal Credit Union savings balance should have been $36.97 and the checking balance should have been $3,010.81. The total asset for February 2007 was $3,149.30. The Department did not indicate whether any of the excess resources were designated for burial.

The petitioner was concerned that the Department did not contact her regarding pending information and that the nursing home social services department would not send her a bill for the patient responsibility until a determination of eligibility was made by the Department. As a result, the petitioner's account balances accumulated allowing her resources to exceed allowable program limits. The petitioner contacted the Department and was advised that she must spend down the assets before March 2007 passed or the petitioner would continue to be ineligible. At that time the petitioner paid the nursing home $5,000 reducing the countable resources to within applicable limits.

CONCLUSIONS OF LAW

20 C.F.R.§416.1201 in part states:

> Resources; general. (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

20 C.F.R.§416.1205 sets forth the maximum asset limitation in the Institutional Care Program at $2,000.00 for an individual.

Fla. Admin. Code §65A-1.303 in part states

> Assets. (1) Specific policies concerning assets vary by program and are found in the program specific rule sections and codes of federal regulations. In general assets, liquid or non-liquid, are resources or items of value that are owned (singly or jointly) or considered owned by an individual who has access to the cash value upon disposition. Assets of each member of the SFU must be determined. A decision of whether each asset affects eligibility must be made. (2) Any individual who has the legal ability to dispose of an asset owns the asset...(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available

> are not considered in determining eligibility on the factor of assets. Assets are considered available to an individual when the individual has unrestricted access to the funds. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for the individual's support and maintenance, even though the individual chooses not to do so...

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

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

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

> (5) SSI-Related Program Standards.
> (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:
> 1. $2000 per individual.

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

> (d) The individual, and their spouse, may designate up to $2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

The Findings of Fact show that the petitioner had a checking account, a share account at Tyndall Federal Credit Union and a checking account at Regions Bank. The

Findings of Fact also show that the petitioner had a preneed burial contract. The value of the pre-paid burial contract was not verified and there was no evidence to show whether any of the funds in the checking account were to be designated for burial. The undersigned authority reviewed the asset determination and finds that the Department erroneously failed to subtract income from the balances to arrive at the asset value. The Findings show that the balance in the bank accounts for January 2007, after deducting direct deposited income, did not exceed the asset limit of $2,000 for the ICP Program. The undersigned authority is unable to determine if the assets were over the applicable program limit for February 2007 because there was no evidence to show that the petitioner was allowed to designate funds for burial.

According to the above authorities, if an individual's total resources are equal to or below the prescribed resource limits at any time during the month, the individual is eligible on the factor of resources for that month. In addition, the regulations state the individual may designate up to $2,500 of their resources for burial funds for any month, including the three months prior to the month of application regardless of whether the exclusion is needed to allow eligibility. The $2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts.

DECISION

The appeal is granted. The Department's action is reversed and remanded. The Department is to reevaluate the asset value for January and February 2007 and apply applicable policy with regard to burial exclusion and exclusion of income in determining

asset value. The petitioner is to be advised in writing, upon disposition, to include appeal rights.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 5th day of July, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
2 DPOES: Denise Parker
[redacted]

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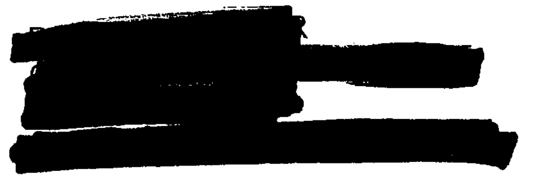
DEPT. OF CHILDREN & FAMILIES

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



APPEAL NO. 07F-02506

PETITIONER,

Vs.

CASE NO. 1244202037

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Okaloosa
UNIT: 88172

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 26, 2007, at 9:40 a.m., in Ft. Walton Beach, Florida. The petitioner was not present but was represented by her attorney, Steven Quinnell, of Chase Quinnell & Jackson, P. A. Testifying on behalf of the petitioner was her son, [redacted]. The respondent was represented by Eric Schurger, senior attorney, Circuit One, Department of Children and Families. Testifying on behalf of the respondent was Jo Ann Painter, economic self-sufficiency specialist I and Lenn King, adult payments supervisor.

The hearing was originally scheduled to be held on May 21, 2007 but was continued at the request of the petitioner.

ISSUE

1. At issue is the Department's action of October 2, 2006 to deny Institutional Care Program (ICP) and Medicaid benefits for the months of June through September 2006 based on the contention that asset value in the form of real property exceeded program eligibility limits. The status of real property as the petitioner's principal place of residence is at issue.

2. Also at issue is the Department's untimely delay in submitting the petitioner's request for a hearing and the petitioner's contention that she was subsequently harmed by that delay.

The petitioner bears the burden of proof.

FINDINGS OF FACT

The petitioner (age 84) lived in her own home in [redacted] She was diagnosed with the early stages of Alzheimer's in 2004. On January 15, 2005 the petitioner moved into her son's home in [redacted] Florida. On the advice of their attorney, the petitioner's son and financial representative began transferring $3,000 from the petitioner's funds to himself beginning February 2005. In addition, the petitioner paid her son $2,000 monthly for rent.

The petitioner sold her home in [redacted] on May 31, 2005 and netted $87,344.48. The petitioner spent down the proceeds from the sale of her home through systematic transfers to her son and for rent. In addition, the petitioner placed her household items in storage paying $53 per month from January 7, 2005 through

May 2006 and $68.90 per month from June 2006 through at least June 2007 (petitioner's exhibit 2). Her remaining liquid assets in November 2005 were approximately $39,000 per petitioner's testimony.

In November 2005, the petitioner purchased a house in [redacted] for $173,000. The down payment was $62,652.24. This was paid by the petitioner's son from funds transferred to him by his mother. The remaining balance of approximately $113,000 was subsequently paid off by the son. The house was listed solely in the petitioner's name. The petitioner moved her furnishings and personal belonging into the property in November 2005 but continued to rent the storage unit for belongings she would not need. The utilities were put in her name. At the time she purchased the property, the petitioner was unable to declare homestead exemption until the following year. The petitioner never declared the homestead exemption on the property.

The petitioner indicated that it was her intent to live in the [redacted] property and to make it her homestead. However, due to her deteriorating medical condition, the petitioner was unable to live independently in her home. The petitioner's family would take her to the property on holidays and during weekends. The family utilized the services of live in care to provide for the petitioner's need and to provide respite care so they could take care of basic necessities. The petitioner stayed at the [redacted] property approximately 7 days in November 2005, approximately 10 days in December 2005, 8 to 10 days in January 2006, and 3 days in February 2006. The petitioner resided with her son and his family in [redacted] the rest of the time and

continued to pay him $2,000 rent. The petitioner's family accompanied her to her property in [redacted] and did not choose to allow contract help to be with her so far from home and her primary hospital and physicians (Respondent's Exhibit 1).

It became evident to the petitioner's family that her medical condition would require more permanent care. She returned to her son's home in [redacted] full time in February 2006 and shortly thereafter, was hospitalized. She transferred from the hospital to [redacted] Nursing and Rehabilitation Center in March 2006 and continues to reside there.

On June 12, 2006, the petitioner applied for ICP and Medicaid benefits. The petitioner reported income from Social Security of $730. At the time of the interview, the petitioner's representative informed the Department that the petitioner owned property in [redacted] Florida and that the property was intended to be her homestead. The Department made every effort to determine if the property at issue could be excluded as the petitioner's homestead. Based on information provided by the representative, the Department determined that the property had not been homesteaded and was not her principal place of residence.

The Department determined the value of the petitioner's property was $173,000 and that there were no liens or other indebtedness. The Department determined that the value of the petitioner's property exceeded the Institutional Care Program (ICP) asset limit of $5,000 for an individual that has income below 88% of the poverty level. The petitioner's income is below the above referenced poverty level. On October 2,

2006, the Department notified the petitioner that her ICP and Medicaid benefits were denied based on excess assets.

The petitioner's property was listed for sale on October 17, 2006 and remains on the market. The petitioner reapplied for ICP and Medicaid benefits on October 17, 2006 and was subsequently approved beginning October 2006 because the property was excluded due to a bona fide effort to sell.

CONCLUSIONS OF LAW

20 C.F.R.§416.1201 in part states:

(a) Resources; defined. For purposes of this Subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.
(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse)...
(2) For purposes of this Subpart L, the "equity value" of an item is defined as:

(i) The price that item can reasonably be expected to sell for on the open market in the particular geographic area involved; minus

(ii) Any encumbrances.

20 C.F.R.§416.1212, Exclusion of the home, in part states:

(a) Defined. A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings....
(c) If an individual changes principal place of residence. If an individual (and spouse, if any) moves out of his or her home without the intent to

return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, we still consider the home to be the individual's principal place of residence, irrespective of the individual's intent to return as long, as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

Program Policy Manual appendix A-9 sets forth the maximum asset limitation in the Institutional Care Program (ICP-MEDS) at $5,000 for an individual.

Florida Administrative Code §65A-1.303 in part states

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

The Department's online Integrated Policy Manual 165-22, Section 1640.0534 states in part:

Home property is excluded as an asset, regardless of its value, if it is the individual's principal place or residence. Only one residence can be excluded under this provision.

The Department's online Integrated Policy Manual 165-22, Section 1640.0534.01 states in part:

> An individual's temporary absence from the home does not affect the exclusion of the home as an asset regardless of the length of absence, if:
> 1. a spouse or dependent relative continues to reside in the home, or
> 2. the sale of the home would cause undue hardship due to loss of primary residence to a co-owner of the property, or
> 3. the individual(or, on his behalf, a designated representative) states an intent to return home.
>
> ...Intent to return policy applies only to the continued exclusion of property which met the definition of the individual's home prior to the time the individual left the property...

The Findings of Fact show that the petitioner is listed as the owner of property in [redacted], Florida. The [redacted] County Property Appraiser's Office shows there is no homestead exemption on the property. There are no liens on the property. The Findings also show that the petitioner lived with her son and his family and continued to pay rent to her son after she purchased the property in [redacted] Florida. Further, the Findings show that the petitioner moved in permanently with her son in February 2006 and entered the nursing home from the hospital in March 2006. Based on the above, it is determined that the petitioner is the owner of the land at issue and that it was not her principal place of residence. The Findings show the value of the property exceeds the Institutional Care Program's asset limit and that the petitioner was not eligible to receive Institutional Care Program benefits.

According to the above authorities, if an individual moves out of his or her home without the intent to return, the home becomes a countable resource because it is no

longer the principal place of residence. Therefore, the Department correctly denied the petitioner's Medicaid and Institutional Care Program benefits effective June 2006 through September 2006. The Findings show that the property was listed for sale in October 2006 and the petitioner was determined eligible for ICP and Medicaid benefits effective October 2006.

Florida Administrative Procedures Act (APA) Section 120.59(1) F. S. states:

> (1) The final order in a proceeding which affects substantial interests shall be in writing or stated in the record and include findings of fact and conclusions of law separately stated, and it shall be rendered within 90 days...

42 C.F.R. Sec. 1396(a)(3) states in part:

> A State plan for medical assistance must...(3)provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied...

42 C.F.R. Sec. 431.244(f)(1)(ii) states:

> The agency must take final administrative action as follows:
> (1) Ordinarily, within 90 days from the earlier of the following:
> ...(ii) If permitted by the State, the date the enrollee filed for direct access to a State fair hearing..

The Findings of Fact show that the petitioner requested a hearing on October 5, 2006. The Findings also show that the hearing request was not submitted to the Office of Appeals Hearings until April 17, 2007. This was 194 days after the petitioner's request for hearing. The hearing was scheduled on May 21, 2007 but was continued at the request of the petitioner until June 26, 2007.

Although section 120.59(1) says that final orders shall be rendered within 90 days, it does not specify any sanction for violation of the time requirement. In the absence of direction to be followed when the time standard is not met, the hearing officer cannot provide benefits to an otherwise ineligible petitioner. The failure of the agency to act within the 90 day time limit is characterized as harmless error and does not result in impairment of either fairness of proceeding or correctness of action or prejudice to party.

DECISION

The appeal is denied. The Department's denial 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 17th day of July, 2007,

in Tallahassee, Florida.

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

Copies Furnished To [redacted] Petitioner
1 DPOES: Linda W. Wright
Steven Quinnell
Eric Schurger

FILED
JUL 02 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-02366

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_______________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on May 9, 2007, at 3:25 p.m., in Tampa, Florida. The minor petitioner was not present but was represented by his father, His mother and caregiver, was present as a witness. was present by telephone to provide any requested translation for from Arabic to English or vice versa.

Maria Diaz, registered nurse specialist with the Agency For Health Care Administration (AHCA), represented the Agency and was present as a witness. Sandra Barile, also a registered nurse specialist with (AHCA), also appeared as a witness for the respondent. Three other individuals with AHCA appeared by telephone: Glory Bell Ramirez, senior human services program specialist with AHCA, Theresa Ashey, review operations supervisor with Kepro, and Dr. Rahish Mittel, consulting pediatrician with Kepro South.

ISSUE

At issue is the respondent's decision of March 31, 2007 to reduce private duty nursing (PDN) services paid by Medicaid from 16 hours a day, 7 days weekly to 12 hours a day, 7 days weekly. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner will be three years-old on [redacted] 2007. The petitioner lives with and receives care from his mother, [redacted] [redacted] is attempting to take English classes as she speaks Arabic. The petitioner's father, [redacted] speaks English but does not live in the home.
2. The petitioner has diagnoses to include congenital leukodystrophies, seizure disorder, Laryngo Malacia with apnea episodes, respiratory distress, and failure to thrive with g-tube placement. The petitioner also has a genetic diagnosis of Alexander Disease.
3. The petitioner's mother has demonstrated competence to provide treatment in three needed areas. She is able to accurately use the feeding pump, though formula may need draining due to gasses. She is able to provide breathing treatment through a vest. Further, she is able to help the petitioner with use of a stander. The petitioner's mother has not yet had cardiopulmonary resuscitation (CPR) training due to language barrier. The petitioner has had two

seizures in five months. The petitioner remains concerned about actions that may be needed in the event of an emergency.

4. The respondent determines the medical necessity of the requested private duty nursing services through the contracted KePro South provider. The petitioner has received approved private duty nursing services of 16 hours daily since November 2005. Kepro South initially reduced approved nursing hours to 8 hours . However, Kepro South determined 12 hours daily nursing services to be medically necessary upon reconsideration. The reviewing KePro South pediatrician, Dr. Patel, questioned the petitioner's mother about her ability to provide care and treatment at the hearing. After these questions, Dr. Patel opined 12 hours daily nursing services to be medically necessary.

5. In her letter of May 9, 2007, the petitioner's treating physician, Elizabeth Yakubu, opines the petitioner needs skilled nursing care 16 hours daily to manage his complex medical problems. Dr. Yakubu notes that the petitioner's mother is young, pregnant, and has language difficulty with urgent medical information. Dr. Yakubu's letter does not address the specific basis of the opined need for 16 hours daily, and does not address the petitioner's mother's ability to provide treatment. Dr. Yakubu did not testify at the hearing.

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 residential 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. Kepro South reviewing pediatrician recommends the reduction of nursing services to 12 hours daily. However, the petitioner's treating physician opines the petitioner to continue to require 16-hour skilled nursing services.

The petitioner's caregiver is sufficiently trained to the extent that she can provide care in the three major areas of treatment: feeding, respiratory, and

standing. 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 petitioner's caregiver demonstrates capability to provide most of the petitioner's treatment needs in the three needed areas. It is reasonable that the petitioner's mother has concerns in the event of a respiratory and/or epileptic emergency, and has not been yet trained in CPR. Based on these factors, it is a reasonable compromise to have a less intensive reduction of nursing services to 12 hours daily, rather than to 8 hours daily as initially determined by KePro South.

It is not known to what extent the petitioner's treating physician has knowledge of the petitioner's mother's ability to provide care to the petitioner, and there was no testimony on such. Therefore, the relative weight customarily given the treating physician's opinion of needed nursing hours is reduced due to this uncertainty. Thus, the consulting physician opinion on the asserted need for 12 hours daily nursing care is afforded greater weight in this appeal.

In sum, the evidence as applied to the listed authorities shows that the Agency has met its burden to prove that nursing hours can be reduced to 12 hours daily. If the petitioner's and/or her caregiver's circumstances change to

warrant a request for an increase in nursing hours, the petitioner may request such hours, as also advised by the respondent.

DECISION

This appeal is denied in that the Agency has met its burden to prove that nursing services can be reduced to the amount(s) at issue, 12 hours daily.

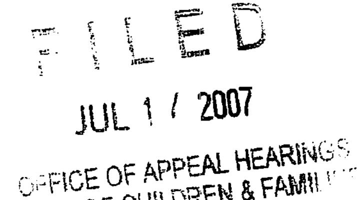
NOTICE OF RIGHT TO APPEAL

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 2nd day of July, 2007, in Tallahassee, Florida.

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

Copies Furnished To [redacted], Petitioner
Patrick Glynn, Area 6 Medicaid Adm.
Mary Wheeler



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

APPEAL NO. 07F-02789

PETITIONER,

Vs.

CASE NO. 1066448965

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 02 Bay
UNIT: 88141

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 27, 2007 at 8:15 a.m., in [redacted] The petitioner was not present but was represented by her daughter, [redacted]. The Department was represented by Judy Rivero, economic self-sufficiency specialist I.

ISSUE

The petitioner is appealing the Department's action of April 25, 2007 to deny Institutional Care Program (ICP) Medicaid benefits for January and February 2007 based on the contention that her assets were in excess of allowable program limits. The petitioner bears the burden of proof.

FINDINGS OF FACT

On January 24, 2007 the petitioner (age 77) filed an application for ICP Medicaid through the nursing home social services staff. The petitioner had been a resident of

Assisted Living Facility prior to entering Hospital. The petitioner was released from the hospital and was admitted to Health Care on January 16, 2007. The petitioner was receiving Home and Community Based Care Services (HCBS) Medicaid Waiver in the community prior to her admission to the nursing home. The petitioner reported income from Social Security (SSA) of $845 monthly. Based on the petitioner's income, the Department determined the asset limit was $2,000.

The petitioner reported assets in the form of three life insurance policies consisting of Woodmen of the World certificate with a face value of $2000, Woodman of the World certificate with a face value of $3,000 and Reassure America Life insurance certificate with a face value of $1,000. In addition, the petitioner reported a checking account at Bank & Trust Co. and a share and share draft account at Federal Credit Union.

On February 5, 2007, the Department sent a verification list to the nursing home social services representative requesting proof of face value and cash value of the life insurance policies (Respondent's Exhibit 3). The information was due to the Department by February 15, 2007. On February 6, 2007, the Department received copies of bank statements, cash value of policy effective September 2004, face value of policies and The cash value information was not received for policies and In addition, an authorized representative designation allowing the petitioner's daughter to represent the petitioner was received on February 7, 2007. The Department believes it attempted to obtain the cash value of

policies by a fax request on February 26, 2007 but did not receive a response. A telephone call was made to the petitioner's daughter to advise her of information necessary to complete determination of eligibility. The representative requested additional time to obtain the cash values. The requested information was received on March 14, 2007.

The Department determined the cash value of policy was $1,456.56, policy was $2,561.09 and policy was $278.50. The total cash value was $4,296.12. The Department allowed a burial exclusion of $2,500 reducing countable cash value of the policies to $1,796.12. The bank balance of Bank & Trust was $692.87 in January 2007 and $231.74 in February 2007 after subtracting direct deposited social security income. The share balance for the months at issue was $5.74 and the share draft balance was $25.00. The total countable resources for January 2007 was $2,509.33 and for February 2007 was $2,058.60.

On March 14, 2007, the Department mailed a Notice of Case Action denying ICP Medicaid as the petitioner's resources exceeded the allowable program limit.

On March 22, 2007, the petitioner's representative filed an application for ICP Medicaid benefits. The petitioner reported the same resources; however, ownership of policy was irrevocably assigned to Funeral Home on March 14, 2007. The countable resources were reduced below the applicable resource limit of $2,000 in March 2007. ICP Medicaid benefits were approved beginning March 2007.

The petitioner's representative was concerned that the Department did not complete her application in a timely manner and that she was not contacted by the Department until it was too late for her to reduce the resources. The representative had power of attorney and was the petitioner's representative for HCBS Medicaid waiver. In addition, the representative continued to retain funds in the petitioner's account while trying to resolve a bill for services from the assisted living facility. There was also a conflict in the petitioner's mailing address. The petitioner and the nursing home received copies of Departmental correspondence but her copies were sent to an incorrect address based the initial application dated January 24, 2007. Finally, the Department contacted a nursing home representative who acted as the authorized representative on the January 24, 2007 application rather than the petitioner's daughter.

CONCLUSIONS OF LAW

Federal Regulations at 20 C.F.R. §416.1201 in part states:

> Resources; general. (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

20 C.F.R. § 416.1205 sets forth the asset limitation in the Institutional Care Program at $2,000.00 for an individual.

Florida Administrative Code 65A-1.303 in part states

> Assets. (1) Specific policies concerning assets vary by program and are found in the program specific rule sections and codes of federal regulations. In general assets, liquid or non-liquid, are resources or items of value that are owned (singly or jointly) or considered owned by an individual who has access to the cash value upon disposition. Assets of

each member of the SFU must be determined. A decision of whether each asset affects eligibility must be made. (2) Any individual who has the legal ability to dispose of an asset owns the asset...(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility on the factor of assets. Assets are considered available to an individual when the individual has unrestricted access to the funds. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for the individual's support and maintenance, even though the individual chooses not to do so...

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

states in relevant part:

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

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

part.

(5) SSI-Related Program Standards.
(a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:
1. $2000 per individual.

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

part.

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

> be processed and determinations of eligibility made within the following time frames:...
> Medical Assistance and State Funded Programs for applicants on the basis of no-disability eligibility... 45 days.
> (d)...If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, ...the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. ..If the verification or information is difficult for the person to obtain, the eligibility specialist must provide assistance in obtaining the verification or information when requested or when it appears necessary. If the required verifications and information are not provided by the deadline date, the application is denied, unless a request for extension is made by the applicant or there are extenuating circumstances justifying an additional extension... When all required information is obtained, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

The petitioner's representative argued that the Department delayed in contacting her for additional information and that the Department's delay contributed to the petitioner's ineligibility for ICP benefits. The petitioner applied on January 24, 2007. A determination of eligibility was made on March 14, 2007. The number of days the Department used to determine eligibility was 49 days. Although the Department completed the disposition of the ICP application shortly over the time standard, there was no evidence to show that the Department's action contributed to the petitioner's ineligibility for benefits. The evidence shows that the petitioner's representative requested more time to provide documentation necessary for a determination of eligibility and that the additional evidence was not provided until March 14, 2007.

In addition, the petitioner' daughter argued that she was not provided a copy of a pending notice because of an incorrect address. The Findings show that the petitioner's

authorized representative for ICP was an individual from the nursing home social services department. In addition, the Findings show that an incorrect address was provided by the representative. However, even with the incorrect address, the petitioner, the nursing home and her daughter were aware of information needed by the Department to complete a determination of eligibility.

The Findings of Fact show that the petitioner had a checking and saving account at the [redacted] Federal Credit Union, a checking account at [redacted] Bank and Trust Bank, and life insurance policies with total face value of $6,000 and countable cash value of $1,796.12 after the deduction of the burial exclusion allowance. The Findings of Fact also show that the combined bank balances and countable cash value for January through February 2007 exceeded the asset limit of $2,000 for the ICP Program.

According to the above authorities, if an individual's total resources are equal to or below the prescribed resource limits at any time during the month, the individual is eligible on the factor of resources for that month. The Findings also show that the Department applied the proper asset limit of $2,000 to the ICP program.

The resources exceeded the applicable limit for the months at issue, therefore, the Hearing Officer concludes that the petitioner was not eligible for ICP for the months at issue. The Department correctly denied her ICP benefits for January and February 2007.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17th day of July, 2007,

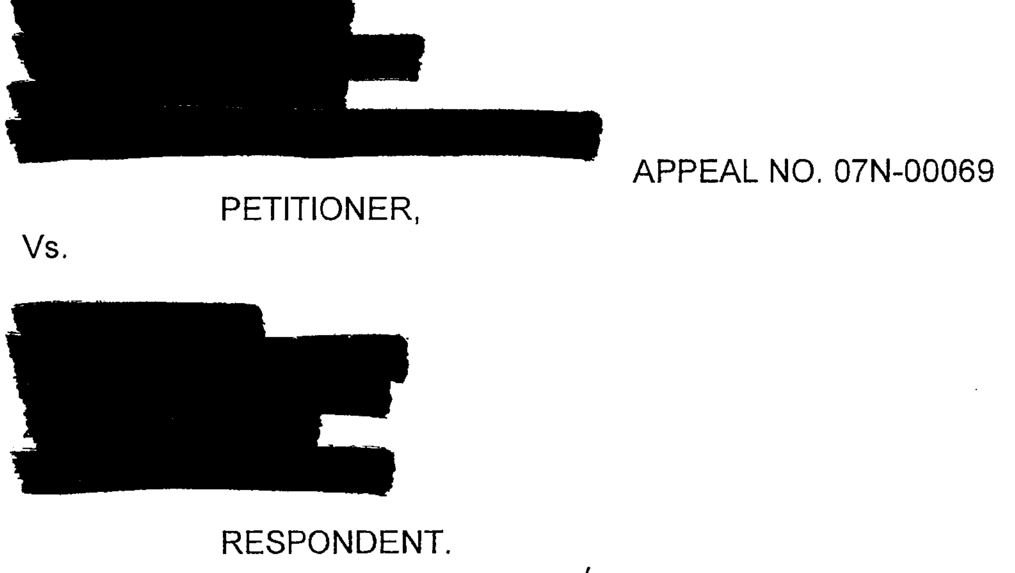
in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
2 DPOES: Denise Parker
[redacted]

FILED
JUL 06 2007
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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



APPEAL NO. 07N-00069

PETITIONER,

Vs.

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on May 22, 2007, at 2:30 p.m., at , in Melbourne, Florida. The petitioner was present, but was represented by attorney, and his associate, administrator, and , business office manager, represented the respondent.

ISSUE

At issue is whether or not notice of intent to discharge from the facility to the location listed on the discharge notice is correct based upon nonpayment following reasonable and appropriate notice to pay. The facility has the burden of proof.

FINDINGS OF FACT

The petitioner began residing in [redacted] on April 13, 2005. Medicare was the primary payer until May 23, 2005 when the petitioner's status changed to private pay. On June 1, 2006, the petitioner was approved for Medicaid benefits retroactive to December 1, 2005. The petitioner was not eligible for Medicaid for the months of July 2005 through November 2005, March 2006 and May 2006, because of either transfers or insufficient deposits to an income trust (Respondent's Exhibit 3). She accumulated a bill for her care in excess of $40,000. When payment for services was not received, a Notice of Intent to Discharge was issued on April 4, 2007. The discharge location on the notice is to the home of [redacted], in Indian Harbour Beach, Florida (Respondent's Exhibit 1).

The parties stipulate that there is a very significant outstanding balance owed, and that the petitioner's representative was aware of such after reasonable and appropriate notice to pay was issued. As of May 31, 2007, the petitioner's outstanding bill for services was $41,311.00. The distribution of the petitioner's retirement account has been liquidated. Counsel for the petitioner has attempted on several occasions to have the Department of Children and Families adjust her patient responsibility to reflect the change in income. The facility will continue to be underpaid each month it is not adjusted, thereby adding more debt.

A hearing was requested because of the location in which the petitioner is to reside upon discharge. The facility has not contacted [redacted] about discharge planning. [redacted] works for FEMA. He is away from home for long periods, and the petitioner requires 24-hour skilled nursing care. He was unavailable at the time of the

hearing because he was out of state working a disaster. The petitioner believes he will not accept her and he has not told the nursing facility he would.

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--
>
> (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
>
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. ...
>
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and telephone number of the State long term care ombudsman;

...

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

Facts show there has been reasonable and appropriate notice to pay, yet nonpayment has occurred. Additionally, facts show the location planned for discharge is unsatisfactory. There was no authority found under which [redacted] can be bound to accept the petitioner into his home.

In the final analysis, it is concluded that the facts and regulations provide sufficient support for the discharge notice as issued on April 4, 2007 with regard to the reason shown. Significant nonpayment following reasonable and appropriate notice has occurred. Because the facility has met its burden to show that the reason for the discharge is within the federal authority, the discharge is affirmed. However, based on the findings, the discharge location does not appear to be appropriate. If the final discharge location determined is still problematic, the parties may wish to address this through the Agency for Health Care Administration's complaint and survey process.

DECISION

The appeal is denied.

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 6th day of July, 2007,

in Tallahassee, Florida.

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

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

FILED
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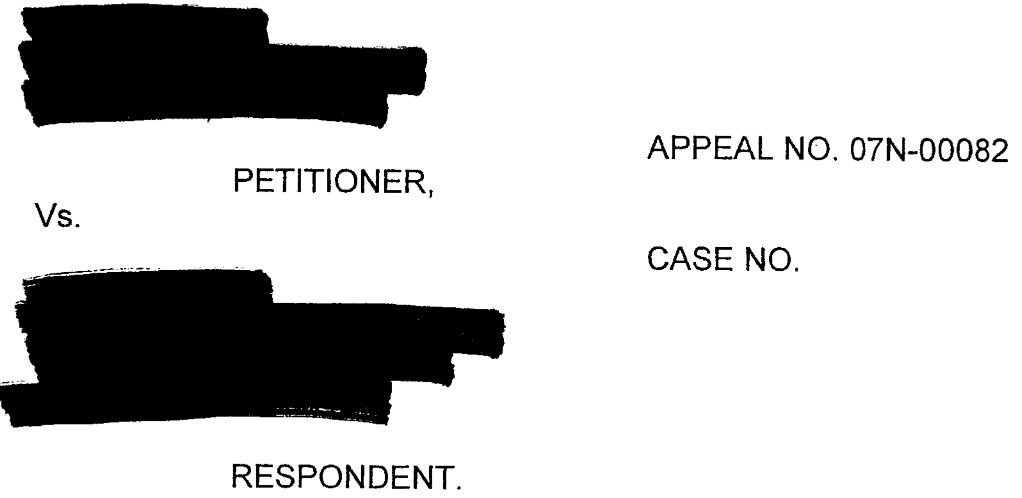
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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



PETITIONER,

Vs.

RESPONDENT.
_________________________________/

APPEAL NO. 07N-00082

CASE NO.

FINAL ORDER

Per notice, a nursing home discharge hearing was held on June 21, 2007 at 3:30 p.m., at the respondent nursing facility. The respondent was represented by the facility administrator, [redacted], who also testified. The petitioner was present to testify and represented himself. The petitioner's friend and former facility resident, [redacted] testified as a witness for the petitioner. [redacted] regional operations director for the facility, observed. [redacted] district long-term care ombudsman, testified for the petitioner.

The following facility staff appeared as witnesses for the respondent: [redacted] director of nursing; [redacted] social services director; [redacted] social services assistant; and [redacted] registered nurse.

The following facility residents also appeared as witnesses: [redacted] [redacted]; and [redacted]

ISSUE

At issue is whether or not the petitioner can be discharged from the respondent facility. The prior reason for discharge was because the petitioner's health had improved sufficiently so that facility services were no longer needed, per notice dated April 25, 2007. However, the respondent verbally withdrew this discharge reason at the hearing and stated another. The respondent believes the petitioner should be discharged because the health and safety of other individuals is endangered. The respondent has the burden of proof in the merit of the discharge action under appeal.

FINDINGS OF FACT

1. The petitioner was admitted to the respondent facility from prior care provided at home with family. The petitioner has been a facility resident since at least February 2007. The petitioner's date of birth is [redacted].
2. The petitioner has a principle diagnosis of paraplegia. Further, the petitioner has additional diagnoses of neurogenic bladder, recurrent urinary tract infections, multiple decubitus and anxiety disorder.
3. On April 25, 2007, the petitioner was given written notice that he was being discharged because his health had improved so that he no longer needed facility services. On this notice, the facility listed a discharge location of [redacted] ALF. However, the facility withdrew the discharge action for this reason at the hearing. This discharge reason was withdrawn because the petitioner still has

stage IV decubitus ulcers, which require treatment at a skilled nursing facility.

4. The respondent believes the petitioner should be discharged in the belief that the safety of other individuals is endangered. The petitioner has not cooperated with nursing treatment on many occasions. The petitioner has many visitors at different times of the day and night, and has had occasions of leaving the facility without permission. The petitioner has been loud, cursed, and used foul language in verbal altercations with various staff members. The petitioner has been seen in the employee smoking area without permission. However, there is no credible evidence that the petitioner has been physically abusive or physically threatened individuals. None of the residents testified to feeling unsafe with the petitioner.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42C.F.R.§431.200. Federal Regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the respondent believes the petitioner should be discharged because the safety of individuals is endangered. Federal Regulations do permit a discharge based on the potential endangerment of other residents, as set forth at 42C.F.R. §483.12(a)(2)(iii), as follows: "The safety of individuals in the facility is endangered;..."

The petitioner has displayed problem behaviors to include non-cooperation with treatment, cursing and loud language, and a failure to abide by facility rules. It is noted that these behaviors are not acceptable and need correction. However, there is not the requisite level of clear and convincing evidence that the petitioner's continued stay at the respondent facility endanger others' safety.

Further, Florida Statutes 400.0255 (7)(b) requires the resident's physician or medical director to document why the petitioner's stay at the facility would endanger the safety of other individuals at the facility, as follows:

> (7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:
>
> (b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available. The evidence is absent documentation from the resident's physician or medical director that other residents or employees safety is endangered by the petitioner's continued stay at the facility. In sum, the respondent facility has not met its burden by clear and convincing evidence that the petitioner's continued stay at the facility endangers other residents or facility employees. Further, there is no evidence that the facility physician has documented that the petitioner must be discharged for the reason that others' safety is endangered.

DECISION

The appeal is granted. The respondent facility is not permitted to discharge the petitioner pursuant to this discharge action under appeal.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 24th day of July, 2007,

in Tallahassee, Florida.

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

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

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JUL 02 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 02 Wakulla
UNIT: 88312

RESPONDENT.
_______________________________/

APPEAL NO. 07F-02248

CASE NO. 1247910466

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on April 25, 2007, at 1:05 p.m., in Tallahassee, Florida. The petitioner was not present. Present representing the petitioner was her daughter, [redacted] The respondent was represented by Mary Burch, ACCESS supervisor. Present as a witness for the respondent was Betsy Wood, ACCESS processor.

ISSUE

The petitioner is appealing the respondent's action of April 4, 2007, to deny her application for Institutional Care Program (ICP) benefits based on excess assets.

The petitioner has the burden of proof as she is applying for Institutional Care Program benefits.

FINDINGS OF FACT

1. The petitioner has been a resident of [redacted] Center since at least September 2006. On December 11, 2006, the respondent received an application for Institutional Care Program benefits from the petitioner. The petitioner was requesting Institutional Care Program benefits for the retroactive months of September 2006 and ongoing. On the above application, the petitioner listed her monthly income as alimony of $600 and Social Security benefits of $481 for a total income of $1,081 per month.

2. At the time of the application, the petitioner had a checking account at the Bank of America account number [redacted] The lowest monthly balance in the checking account was $2,339.37 during September 2006; $2,800.37 during October 2006; $1,400.37 during November 2006; $2,593.02 during December 2006; $3,087.02 during January 2007; $79.44 during February 2007 and $3,475.90 during March 2007.

3. The petitioner had a bank account at the Premier Bank. The balance in the account was $39.80 during November 2006, $39.90 during December 2006 and $39.92 during January 2007. The petitioner also had a balance in her trust account at the Capital Healthcare Center of $27 during January 2007; $8 during February 2007 and $8 during March 2007.

4. The petitioner had an account at [redacted] The balance in the account was $2,022.14 during March 2007. According to the petitioner's daughter the balance in the account was not less that $2,022.14 from September 2006 through the date of the hearing. The respondent was not aware that the petitioner had an account with Raymond James until the date of the hearing.

5. On the above application, the petitioner stated that she had a life insurance policy with Met Life Insurance Company. The face value of the policy was $5,000. The petitioner also listed the cash value of the policy at $2,300. On March 5, 2007, the petitioner cashed in the policy. The proceeds of the policy were deposited into the petitioner's Bank of America check account number [redacted]. The Bank of America checking account statement for the above account listed a deposit of $4,773.59 that was made into the account on March 6, 2007. A hand written notation on the statement next to the deposit that was made by the petitioner's daughter states that the deposit was a Met Life Insurance payment.

6. The total of the petitioner's accounts at the Bank of America, Raymond James, the Premier Bank and the Capital Healthcare Center trust plus the cash value of the petitioner's life insurance policy exceeded the Institutional Care Programs asset limit for an individual of $2,000 from September 2006 through March 2007.

7. On April 4, 2007, the respondent denied the petitioner's application for the months of September 2006 through March 2007 because her total assets exceeded the Institutional Care Program's asset limit of $2,000 during the above months. The petitioner's assets would have exceeded the asset limit even if the burial exclusion of $2,500 would have been subtracted from the total assets for each of the above months. As of the hearing date, the petitioner did not have a burial account.

CONCLUSIONS OF LAW

20 C.F.R. § 416.1201 in part states:

Resources; general. (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to

cash to be used for his or her support and maintenance... (b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are ...life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit)...

Fla. Admin. Code 65A-1.303 in part states

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

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

(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period).

Fla. Integrated Pub. Policy Manual, passage 1640.0100 in part states:

ASSET DEFINITION (MSSI, SFP)
Assets, liquid or non-liquid, are assets or items of value that are owned (single or jointly) by an individual who has access to the cash value upon disposition.

Liquid assets are cash assets or assets that are payable in cash on demand. Nonliquid assets are assets that cannot be readily converted to cash.

Fla. Integrated Pub. Policy Manual, passage 1640.0205 in part states:

Asset Limits (MSSI, SFP)

Total countable assets for an individual or a couple must not exceed $2,000 or $3,000 respectively.

Exceptions to these asset limits include the following:

1. for MEDS-AD, assets cannot exceed $5,000 for an individual and $6,000 for a couple;

2. for QMB, SLMB and QI1, assets cannot exceed the MEDS/MN asset limit ($5,000 for an individual and $6,000 for a couple);

3. for working disabled benefits, assets cannot exceed the MEDS/MN asset limit ($5,000 for an individual and $6,000 for a couple); and

4. for ICP, PACE, and Hospice individuals (admitted to an institution on or after September 30, 1989) and for Assisted Living Waiver (ALW) individuals (applying for ALW Medicaid on or after July 1, 2003) with community spouses, the individual's assets must not exceed $2,000 after the community spouse's asset allocation allowance is subtracted from the couple's total countable assets. For ICP-MEDS, the asset limit cannot exceed $5,000 for the institutionalized individual, after allocation of the assets to the community spouse.

Fla. Integrated Pub. Policy Manual, passage 1640.0502 in part states:

Checking and Savings Accounts (MSSI, SFP)
The asset value is the balance in the account on the date on which eligibility is established. If the total asset value of the account does not affect eligibility, it is not necessary to determine the amount of any transactions that have not cleared the account or the individual's portion of a joint bank account. However, the individual still may be given the opportunity to rebut full or partial ownership to ensure that future changes to the account will not affect his eligibility.

Fla. Integrated Pub. Policy Manual, passage 1640.0514 in part states:

Burial Exclusion Policy (MSSI, SFP)
An individual and the individual's spouse may set aside funds of up to $2,500 each for burial expenses. These funds are excluded as assets as long as the individual shows that they are clearly designated as being set aside for burial. This is true even if the case has been closed as long as the funds continue to be designated for burial. The funds must be separately identifiable (not commingled with other funds) unless the asset cannot be separated or it is unreasonable to require it. The individual (or deemed individual) must provide a written statement defining:

1. the amount of funds set aside,
2. for whose burial the funds are set aside, and
3. the form in which the funds are held.

The individual and the individual's spouse must be given the opportunity to designate funds for burial at the time of application and at review if the maximum amount is not already designated. These funds may be excluded regardless of whether the exclusion is needed to allow eligibility.

Fla. Integrated Pub. Policy Manual, passage 1640.0514 in part states:

Life Insurance (MSSI, SFP)
A life insurance policy is considered only to the extent of its cash surrender value. However, if the face value of all life insurance policies on any one individual totals $2,500 or less, no part of the cash surrender value of any such policy or policies will be taken into account. Life insurance having no cash surrender value (for example, term insurance or burial insurance) is not considered in determining the face value of insurance and is excluded from all computations.

The policy must be owned by the individual or the person whose assets are deemed to the individual to be considered a countable asset to the individual.

When the total face value of all life insurance policies on an eligible individual, or an eligible/ineligible spouse whose assets are deemed to the eligible individual exceed $2,500, the cash surrender values of all such policies must be counted as assets. When the cash surrender values of such policies exceed the asset limitation, an individual may adjust his insurance holdings to policies of a reduced face value. If an adjustment is made, the life insurance policies (and any cash adjustments) are reconsidered in determining eligibility.

Fla. Integrated Pub. Policy Manual, Appendix A-9 establishes an asset limit in the Institutional Care Program of $5,000 for individuals with an income of $719 or less. This income limit was effective April 2006 and was increased to $743 effective January 2007. Appendix A-9 establishes an asset limit of $2,000 for individuals with an income that exceeded the above income limits.

The Findings of Fact showed that the petitioner's income as stated on her application was $1,081 per month. Therefore, the petitioner had to meet the asset limit of $2,000 in order to receive Institutional Care Program benefits. The findings show that the petitioner's assets from her Bank of America, Raymond James, the Premier Bank and the Capital Healthcare Center trust accounts plus the cash value of the petitioner's life insurance policy exceeded the $2,000 asset limit in the Institutional Care Program from at least September 2006 through March 2007. Based on the amount of the assets, the petitioner was not eligible to receive Institutional Care Program benefits from September 2006 through March 2007. Therefore, the respondent correctly denied the petitioner's application for Institutional Care Program benefits.

DECISION

The appeal is denied. The respondent action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the respondent. 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 respondent has no funds to assist in this review, and any financial obligations incurred

will be the petitioner's responsibility.

DONE and ORDERED this 2nd day of July, 2007,

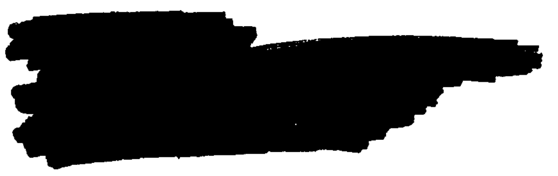
in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
2 DPOES: Denise Parker
[redacted]

FILED
JUL 23 2007
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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



APPEAL NO. 07F-02484

PETITIONER,

Vs.

CASE NO. 1004221002

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 14 Polk
UNIT: 88119

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 11, 2007, at 10:50 a.m., in [redacted], Florida. The petitioner was not present. He was represented by [redacted], Medicaid representative. The respondent was represented by [redacted], economic self-sufficiency supervisor.

The petitioner was allowed 10 days to return further evidence. Evidence was received from the petitioner on May 11, 2007. It was accepted as Petitioner's Exhibit 2.

ISSUE

At issue is the April 12, 2007 action by the respondent denying the petitioner's application for Medicaid due to his failure to meet the disability criteria.

FINDINGS OF FACT

1. On February 7, 2007, the petitioner filed a Request for Assistance to apply for Medicaid. He resided in a nursing facility. The petitioner is 63 years old. Since he was under age 65, a disability assessment was required.
2. On April 5, 2007, the respondent forwarded a request for a disability assessment to the District Medical Review Team as the petitioner resided in a nursing facility.
3. The petitioner receives retirement benefits from the Social Security Administration. He has not been determined disabled by that agency. His retirement benefit makes him ineligible for Supplemental Security Income. He is considered 80% disabled by the Veteran's Administration and receives monthly benefits from that agency.
4. The petitioner has been diagnosed with subdural hematomas, renal insufficiency, COPD, insulin dependent diabetes, hypertension, organic dementia, and seizures. He is severely confused and disoriented. The petitioner is ambulatory. He is continent. He is supervised by staff in a secure unit due to his dementia and confusion.
5. The petitioner was admitted to the hospital on October 5, 2006 with shortness of breath and confusion. He left the hospital against medical advice on November 8, 2006 but was readmitted the same day. He was discharged to the nursing facility on November 11, 2006. He has remained in the nursing facility since that date. CARES issued a level of care on January 3, 2007 establishing

that the petitioner required skilled care in a nursing facility due to medical and mental reasons.

6. The petitioner completed the 11th grade. He spent two years in the military. He worked in construction over the years but has not been employed for over 10 years.

CONCLUSIONS OF LAW

The Florida Administrative Code, Section 65A-1.710 et seq., set forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. §416.905. The regulations state, in part:

> The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy...

The hearing officer evaluated [redacted] claim of disability using the sequential evaluation as set forth in 20 C.F.R. §416.920. The first step is to determine whether or not the individual is working. [redacted] is not working and therefore meets the first step.

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

The third step is to determine whether or not the individual's impairment(s) meets or equals a listed impairment in Appendix 1 of the Social Security Act. A review of the listings at 3.00 "Respiratory System", "Endocrine System", 11.00, "Neurological", and 12.00, "Mental Disorders" does not show that the petitioner meets a required listing.

The fourth step is to determine whether or not the individual's impairment(s) prevents him from doing past relevant work. The petitioner's past relevant work was in construction. The Dictionary of Occupational Titles describes this work as requiring the residual functional capacity to perform at least moderate strength work. The medical evidence establishes that the petitioner cannot perform his former work requiring having a moderate strength requirement.

The fifth step is to determine whether or not the individual's impairment prevents him from performing other work. The petitioner is an individual of advanced age, with a limited education, a skilled or semi-skilled work history, and without the residual functional capacity to do sedentary work due to his combined impairments. Pt. 404, Subpart P, Appendix 2 of 20 C.F.R. calls for a finding of disabled for an individual with the petitioner's age, education, work experience and residual functional capacity.

DECISION

This appeal is granted. The department's action denying the petitioner's application for Medicaid based on disability is reversed. The department should reevaluate the petitioner's eligibility considering that he meets the disability criteria.

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 23rd day of July, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
14 DPOES: Ellen Schultz

FILED
JUL 18 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-03114

PETITIONER,

Vs.

CASE NO. 1208837362

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 21, 2007, at 10:30 a.m., in Pensacola, Florida. The petitioner was not present but was represented by his son, Testifying on behalf of the petitioner was Michelle Grisanti, business office manager, of Pensacola. The Department was represented by Franzaro Dudley, supervisor, Access Florida.

ISSUE

At issue is the amount of the patient responsibility effective January 2007, assigned in the Medicaid Institutional Care Program (ICP). The petitioner bears the burden of proof.

FINDINGS OF FACT

The petitioner has been a resident of [redacted] of [redacted] since at least 2005. Prior to the action under appeal, the petitioner was eligible for ICP Medicaid benefits with a patient responsibility of $168.74 for February 2006 through December 2006 and $179.74 for January through April 2007.

The petitioner's income consisted of Veteran's Administration (VA) pension of $1,126 effective January 2006. The VA pension increased to $1,254 effective January 2007 (Respondent's Exhibit 2 and Composite Exhibit 1). The Department originally determined that all of the VA improved pension included Aid and Attendance and unreimbursed medical expenses, which were excluded (Respondent's Exhibit 1). In addition, the petitioner reported income from Social Security and interest income. The Social Security income was $346 effective January 2006 and increased to $357 effective January 2007.

Beginning January 2007, the Department continued to exclude all of the VA income. The Department counted Social Security (SSA) benefits of $357 and interest income of $.04. To determine the patient responsibility, the Department subtracted $35 for the personal needs allowance. The remaining balance of $179.74 was the patient responsibility .

On February 28, 2007 the Department received verification that the VA improved income included $589 Aid and Attendance and no unreimbursed medical expenses. The Department determined the countable VA pension was $665. In addition, the

petitioner had Social Security (SSA) income of $357 effective January 2007. The Department used a procedure called "passing dates" to recalculate the patient responsibility retroactive to January 2007 through March 2007 and ongoing for April 2007. To calculate the patient responsibility retroactive to January 2007, the Department added $665 VA, $357 SSA and $.04 interest income to arrive at total gross unearned income of $1,022.04. The Department then subtracted $35 personal need allowance to arrive at a revised patient responsibility of $844.74. The Department's running record comments, as part of its business record, indicated that the petitioner had health insurance premium of $142.30. There was no indication that the Department allowed the cost of medical insurance as a deduction from the patient responsibility.

On April 18, 2007, the Department notified the petitioner, by Notice of Case Action, that the patient responsibility had increased to $844.74 effective January 2007.

The [redacted] adjusted the patient responsibility and billed the petitioner for the revised amount of $844.74 retroactive to January 2007. As a result, the petitioner now owes an arrearage of $2,660. The representative purchased a preneed burial contract that included $2,685 for services and $3,075 for a casket on February 21, 2007 in an effort to spend down some of the resources that were accumulating. It was not until April 18, 2007, that the representative was advised of the revised patient responsibility retroactive to January 2007. The petitioner's representative is concerned that there is not enough money left to pay the arrearage to the nursing home.

CONCLUSIONS OF LAW

Florida Administrative Code Section 65-2.043 in part states:

(2) In cases of intended action to discontinue, terminate, or reduce assistance, the Department shall give timely and adequate notice…(4) In all other cases "timely" means that the notice is mailed at least 10 days before the date of action, that is, the date upon which the action would become effective.

The Department's Integrated Policy Manual, 165-22, Section 3440.0207, Advance Notice of Adverse Action (MSSI, SFP), states:

Adverse actions include the reduction of a benefit, an increase in the Medically Needy Share of Cost or patient responsibility and the termination of an individual's or assistance group's eligibility for benefits. DCF is required to provide advance or adequate notice based upon the specific actions taken on an application or ongoing case. Advance and adequate notice are defined as follows:
1. Advance notice is a notice that is provided giving at least 10 days plus one additional day for mailing prior to the effective date of any adverse action.
2. Adequate notice is a notice that is provided prior to the date an individual or assistance group would receive benefits. In certain situations DCF is not required to provide advance notice before taking adverse action but is required to give adequate notice.

The Department's Integrated Policy Manual, 165-22, Section 1840.0906.02, Veterans Payments-Pensions, states in part:

VA pensions are included as unearned income, excluding the amount of aid and attendance, housebound allowance, and unreimbursed medical expenses…

The Department's Integrated Policy Manual, 165-22, Section 2640.0125.01 Uncovered Medical Expenses (MSSI), states:

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

The Findings of Fact showed that on February 28, 2007, the Department received verification of VA income and determined that it had incorrectly excluded it based on previous documentation showing that it consisted of Aid and Attendance and Unreimbursed Medical Expenses. The Findings show that the Department recalculated the patient responsibility retroactive to January 2007 and notified the petitioner on April 18, 2007 that his patient responsibility would be increased retroactive to January 2007. This notice did not give the petitioner the 10-day advance notice that is required in the above authorities. Therefore the hearing officer concludes that the effective date of the increased patient responsibility should be May 2007.

In addition, the Findings show that the petitioner had a health insurance premium which was not considered in the Department's calculations of patient responsibility.

According to the above authorities, total income amounts for health insurance premiums are to be deducted. The undersigned authority also concludes that the Department incorrectly calculated the patient responsibility when it failed to deduct the cost of health insurance premiums. The hearing officer concludes that the correct patient responsibility effective May 2007, after deducting the health insurance premium of $142.30 should have been $702.44.

DECISION

The appeal is granted. The Department is hereby ordered to reverse its determination of patient responsibility for the months of January through April 2007. The Department is to reduce the patient responsibility to $702.44 beginning May 2007 after subtracting the cost of health insurance.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18th day of July, 2007,

in Tallahassee, Florida.

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

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

FILED
JUL 0 3 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-02047

PETITIONER,

Vs.

CASE NO. 1150079762

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 April 23, 2007, at 10:47 a.m., in Florida. The petitioner was not present. He was represented by his spouse, The respondent was represented by economic self-sufficiency supervisor. Present as a witness for the petitioner was his daughter,

The respondent was allowed 10 days to provide requested information. Evidence was received from the petitioner on April 23, 2007. It was accepted as Respondent's Exhibit 1.

ISSUE

At issue is the action by the respondent increasing the petitioner's patient responsibility for the Institutional Care Program from $241.51 to $505.75 affective April 1, 2007.

FINDINGS OF FACT

1. On February 15, 2007, the respondent mailed an Interim Contact Letter to the petitioner to redetermine his eligibility for the Institutional Care Program. He resided in a nursing facility. His representative was his spouse who resided in the community. She completed the form and returned it to the respondent on February 22, 2007.
2. The spouse worked part-time and was paid biweekly. She returned pay stubs with the Interim Contact Letter. The respondent considered all pays as representative including holiday and vacation pay. The respondent averaged four biweekly pay amounts that totaled $1024.04. They divided by 4 to arrive at an average pay of $256.01 biweekly and multiplied this amount by 2 for a monthly amount of $512.02.
3. The respondent calculated the spouse's monthly income as the earned income of $512.02, interest income of $7.09, and her social security benefit of $583. Her total monthly income was $1,072.11. The increase in the petitioner's earned income from the last review decreased her community spouse income allowance (the amount diverted to her from her institutionalized spouse). The decrease in her allowance increased the petitioner's patient responsibility from $241.51 to $505.75.
4. The petitioner stipulated that the respondent used the correct amounts for their expenses, social security income and interest income. The only factor that she

questioned was the respondent's calculation of her monthly earned income. The petitioner disagreed with the inclusion of non representative weeks such a vacation pay and holidays.

5. The respondent stipulated to the error in the calculation of the petitioner's monthly earned income. The respondent agreed to recalculate the petitioner's monthly earned income using two representative biweekly pay amounts.

CONCLUSIONS OF LAW

The Fla. Admin. Code at 65A-1.7141 SSI-Related Medicaid Post Eligibility Treatment of Income.

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income".
>
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
>
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance.
>
> (b) If the individual earns therapeutic wages, an additional amount of income equal to one-half of the monthly therapeutic wages up to $111 shall be protected for personal need. This protection is in addition to the $35 personal need allowance.
>
> (c) Individuals who elect Hospice service have an amount of their monthly income equal to the federal poverty level protected as their personal need allowance unless they are a resident of a medical institution, in which case $35 of their income is protected for their personal need allowance.
>
> (d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current standard Food Stamp utility allowance is used to

determine the community spouse's excess utility expenses.

The Integrated Public Assistance Policy Manual states in relevant part at

passage 2440.0501 Averaging Fluctuating Income (MSSI, SFP)

To average income, the ESS must consider the assistance group's anticipation of monthly income fluctuations over the entitlement period or eligibility period. When averaging income, use the most recent consecutive four weeks or the best available information when it is representative of the individual's future earnings.
Example 1: At application, [redacted] provides the most recent consecutive four pay stubs from his job. He states he has not received any pay raises or significant changes in the number of hours he is working. As such, the ESS projects his future monthly earnings on an average of the four pay stubs he presented.
Example 2: At eligibility review, [redacted] provides the most recent consecutive four pay stubs from his job. The two more recent stubs indicate a $1.00 increase in his hourly rate. Since he has had a change in his hourly rate, the ESS does not use all four pay stubs to project his future earning potential. Instead, the ESS uses the two pay stubs which are representative of his future earnings and averages these to project his monthly earnings.
Note: Refer to passages 2440.0510 and 2440.0512 for specific policies for averaging income for ICP, Hospice, HCBS and HC/DA.

The Integrated Public Assistance Policy Manual states in relevant part at

passage 2440.0502 When Income should be Averaged (MSSI, SFP)

When computing a budget, income should be averaged whenever it is received:
1. in differing amounts;
2. at varying periods;
3. from sources such as tips, commissions, and overtime;
4. at a regular rate and schedule of pay, but to cover time periods which vary; or
5. in any combination of the above, or any time the same amount is not received at the same time each month, resulting in the amounts to be budgeted varying from month to month.

The Integrated Public Assistance Policy Manual states in relevant part at passage 440.0504 Earned Income (MSSI, SFP):

> A four week average is used when earned income is received more frequently than monthly; for example, weekly or biweekly. When income is received semimonthly, the computation is averaged based on the most recent available one month of pay (two semimonthly payments). When the income is received monthly, use the most recent one month pay if representative. When using an average, use only the weeks in the average that represent the ongoing pattern of employment. For example, if the employee is out sick one week and received no pay, do not use that week in the average.

The Integrated Public Assistance Policy Manual states in relevant part at passage 2440.0510 How to Count Income for Eligibility (MSSI, SFP)

> This policy is to be used to calculate the gross monthly income amount to be used in eligibility budgets for all SSI-Related Medicaid Programs at the time of application or eligibility review. This policy is not to be used for determining patient responsibility, except for determining income of the community spouse. For policy on how to count the individual's income for patient responsibility, see passage 2440.0512.
> Both unearned and earned income are treated the same for the SSI-Related Medicaid Programs. All income must be converted into a monthly amount for budget purposes.
> For applications, budget actual income for months available instead of computing an average. If you are prorating income, begin prorating in the month it is received in a month for which benefits are requested. For example, if an individual is requesting benefits beginning in July, and receives an annual payment every October, no income from the October payment would be counted in the budget until October. Then, schedule a partial for September to start counting the prorated income effective October.
> The method used to determine a monthly amount depends on how often the income is received and the specific program.
> Follow these steps to determine how to count income for eligibility:

Note: Refer to Chapter 2600 for allowable income disregards and deductions.
Step 1: Determine how often the income/payments are received.
If monthly or more often than monthly (weekly, biweekly, semimonthly), go on to Step 2.
If less often than monthly (quarterly, annually, etc.), go to Step 4.
Step 2: Determine if the income/payment fluctuates (i.e., does it vary?)
If the amount does vary, go on to Step 3 to determine an average amount.
If the amount does not vary, use the actual amount and skip to Step 4. 47
Step 3: For amounts that vary and are received monthly or more often than monthly (weekly, biweekly, semimonthly), compute average amount as follows:
1. Add the gross income amounts for the most recent consecutive four weeks to get a total. (If this period is not available or is not representative of anticipated income, you may use more or less than four weeks.)
2. If income is received weekly, add four pay periods and divide by four to get the weekly average.
3. If income is received biweekly, add two pay periods and divide by two to get the biweekly average.
4. If income is received semimonthly, add two pay periods and divide by two to get the semimonthly average.
5. If income is received monthly, use the most recent month if representative.

The above amount is called the averaged amount and must be converted to a monthly amount. Variations of less than $5.00 do not need to be re-averaged until the next complete review or a change is reported.
Note: When an individual's income has just started or terminated in the current month, a full month's income is not budgeted; use only the amount actually received in the month or anticipated to be received.
Go to Step 4 to determine the monthly amount.
Step 4: Establish a monthly figure (see (a) and (b) below), to be used for budgeting. Use the actual amount determined in Step 2, averaged amount determined in Step 3, or the actual quarterly, semiannual or annual income.
1. For MEDS-AD, Institutional MEDS, OSS, Medically Needy, QMB, SLMB, WD, Protected Medicaid and HC/DA:

a. for weekly: multiply by four
b. for biweekly or semimonthly: multiply by two.
c. for monthly: use monthly amount

d. for income received quarterly, semiannually, or annually: divide by the number of months in the period it is intended to cover (quarterly, by three; semiannually by six).

Note: If converting income that is received quarterly, semiannually, or annually causes ineligibility, do not prorate; count income in the month it is actually received.
Note: For Institutional MEDS this step applies only to counting income for eligibility. Patient responsibility is computed using the same rules as ICP, Hospice, and HCBS.
1. For ICP, Hospice and HCBS: use the actual number of payments made in the month to convert to a monthly amount and determine client's eligibility:

a. for weekly: use five weeks in months that have five payments and four weeks in months that have four payments.
b. for biweekly: use two payments in months only two payments will be received; three payments in months where three payments will be received.
c. for income received quarterly, semiannually, or annually, count income in the anticipated month of receipt.

The respondent calculated the spouse's earned income by averaging four biweekly pay amounts. According to the above-cited code and manual material, a monthly average is required. In the petitioner's case two biweekly pay amounts should be multiplied by four to get the monthly amount for the community spouse's income. The pays selected should be representative. The respondent stipulated to the error at the hearing and agreed to re-average the petitioner's income using two representative biweekly pay amounts.

DECISION

This appeal is granted. The respondent agreed to re-average the spouse's income and make the resultant change to the petitioner's patient responsibility.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 3rd day of July, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
8 DPOES: Richard Elwell

FILED
JUL 16 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs.

APPEAL NO. 07F-02456

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 13 Sumter
UNIT: 88006

CASE NO. 1105649091

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 23, 2007, at 9:30 a.m., in [redacted] Florida. The petitioner was not present. Present representing the petitioner was his wife, [redacted] Present as a witness for the petitioner was his son, [redacted] The respondent was represented by [redacted], claims manager, Benefit recovery Program. Present as a witness for the respondent was [redacted] ACCESS processor.

As stipulated during the hearing, the record was held open for seven days to allow the respondent the opportunity to submit additional evidence which has been received and entered into evidence as the Respondent's Composite Exhibit 9.

ISSUE

The petitioner is appealing the respondent's action of April 5, 2007, to seek recovery of a Medicaid overpayment of $3,197.12 that occurred from June 2006 through August 2006 and from October 2006 through December 2006.

The respondent had the burden of proof as the respondent is seeking recovery of the Medicaid overpayment.

FINDINGS OF FACT

1. On April 26, 2006, the petitioner submitted an application for Institutional Care Program benefits. At the time of the application, the petitioner was residing in a skilled nursing facility. The petitioner was married and his wife was living in the community. Therefore, she was considered to be a community spouse for Institutional Care Program purposes.

2. On the above application, the petitioner listed his income from Social Security of $942, his wife's Social Security income of $757 and her pension of $736.07. The petitioner also listed shelter expenses for his wife of $715.55 per month which included a mortgage payment of $482.10, property taxes of $35.45 and the current standard food stamp utility allowance of $198.

3. The respondent approved the petitioner's application for Institutional Care Program benefits. The petitioner received Institutional Care Program benefits from June 2006 through August 2006 and from October 2006 through December 2006. The respondent determined that the amount of the petitioner's income needed to pay for the cost of his nursing home care or the patient responsibility was zero from June 2006 through August 2006 and also zero from October 2006 through December 2006. In calculating

the patient responsibility of zero, the respondent included the petitioner's Social Security income, his wife's Social Security income and her shelter expense of $715.55. However, the pension income of $736.07 per month that the petitioner's wife was receiving was not included in the calculation of the petitioner's patient responsibility. The budgets reflecting the patient responsibility of zero were entered into evidence as the Respondent's Composite Exhibit 3.

4. The respondent determined that the pension that the petitioner's wife was receiving was erroneously excluded and should have been included in the calculation of the patient responsibility. In calculating the patient responsibility, the respondent had to determine the amount of the petitioner's income that would be allocated to meet the needs of his wife. To determine the income allocated to meet the petitioner's wife's need, the respondent subtracted thirty percent of the monthly minimum maintenance income allowance of $1,604, or $469, from the shelter cost of $715.55. The balance of $246.55 was the excess shelter. The monthly minimum maintenance income allowance of $1,604 was added to the excess shelter which resulted in a total of $1,850.55, which was the allowable shelter deduction. The petitioner's wife's total income of $1,493.07 was subtracted from the total allowable shelter deduction. The balance of $357.48 was the amount of the petitioner's income that was to be allocated to meet the needs of his wife or the community spouse income allowance. The community spouse income allowance and the $35 personal needs allowance were subtracted from the petitioner's income of $942. The balance of $549.52 was the patient responsibility for June 2006. The monthly minimum maintenance income allowance was increased to $1,650 effective July 2006. The inclusion of the increased monthly minimum maintenance

income allowance resulted in a patient responsibility of $529.52 from July 2006 and August 2006 and from October 2006 through December 2006.

5. The respondent determined that the petitioner received a Medicaid overpayment of $549.52 for June 2006 and $529.52 for July 2006, August 2006 and from October 2006 through December 2006 for a total overpayment of $3,197.12. The overpayment occurred because the respondent did not include petitioner's wife's pension in determining his patient responsibility. The overpayment was the amount of the patient responsibility for each month. The budgets reflecting the patient responsibility from June 2006 through August 2006 and from October 2006 through December 2006 were entered into evidence as the Respondent's Exhibit 4. The respondent determined that the petitioner did not receive an overpayment during September 2006 as there were no Medicaid payments made on behalf of the petitioner during the month of September 2006.

6. On April 5, 2007, the respondent, by Notice of Overpayment, notified the petitioner that he received a Medicaid overpayment of $3,197.12 from June 2006 through December 2006. The overpayment is considered an agency error as the petitioner reported his wife's pension.

7. During the hearing, the petitioner's wife stated that, at the time of the application, she reported the cost of her homeowner's insurance as a shelter expense which the respondent did not include. The respondent agreed to include the cost of the homeowner's insurance and agreed to recalculate the patient responsibility and the Medicaid overpayment.

8. Subsequent to the hearing, the respondent submitted budgets that included a homeowner's insurance premium of $48.33 per month which increased the total shelter expenses to $763.88. The inclusion of homeowner's premium resulted in a revised patient responsibility of $501.19 for June 2006 and $481.19 for July 2006, August 2006 and from October 2006 through December 2006. The revised Medicaid overpayment was $2,907.14 during the period at issue. The revised budgets and the revised Report of Claim Determination reflecting the Medicaid overpayment of $2,907.14 were entered into evidence as the Respondent's Composite Exhibit 9.

CONCLUSIONS OF LAW

The Fla. Stat. ch. 414.41 "Recovery of payments made due to mistake or fraud" states in part:

> (1) Whenever it becomes apparent that any person or provider has received any public assistance under this chapter to which she or he is not entitled, through either simple mistake or fraud on the part of the department or on the part of the recipient or participant, the department shall take all necessary steps to recover the overpayment. Recovery may include Federal Income Tax Refund Offset Program collections activities in conjunction with Food and Consumer Service and the Internal Revenue Service to intercept income tax refunds due to clients who owe food stamp or WAGES debt to the state. The department will follow the guidelines in accordance with federal rules and regulations and consistent with the Food Stamp Program. The department may make appropriate settlements and shall establish a policy and cost-effective rules to be used in the computation and recovery of such overpayments.

Fla. Admin. Code 65A-1.900 Overpayment and Benefit Recovery in part states:

> (2) Persons Responsible for Repayment of Overpayment...
> (c) Medicaid overpayments shall be recovered as required in section 414.41, F.S.

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

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

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

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

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

(e) For community Hospice cases, a spousal allowance equal to the SSI Federal Benefit Rate (FBR) minus the spouse's own monthly income shall be deducted from the individual's income. If the individual has a spouse and a dependent child(ren) they are entitled to a portion of the individual's income equal to the Temporary Cash Assistance consolidated need standard (CNS) minus the spouse and dependent's income. For CNS criteria, refer to subsection 65A-1.716(1), F.A.C.

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

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

(c) Spousal Impoverishment Standards

1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. § 1396r-5.

2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.

3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMIA

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

4. Food Stamp Standard Utility Allowance: $198.

5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. § 1396r-5. This standard changes January 1 of each year.

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

Patient Responsibility Computation (MSSI)
The following policy applies to ICP, institutionalized MEDS ...:

After the individual is determined eligible, the amount of monthly income to be applied to the cost of care (patient responsibility) is computed as follows:

Step 1 - Deduct the personal needs allowance and one half of the gross therapeutic wages up to the maximum of $111 if applicable, for adults in ICF/DDs. Refer to 2640.0118 for information regarding the personal needs allowance.
Step 2 - Deduct the community spouse income allowance, family member allowance, or the dependent's allowance, if applicable.
Step 3 - Consider protection of income policies for the month of admission or the month of discharge, if appropriate (refer to 2640.0123) for the following programs:

1. Institutional Care Programs, (including institutionalized MEDS and institutionalized Hospice) - the month of admission to and discharge from a nursing facility,
2. Assisted Living Waiver - the month of admission to and discharge from an ALF,
3. PACE and Long-Term Care Diversion - the month of admission or discharge from a nursing home facility or from an assisted living facility.

Step 4 - Deduct uncovered medical expenses as discussed in passages 2640.0125.01 through 2640.0125.04.
The balance is the amount of the patient responsibility.

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

Community Spouse Income Allowance (MSSI)
The following policy applies to the ICP, institutionalized MEDS, institutionalized Hospice, Long Term Care Diversion, PACE, and the

Assisted Living Waiver Programs. When an institutionalized individual has a community spouse whose gross income is less than the state's minimum monthly maintenance income allowance (MMMIA) plus the CS excess shelter expense costs, a portion of the individual's income may be allocated to meet the needs of his community spouse.

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

Community Spouse's Monthly Income Allowance (MSSI)
A community spouse's monthly income allowance depends on the amount of monthly income available to the community spouse and the amount of excess shelter costs the community spouse must pay.

The actual community spouse monthly income allowance is equal to how much the state's MMMIA plus the community spouse's excess shelter costs exceed the community spouse's income.

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

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

(State's MMMIA + community spouse's excess shelter costs) - (the community spouse's total gross income) = (the community spouse's income allowance.)

The community spouse's income allowance is the total amount that can be allotted to the community spouse from the institutionalized individual.
The state's MMMIA plus CS excess shelter cost cannot exceed the state's cap on CS income allowance (see Appendix A-9).

The institutionalized individual's personal needs allowance and deduction for therapeutic wages is deducted prior to deducting the community spouse's income allowance.

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

Determining Community Spouse's Excess Shelter Costs (MSSI)
The following steps are used to determine the community spouse's excess shelter costs:

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

Fla. Integrated Pub. Policy Manual, Appendix A-9 set forth the minimum monthly maintenance income allowance of $1,604 for June 2006 and $1,650 effective July 2006.

The Findings of Fact show that in calculating the petitioner's patient responsibility the respondent must determine the income allocated to meet the needs of his wife, which requires the inclusion of the wife's total income. The findings show that the respondent did not include the petitioner's wife's pension in determining his patient responsibility. Therefore, the petitioner received a Medicaid overpayment from June 2006 through August 2006 and from October 2006 through December 2006. Based on the above findings, it is determined that the respondent is correctly establishing a Medicaid overpayment claim against the petitioner and is correctly seeking recovery of the overpayment. However, based on the inclusion of the homeowner's insurance as an additional shelter expense and the revision of the overpayment, the total overpayment claim is being reduced from $3,197.12 to $2,907.14.

DECISION

The appeal is denied. The respondent's action to seek recovery of the Medicaid overpayment is affirmed. However, the total overpayment is reduced to $2,907.14.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the respondent. 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 respondent 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 July, 2007,

in Tallahassee, Florida.

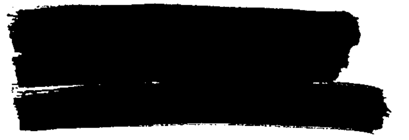
Morris Zamboca

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

Copies Furnished To: [redacted] Petitioner
13 DPOES: Jorge A. Martinez

FILED
JUL 19 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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



APPEAL NO. 07N-00100

PETITIONER,

Vs.

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 13, 2007, at 3:01 p.m., at in Sarasota, Florida. The petitioner was present. Present on behalf of the petitioner was her mother, The respondent was represented by attorney. Witnesses for the respondent were administrator, business manager, and social services director.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of May 30, 2007 is in accordance with the requirements of 42 C.F.R. § 483.12(a):

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

FINDINGS OF FACT

The petitioner received a Nursing Home Transfer and Discharge Notice on May 30, 2007. The notice informed the petitioner of a facility's intent to discharge her as "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".

1. The petitioner was admitted to the facility on December 19, 2006. The petitioner has incurred expenses for her residence in the facility. Medicare paid for the first 100 days. After the first 100 days, the petitioner status was changed to private pay. Private pay can be either from the petitioner or payment from Medicaid. From March 30, 2007 through July 13, 2007, the petitioner has not made any payment to the facility. As of July 13, 2007, all applications for Medicaid have been denied. The petitioner has an outstanding obligation to the nursing home in the amount of $27,826.73, as of June 30, 2007.

2. The petitioner was sent notification on May 30, 2007, advising her of the facility's decision to discharge the petitioner on June 30, 2007. The basis of that discharge was that there had been lack of payment of her bill for services and after reasonable and appropriate notice the financial situation had not been resolved.

CONCLUSIONS OF LAW

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

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

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

The facility has given the petitioner reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial 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 19th day of July 2007,

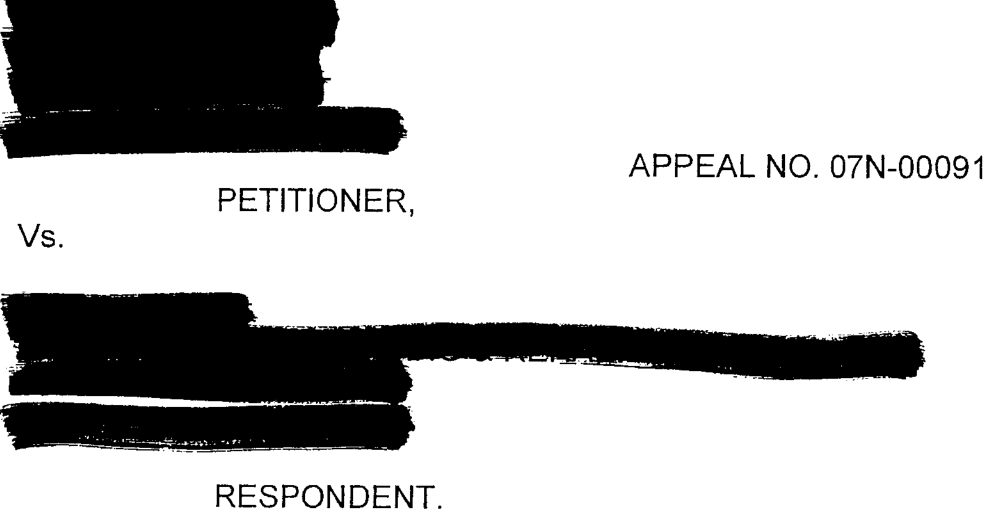
in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
[redacted] Respondent
[redacted] counsel for the respondent
[redacted] Agency for Health Care Admin

FILED
JUL 18 2007
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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



APPEAL NO. 07N-00091

PETITIONER,

Vs.

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 25, 2007, at 9:30 a.m., at [redacted] in North Miami, Florida. The petitioner was not present, but was represented at the hearing by her daughter, [redacted] and her son, [redacted] The respondent was represented at the hearing by [redacted] administrator, [redacted] A continuance was granted on behalf of the petitioner for a hearing previously scheduled on June 19, 2007. The hearing was left open for one additional day in order for the respondent to submit additional information. No additional information was submitted within the time limit allotted.

ISSUE

The respondent provided notice the petitioner was to be discharged for the following reason: "Your bill for services at the facility has not been paid after reasonable

and appropriate notice to pay..." The respondent will have the burden of proof to establish by clear and convincing evidence that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and Fla. Stat. § 400.0255.

FINDINGS OF FACT

The facility provided on April 12, 2007, a notice to the petitioner that she was to be discharged by May 13, 2007. The discharge location that was given was: "[redacted] [redacted]" This address was the last known address where the petitioner previously lived. The petitioner currently resides at the [redacted] [redacted]

Sometime within the last few months, the Department of Children and Families denied/terminated the petitioner's ICP Medicaid benefits. Based on this, the petitioner became private pay at the facility. The DCF decision is under appeal by the petitioner's representative at this time.

The petitioner currently has an outstanding unpaid nursing home bill of about $15,000, Respondent Exhibit 1. The hearing was left open (for one day) for the respondent to submit a copy of the "alleged" bill that was purportedly provided to the petitioner. None was provided while the hearing was left open.

CONCLUSIONS OF LAW

The Code of Federal Regulations at 42 C.F.R. § 483.12(a)(2) sets forth reasons for which a resident may be discharged, and states in part:

> (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;...

This regulation continues and states in part:

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

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

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

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

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

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

As shown in the Findings of Fact, the facility notified the petitioner on or about April 13, 2007 that she was to be discharged by May 13, 2007 to the petitioner's home. Currently the petitioner resides at [redacted] The discharge reason is: "Your bill for services at the facility has not been paid after reasonable and appropriate notice to pay..."

The petitioner's representatives argued that the discharge location address noted in the Findings of Fact, is no longer owned (or rented) by the petitioner. They also argued

that based on the petitioner's medical situation, she needs skilled care. They argued that the petitioner could not be taken care of at either of the petitioner's representative's homes. The petitioner's representatives also argued that they did not receive a bill from the nursing facility. The respondent argued that the nursing home bill was provided to the petitioner herself.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the facility's action to discharge the petitioner is not appropriate as the respondent did not allow the petitioner; reasonable and appropriate notice to pay the bill at the facility. The facility has not met its burden of proof and is not in compliance with the appropriate federal regulation noted above for the discharge of May 13, 2007. This decision does not act to alter or change any outstanding facility bill for the petitioner.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18th day of July, 2007,

in Tallahassee, Florida.

Robert Akel

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

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

FILED
JUL 16 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07N-00070

PETITIONER,

Vs.

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 27, 2007, at 2:45 p.m., in Miami, Florida. The petitioner, was present but was represented at the hearing by her son Also, present on behalf of the petitioner was from the Long-Term Care Ombudsman Program. The nursing home was represented by administrator. Present as witnesses for the facility were director of nursing services; social service director; and assistant director of nursing. The record was held open for eight days to allow the opportunity to submit a more legible copy of a Cares Unit assessment report.

ISSUE

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

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

FINDINGS OF FACT

1. The petitioner was admitted to the [redacted] on August 1, 2005, for rehabilitation purpose. She is 81 years old and was diagnosed with osteoarthritis, total knee arthroplasty, hypertension and depression.

2. On April 11, 2007, the facility issued a notice of discharge to be effective on May 11, 2007. (Respondent Exhibit 1) The reason for the discharge was given as, "Due to Medicaid Assessment you no longer meet the level of care to be at this facility." The notice was not signed by a physician. The discharge location was listed as [redacted]

3. The respondent explained that, "Your health has improved sufficiently so that you no longer need the services provided by this facility" is the reason listed on the discharge notice that closer resembles the explanation provided by the facility to support its action.

4. The respondent further explained that the reason for the discharge was based on the Cares Unit determination that [redacted] no longer meets the level of care and therefore the criteria to be in a nursing home. The respondent noted that Cares informed the facility that funding is going to stop unless she is transferred to an assisted living facility (ALF).

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 § 483.12 states as follows:

Admission, transfer and discharge rights.

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

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

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

As shown in the Findings of Fact, the facility notified the petitioner on or about April 11, 2007 that she was to be discharged from the facility effective May 11, 2007. The facility has indicated that the reason for the discharge was based on a medical assessment completed by the Cares Unit which shows that the petitioner no longer meets the level of care. The Findings of Fact further shows that the discharge notice was not signed by a physician.

[redacted] argues that the discharge notice is illegal because the reason cited is not in accordance with federal regulations and because the notice was not signed by a physician. [redacted] argues that the facility's action to discharge the petitioner was not appropriate. The hearing officer agrees.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the nursing home's action to discharge the petitioner is not a justifiable action due to a deficient discharge notice.

DECISION

This appeal is granted.

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 July, 2007,

in Tallahassee, Florida.

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

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

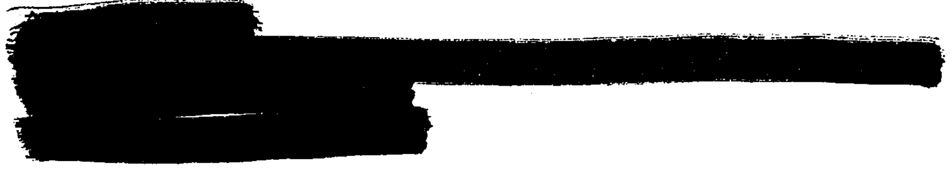
FILED
JUL 0 2 2007
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 07N-00080
07N-00098

PETITIONER,

Vs.



RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 19, 2007, at 9:29 a.m., at in North Miami, Florida. The petitioner was not present, but was represented at the hearing by his wife, Also present on behalf of the petitioner was ombudsman. The respondent was represented at the hearing by administrator, A continuance was granted on behalf of the petitioner for a hearing previously scheduled on May 29, 2007.

ISSUE

The respondent provided notice(s) the petitioner was to be discharged for the following reason: "Your bill for services at the facility has not been paid after reasonable

and appropriate notice to pay..." The respondent will have the burden of proof to establish by clear and convincing evidence that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and Fla. Stat. § 400.0255.

FINDINGS OF FACT

The facility notified the petitioner on or about April 10, 2007 that he was to be discharged by May 10, 2007. The discharge location that was given was: "[redacted]." This is the petitioner's wife's home. Currently the petitioner resides at the [redacted] Under an agreement between the respondent and the ombudsman office, another notice with a later discharge date was issued by the respondent. This "new" discharge notice indicated that the discharge location to be "[redacted].

The petitioner received an outstanding bill from the facility based on his failure to pay for his stay at the facility. As of March 31, 2007, the outstanding bill was about $31,531. As of April 30, 2007, the petitioner's outstanding nursing home bill was $34,882.10, Respondent Exhibit 1.

CONCLUSIONS OF LAW

The Code of Federal Regulations at 42 C.F.R. § 483.12(a)(2) sets forth reasons for which a resident may be discharged, and states in part:

> (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;...

This regulation continues and states in part:

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

As shown in the Findings of Fact, the facility notified the petitioner on or about April 10, 2007 that he was to be discharged by May 10, 2007 to the petitioner's wife's home. Another later dated discharge notice was provided to the petitioner with the discharge location changed to a nursing home. Currently the petitioner resides at [redacted]r. The discharge reason is: "Your bill for services at the facility has not been paid after reasonable and appropriate notice to pay..."

The petitioner's representative argued that he had contacted the discharge location nursing home and was told that currently a "bed" is not available. The respondent argued that a "bed" was available at the discharge nursing home when the second discharge notice was prepared. The petitioner did not dispute the unpaid overdue nursing home bill.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the facility's action to discharge the petitioner is appropriate as the petitioner has failed to, after reasonable and appropriate notice, to pay the his bill at the facility. The facility has met its burden of proof and is in compliance with the appropriate federal regulation noted above for the discharge of March 10, 2007; for April 10, 2007 to be appropriate.

DECISION

This appeal is denied and the facility's action upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the

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

DONE and ORDERED this 2nd day of July, 2007,

in Tallahassee, Florida.

Robert Akel

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

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