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

APPEAL NO. 08F-2625

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 May 20, 2008, at 8:05 a.m., in Miami, Florida. The petitioner, , represented herself at the hearing. Representing the agency was Hector Gutierrez, program administrator with the Agency for Health Care Administration (AHCA). Appearing as witnesses telephonically was Dr. Marcelino Oliva, medical director and Gary Garickson, fair hearing specialist, both with KēPRO (Keystone Peer Review Organization) South. Also appearing telephonically was Diane Weller, RN, nurse consultant. Guillermo Carton served as translator.

## ISSUE

At issue is the agency's February 2, 2008, February 11, 2008 and February 23, 2008 denial of authorization for inpatient hospital services for February 1, 2008 through February 3, 2008, due to "your medical care as described to us does not appear to require

inpatient services, and the authorization request is denied pursuant to rule 59G-4.150."

The petitioner has the burden of proof.

## FINDINGS OF FACT

1. The petitioner (age twenty-nine years old) is a beneficiary of the Florida Medicaid Program. The petitioner was hospitalized from January 31, 2008 through February 3, 2008.
2. On February 1, 2008, the provider (Tenet Hialeah Health Systems) submitted to AHCA an authorization request for admission on February 1, 2008 and subsequent 2-day patient stay through February 3, 2008.
3. The provider submitted the following information for consideration: "ED [emergency department] with vaginal bleeding ... admitted to OB [obstetrics] with missed abortion. ... Consent for D&C [Dilation and Curettage]... Gestational [sic] age 12 weeks 5 days..."
4. This request was reviewed by KēPRO, an organization under contract with AHCA that conducts medical reviews for Medicaid prior authorizations, for inpatient hospital medical services for Medicaid recipients in the state of Florida. This review is for determining medical necessity under the terms of the Florida Medicaid Program. KēPRO considered all clinical information made available to them by the provider on the petitioner's condition.
5. Upon review by registered nurse reviewer, the clinical information submitted by the petitioner's physician did not meet the InterQual® criteria (procedures criteria used by first level reviewer) under "Adult Admission subset:

Obstetrics/antepartum criteria." The request was referred to a physician consultant, board-certified in obstetrics.

6. The physician consultant denied the request documenting, "... Denied based on the information provided for this patient where the diagnosis does not seem to be fully established and usually this is an outpatient procedure."
7. The petitioner and provider were notified of the denial.
8. On February 23, 2008, a request for reconsideration was received with additional information submitted by the provider. A second physician consultant denied the request documenting, "... A missed AB [abortion] at 12 weeks can be managed with a D&C as an outpatient or an observation status. It is unclear why multiple inpatient days requested. There is no documentation of infection, heavy bleeding with need for transfusion etc. This appears to be a straightforward case of a pt who needs a D&C only, which can be accomplished in 23 hours or less."
9. The petitioner and provider were notified of the denial.

## CONCLUSIONS OF LAW

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

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

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

(a) Meet the following conditions:

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

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

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

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

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

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

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

(1) This rule applies to all hospital providers enrolled in the Medicaid program.

(2) All hospital providers enrolled in the Medicaid program must comply with the Florida Medicaid Hospital Coverage and Limitations Handbook and the Florida Medicaid Provider Reimbursement Handbook, UB-92, both incorporated by reference in Rule 59G-4.160, F.A.C. Both handbooks are available from the fiscal agent contractor.

The Florida Medicaid Coverage and Limitations Handbook, Hospital Services page 2-28 (June 2005) states as follows:

> Authorization for Inpatient Admissions Effective March 1, 2002, Medicaid recipient admissions in Florida for medical, surgical, and rehabilitative services *must* be authorized by a peer review organization (PRO). The purpose of authorizing inpatient admissions is to ensure that inpatient services are medically necessary. Certain types of admission, e.g., emergencies, are exempt from prior authorization by the PRO; other types do not require authorization to be admitted to the hospital, but the PRO *must* authorize the concurrent and *continued* inpatient stays. ...

The respondent explained that the petitioner's procedure does not require an inpatient hospital stay. They stated that the hospital will be denied payment, but she should not be billed for services by the provider, unless she agreed with the hospital during the stay, to assume financial responsibility.

After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer finds that the medical consultant's decision to deny coverage for an inpatient hospital stay for February 1, 2008 through February 3, 2008 was correct.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of July, 2008,

in Tallahassee, Florida.

A. G. Littman

A. G. Littman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To:

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

APPEAL NO. 08F-03181

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 01 Escambia
UNIT: AHCA

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 4, 2008, at 1:30 p.m., in Pensacola, Florida. The petitioner was present. He was represented by his mother, . Observing the proceedings was friend. The Agency/respondent was represented by Cynthia Henline, medical health care program analyst, Agency for Health Care Administration (AHCA).

## ISSUE

At issue is whether or not it was correct to deny Prescribed Pediatric Extended Care (PPEC) services due to "this service is not considered medically necessary." The respondent has the burden of proof.

## FINDINGS OF FACT

1. The petitioner was born on August 2, 1997. Because of serious health problems since birth, he began receiving PPEC services from at least October 19, 2006 under state-plan Medicaid. His mother is his primary caregiver. He lives with his mother, step-father and two siblings, ages 10 and 13. Another child, age 6, visits his mother every other weekend. The mother and stepfather work outside the home.

2. The petitioner's representative requested PPEC services for the certification period of March 10, 2008 through September 10, 2008. The request for service authorization was reviewed and returned to the provider, , on March 12, 2008 pending information regarding the date of his last seizure and the frequency and duration that Diastat was administered. The petitioner was also pended for information regarding the skilled nursing services provided and if the petitioner was on supplemental oxygen. The information was due to the respondent by March 26, 2008.

3. The service authorization request was re-pended on March 20, 2008 for information regarding skilled nursing services provided for the petitioner. The provider was requested to be specific regarding the skilled nursing services provided. This information was due to the respondent by March 26, 2008. Following AHCA review during March 2008, the agency approved half-time PPEC services for the period of March 10, 2008 through April 30, 2008 when the mother works, and full time on school holidays March 21, March 31 to April 4, and April 17, 2008. The date of service

authorized was to end April 30, 2008. The agency requested clinical or physician notes on current seizure activity and skilled care. The mother was encouraged to research other day care possibilities. The mother believes that no other day care facilities will accept her son due to his complex medical conditions.

4. On or about April 16, 2008 the petitioner requested authorization for PPEC services for May 1, 2008 through September 10, 2008. The request was placed in pending status so that a pediatric physician consultant at AHCA's headquarters could review for medical necessity. The respondent's pediatric physician recommended the termination of PPEC effective May 1, 2008 due to not being medically necessary. Notice was issued on April 30, 2008 (Respondent's Exhibit 1) and was appealed.

5. was the PPEC service provider. Request to continue PPEC was submitted by registered nurse case manager on April 16, 2008. Administrative guidelines and documentation from the AHCA review are in Respondent's Exhibit 2.

6. Information submitted by the provider during the review showed the petitioner had no seizure activity requiring administration of Diastat for over a year, per his mother. The petitioner was having break through seizures during March and April 2008. His medication dosage was increased and he was to have follow-up consultations. The petitioner's diagnosis is cerebral palsy, epilepsy with seizure activity, static encephalopathy, and cortical blindness. He attended school five times a week and went to PPEC after school. There were no services provided that required skilled

intervention. The petitioner is able to take feedings by mouth with supervision to prevent choking. The petitioner's Plan of Care indicated no feeding tubes or oxygen and no surgeries requiring skilled care.

7. The Plan of Care indicated the petitioner eats by spoon and drinks from a sippy cup but has difficulty swallowing. "His blood pressure med. Has been d/c'd but he is still being followed by Cardiology. He is also followed by neurology and orthopedics. There have not been any seizure activity requiring administration of Diastat for long while, according to his Mom..." As per his doctor's order, the petitioner's representative is requesting five half days after school and full days on school breaks, holidays and NCID's of PPEC service to cover the Mom's work schedule.

8. There was no indication that the petitioner has been hospitalized during the previous six month certification period.

9. The petitioner's mother indicated at the hearing that the petitioner was going to require surgery shortly. The May 8, 2008 clinical notes from his physician recommended feeding-tube placement due to his poor nutritional state and to improve the petitioner's nutrition so that he could better tolerate orthopedic surgical procedures and to help with wound healing. She was advised to reapply for after school care through PPEC should the petitioner require skilled care as a result of the surgery.

## CONCLUSIONS OF LAW

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

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) describing "medical necessity or medically necessary" standards and saying in relevant part that: "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity..." Consistent with statute, Fla. Admin. Code 59G-1.010 (166) defines "medically necessary," informing that such services must:

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

Additionally relevant is Fla. Admin. Code 59G-4.260, addressing **Prescribed Pediatric Extended Care Services**. Subsection (2) informs as follows:

> All Medicaid enrolled prescribed pediatric extended care service providers must be in compliance with the Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, February 2007, incorporated by reference, and the Florida Medicaid Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent's website....

The Florida Medicaid **Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook** informs in Chapters 1 and 2 as follows:

> **Purpose**
> The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Program is to enable children with medically-complex conditions to receive medical care at a non-residential pediatric center. PPECs provide a cost effective and less restrictive alternative to institutionalization, and reduce the isolation that homebound children may experience.
> ...
> **Description**
> A PPEC is a non-residential facility that serves three or more children under the age of 21 who require short, long-term, or intermittent medical care due to medically-complex conditions. A PPEC offers services that meet the child's physiological, developmental, physical, nutritional, and social needs.
> ...
> **Who Can Receive Services**
> To receive PPEC services, a recipient must meet the following criteria:
> • Be Medicaid eligible;
> • Be medically complex or medically fragile...
> • Be age 20 or under;
> • Be medically stable; **and**
> • Require short, long-term or intermittent continuous therapeutic interventions or skilled nursing supervision due to a medically-complex condition.

**Definition of Medically Necessary or Medical Necessity**
Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service...

**Recommendation for PPEC Services**

An attending physician must order PPEC services before the services begin. The order must be written on letterhead or printed prescription, and must :

- Indicate that PPEC is an appropriate place for care; and
- Specify the duration of PPEC service not to exceed six months. (PPEC services must be reordered every six months.)

An order that includes the above constitutes an attending physician's recommendation for PPEC services and medical necessity. ... Medicaid reimbursement for PPEC services is based on the definition for medical necessity on page 2-2 of this chapter....

**Approval of Services**
PPEC services must be:

- Ordered by an attending physician or the Medicaid physician consultant;
- Outlined in the plan of care that is written by the PPEC center...
- Authorized by Medicaid or an approved designee.

Under appropriate statute and administrative guidelines, AHCA is charged with determining whether medical necessity has been adequately established and AHCA must assess whether the Medicaid reimbursement criteria have been met. AHCA's procedure to review the continuation of PPEC for the petitioner involved a registered nurse collecting and reviewing the documentation compared with the Medicaid handbook and forwarding the documentation and request to its reviewing pediatric physician, Dr. Deeb, for his expert opinion of medical necessity of the service. Dr. Deeb determined that the medical necessity criteria were no longer met.

While the mother argued that medical necessity standards would best be met in PPEC and that no other day care providers would take care of the petitioner during her work hours due to his medical condition, evidence did not support such during the review process or before date of hearing. Moreover nutrition at PPEC was not achieved via GTube and there has been no seizure activity requiring the administration of Diastat during the previous 12 months per the mother's testimony. The above Medicaid authorities require that a recipient of PPEC must require short, long-term or intermittent continuous therapeutic interventions or skilled nursing supervision due to a medically-complex condition.

As of the April 2008 review period and cancellation on May 1, 2008, the information available from the appropriate source did not support the need for skilled intervention or supervision of a medically complex situation as set forth in the above authorities. Available information supported the AHCA plan to discontinue PPEC services as set forth on notice of May 1, 2008. Thus, it is concluded that cancellation notice was justified as issued. The petitioner's representative indicated he may have surgery in the near future which could change the medical necessity for PPEC services.

## DECISION

The appeal is denied.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9 day of July, 2008,

in Tallahassee, Florida.

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

Copies Furnished

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

APPEAL NO. 08F-02797

PETITIONER,

Vs.

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

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 9, 2008, at 9:15 a.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by his mother and his father The respondent was represented by Lorraine Wasserman, registered nurse specialist. Present on the telephone from Kepro was Dr. Ratish Mittel, and Gary Erickson, registered nurse reviewer.

## ISSUE

At issue is the Agency's April 10, 2008 action of approving the petitioner's skilled home nursing services for 3,750 hours, and denying 518 hours for April 16, 2008 to October 12, 2008. The petitioner has the burden of proof.

## FINDINGS OF FACT

1. The petitioner, date of birth December 11, 1993, is 14 year old, and he is a Medicaid benefits recipient in Broward County, Florida.

2. Included in the evidence is a copy of a Recipient Denial Letter dated April 10, 2008, stating that 3,750 hours of skilled home nursing services were approved, and 518 hours were denied for the petitioner for April 16, 2008 to October 12, 2008.

3. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld notice dated April 16, 2008. This notice informs the petitioner that upon reconsideration, the approval of 3,750 hours of skilled home nursing services, and the denial of 518 hours from April 16, 2008 to October 12, 2008, was upheld.

4. Included in the evidence is a copy of a Kepro Case Synopsis dated April 9, 2008, stating that the petitioner was receiving 166 hours of weekly skilled home nursing services. There are 168 hours in a 7 day week, and the petitioner was receiving the services 24 hours daily except for the hours of 7:00 p.m. to 9:00 p.m. on Sundays. The petitioner requested to continue to have these skilled home nursing care hours.

5. According to the Case Synopsis, the petitioner's parent's work hours were considered in determining the denial of requested nursing hours. It was determined that the petitioner's parents can take care of him on Tuesdays to Fridays from 8:00 p.m. to 10:00 p.m., on Saturdays from 5:00 p.m. to 11:00 p.m., and on Sundays from 2:00 p.m. to 10:00 p.m. Skilled home nursing care was denied for the petitioner for these times.

6. According to a Kepro Internal Focus Review Findings report dated April 30, 2008, the petitioner was diagnosed with Dyspnea, respiratory abnormality, convulsions, anoxic brain damage, chronic bronchitis, and he has symptoms involving the nervous system.

7. The petitioner submitted into evidence copies of statements from four different physicians concerning the petitioner. According to a statement from Dr. dated February 13, 2008, he recommends 24 hours nursing care for the petitioner. According to a statement from this physician dated April 10, 2008, his recommendation of nursing care is not expected to change for the future.

8. Included in the evidence is a copy of a statement dated April 28, 2008, from Dr. . He urges to continue full time nursing care for the petitioner.

9. Included in the evidence is a copy of a statement dated May 1, 2008, from Dr. . According her, the petitioner requires high daily maintenance and needs 24 daily hours of nursing care. He has cerebral palsy, a spastic quadriparesis seizure disorder, chronic respiratory failure, he is ventilator dependant, he has a tracheostomy to maintain his airway, and he has a gastrostomy tube to receive feedings.

10. Included in the evidence is a statement from Dr. dated May 7, 2008, stating that the petitioner has cerebral palsy of a quadriplegic type, a seizure disorder, he is totally wheelchair dependent, he is fed by a G-tube, and he has a tracheostomy.

## CONCLUSIONS OF LAW

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

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

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

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. Physicians at Kepro for the Agency, approved the petitioner for skilled home nursing services of 3,750 hours, and denied 518 hours for the time period of April 16, 2008 to October 12, 2008.

The petitioner was previously approved for 24 hours daily nursing services except for 2 hours on Sundays. There are two physicians that assert that the petitioner should receive 24 daily hours of skilled home nursing care, and one physician that asserts that he should continue full time nursing care. After careful consideration of the proper authorities and evidence, including the petitioner's diagnosis and condition, it is determined that the Agency's action of denying 518 hours of skilled home nursing care is not upheld, and the petitioner's request for 24 hours of daily skilled home nursing care, except for 2 hours on Sundays, is granted.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 3rd day of July, 2008,

in Tallahassee, Florida.

Stuart Imberman

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

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

PETITIONER,

Vs. APPEAL NO. 08F-01475

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 13 Hernando
UNIT: AHCA

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 2, 2008, at 1:05 p.m., in Brooksville, Florida. The petitioner was not present. Present representing the petitioner was her mother,

The respondent was represented by Joann Dohn, RN. Testifying by telephone on behalf of the respondent were Dr. Robert Buzzeo, associate medical director, Keystone Peer Review Organization (KePRO); Gary Erickson, fair hearing specialist, KePRO and Mary Wheeler, RN, review operations manager, KePRO.

The hearing was scheduled on March 21, 2008 and April 4, 2008. However, continuances were granted at the request of the petitioner.

## ISSUE

The petitioner is appealing the respondent's action of February 12, 2008, to decrease her private duty nursing services that she was receiving on Sundays by four hours.

The respondent had the burden of proof.

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving private duty nursing services through Medicaid of 20 hours per day from 11:00 p.m. to 7:00 p.m. seven days per week. The petitioner requested the continuation of private duty nursing services at the same level for the period of January 8, 2008 through March 7, 2008. Additionally, the petitioner requested 24 hours per day nursing services from January 31, 2008 through February 4, 2008 as her mother would be out of town on a business conference/seminar with her employer and peers from work.

2. Keystone Peer Review Organization (KePRO) is the Peer Review Organization (PRO) contracted by the Agency for Health Care Administration to perform medical review for the private duty nursing and personal care Prior Authorization Program for Medicaid recipients in the State of Florida.

3. A prior authorization review was completed by KePRO. On February 1, 2008, KePRO approved 20 hours per day Monday through Friday and denied four hours of nursing services on every other Saturday and on Sundays. The petitioner's request for 24 hour nursing services from January 31, 2008 through February 4, 2008 was approved.

4. On February 9, 2008, a reconsideration review was completed by KePRO. On reconsideration KePRO approved 20 hours per day of nursing services Monday through Saturday. KePRO also approved 16 hours of nursing services on Sundays as the petitioner's mother did not work on Sundays and could take care of her when the nursing services were not being provided which was from 3:00 p.m. to 11:00 p.m. The

number of hours approved for Sundays was four hours less than number of hours she was previously receiving.

5. The petitioner is 13 years old. She has been diagnosed with microcephalus, cerebral palsy with spasticity, seizure disorder, severe global delays, has a G-tube, gastroesophageal reflux disease and chronic constipation. The petitioner has seizure precautions for her active seizure disorder requiring interventions including vagal nerve stimulation which must be accessed by the nurse. The petitioner is nonverbal, nonambulatory and incontinent of bowel and bladder. She requires G-tube care and feeds, three boluses via pump during the day and continuance feeds that are given throughout the night. The petitioner requires constant supervision and cannot be left alone.

6. The petitioner lives with her single mother. Her father does not live in the home. The mother works six days per week from 7:15 a.m. or 8:30 a.m. to 6:15 p.m. as a dental hygienist. After work the mother has to pick up her other daughter from the babysitter. She does not get home until 8:00 p.m. The 20 hours of nursing services from 11:00 p.m. to 7:00 p.m., six days per week, allows the mother to sleep eight hours per night, work eight hours per day and allows her to do her household chores, grocery shopping, errands, cook dinners and meet the needs of her other daughter. As the petitioner does not work on Sundays she can spend more time with the petitioner and can provide for her care when the nursing services are not being provided. Additionally, she would be able to attend to any errands and chores on Sundays as 16 hours of private duty nursing services had been approved.

## CONCLUSIONS OF LAW

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

Medical necessity or 'medically necessary means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided."

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

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

(a) Meet the following conditions:

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

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

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

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

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

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

The Home Health Services Coverage and Limitations Handbook defines the guidelines for private duty nursing services as follows at page 2-17:

> Private Duty Nursing Definition. Private duty nursing services are medically necessary skilled nursing services that may be provided in a child's home or other authorized settings to support the care required by the child's complex medical condition...
>
> Private Duty Nursing Requirements. Private duty nursing services must be: ordered by the attending physician; documented as medically necessary; provided by a registered nurse or a licensed practical nurse; consistent with the physician approved plan of care; and authorized by the Medicaid service authorization nurse...
>
> Parental Responsibility. Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render.
> Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver...

The petitioner lives with her mother who works six days per week. Her mother does not work on Sundays and can care for the petitioner on Sundays when the petitioner is not receiving private duty nursing services. The evidence presented did not establish that it was medically necessary for the petitioner to have 20 hours of private duty nursing services on Sundays because the mother was able to care for her as she is not working. Therefore, it is determined that the respondent correctly decreased the petitioner's request for private duty nursing services by four hours on Sundays.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 3rd day of July, 2008,

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: Petitioner
Marilyn Schlott, Area 3 Medicaid Adm.

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

APPEAL NO. 08N-00082

PETITIONER,

Vs.

RESPONDENT.
_____/

**FINAL ORDER**

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 29, 2008, at 1:30 p.m., in Tallahassee, Florida. The petitioner was present and represented himself. Testifying on behalf of the petitioner was his friend and life partner, The respondent was represented by executive director, Testifying on behalf of the respondent was , assistant to the director of social services, , direct of social workers, , acting direct of social workers, LPN, Unit manager and , RN, director of nurses.

**ISSUE**

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

## FINDINGS OF FACT

1. The petitioner (DOB / 1) has been a resident of the facility since October 17, 2007. The respondent entered into evidence records of incidents of non-compliant behavior potentially dangerous to the safety and well being of the petitioner and the facility, specifically violations of the established facility smoking policy (Respondent's Exhibits 2). In addition, the respondent entered into evidence incidents of verbally abusive behavior such as calling the staff "monkeys". The record indicates the petitioner is able to assist with simple self care tasks but often refuses to participate and becomes "nasty during care, calling staff names." Other incidents indicate he exhibits other inappropriate behavior, i.e. pouring urine in bed and bowel movements on the floor and smoking in unauthorized places such as the patients' room and bathroom. Some of the incidents occurred on the following dates: January 14, 2008, January 28, 2008, April 20, 2008, and April 21, 2008 (Respondent's Composite Exhibit 3).

2. The petitioner requested cigarettes according to the clinical progress notes, kept as a part of the facility's business record, dated February 21, 2008 (Respondent's Exhibit 3). The petitioner's partner and friend indicated he did not want cigarettes given to the resident. The resident wanted to smoke and has the right to do so. The petitioner was screened to assess his safety with regard to smoking on at least February 26, 2008. The facility designated him as an unsafe smoker requiring him to be supervised with smoking and to use a smoking blanket/apron. In addition, the petitioner

was given a copy of the smoke break designated times and designated smoke areas dated February 22, 2008 (Respondent's Exhibit 2). The petitioner does not recall receiving the smoking policy.

3. Clinical Progress Notes dated April 16, 2008 indicate that tobacco stains and tobacco were smeared in the floor. On April 19, 2008 the resident was found smoking in the bathroom. He tossed the cigarette butt on the bathroom floor. He was reminded that he is not allowed to smoke in the building and that he "has been informed of that several times by staff members". He was informed that if he would not comply with facility policy a 30 day Notice of Transfer and Discharge would be issued. In addition, the petitioner's friend and partner was contacted and informed of the resident's inappropriate behavior and violation of the smoking policy. The petitioner's partner stated the staff should not give him packs of cigarettes. The respondent explained that cigarettes are issued to residents during designated smoke breaks. The resident was found with a pack of cigarettes later in the day. He turned them over to the staff but refused to surrender the matches. Later on April 20, 2008, the petitioner was witnessed smoking in the facility.

4. The facility's written smoking policy established at least by February 22, 2008, indicates that the nursing home staff determines if a resident is a smoker and implements a smoking care plan before the resident exercises the privilege to smoke. A determination is performed for all residents/participants upon admission, when there is a significant change of status, quarterly, and annually thereafter to determine if a resident

is a smoker. Smokers will have a smoking care plan implemented. The procedure is established in the facility's smoking policy. Residents who smoke and do not demonstrate safe-smoking abilities will be required to wear a protective smoking vest/apron and be supervised while smoking. Staff members maintain all smoking materials for residents who smoke cigarettes, pipes, lighters, matches, etc. In addition, residents are instructed not to share lighted cigarettes with other residents (Respondent's Exhibit 2). To accommodate the residents who smoke, the facility has established a smoking schedule that allows its residents to smoke at least five times a day for periods of at least 30 minutes in duration. The frequency of the smoking period is from at least two hours apart.

5. The respondent indicates the penalties for infractions of the smoking policy. The first infraction of the smoking policy results in a warning indicating the risks on non-adherence to the policy. This warning may be verbal and is to be documented in the medical record. The second infraction of the smoking policy results in notice of discharge. The reason for discharge is endangerment to the health and safety of individuals within the facility. Because there were multiple incidents of violations of the facility's smoking policy, the petitioner was given a verbal warning as documented in medical record (progress notes) on April 19, 2008. A second counseling with the petitioner regarding non-compliance with smoking policy and displays of inappropriate behaviors was scheduled on April 19, 2008.

6. On April 20, 2008, the respondent met with the petitioner to discuss continued violation of the facility's smoking policy and concerns that he was placing himself and other residents at risk for injuries. The option for alternate placement was discussed with the petitioner. The petitioner understood that due to his continued violation with counseling, a 30 day discharge notice would be issued per the facility's policy.

7. Because the petitioner had been instructed on the smoking policy on several occasions and continued his non-compliant behavior, he was advised that alternate placement would be recommended. The Notice of Discharge and Transfer was reviewed and signed by the facility physician on April 23, 2008.

8. On April 23, 2008, the respondent notified the petitioner of its intent to discharge him, effective April 23, 2008, because the health and safety of other individuals in the facility was endangered. On April 23, 2008, the Nursing Home Transfer and Discharge Notice was presented to the petitioner and filed in his clinical record. The petitioner refused to sign for the notice. The nursing facility mailed the notice to the petitioner's friend and partner but he did not sign for the document.

9. The Nursing Home Transfer and Discharge Notice indicated the resident was to be discharged to his friend Previously, the petitioner was considered for placement at the St. Petersburg, Florida. The petitioner was sent a copy of the smoking policy but at the advise of his partner, he refused to sign the document. The petitioner's partner has submitted the names of

several facilities to which the petitioner would be willing to relocate. The facility is attempting to find appropriate placement for the petitioner.

10. The petitioner's objection to the transfer is that it will limit his family and partner's ability to visit. Further, the petitioner's partner believes that the smoking policy is not consistently followed by the staff at the facility. He has personally observed residents and staff smoking in areas around the facility that are not designated as smoking areas. Also, he believes the staff and residents provide the cigarettes and smoking paraphernalia to the resident. The respondent indicated that smoking materials are kept in a lock box and issued to "unsafe" smokers during designated smoking periods. All residents, family and visitors are asked to adhere to the smoking policy. Individuals smoking outside of the designated smoking area are deemed "safe" smokers" and thus are not limited to the times and places where they may smoke. The petitioner has been advised of his responsibility to adhere to the smoking policy and he acknowledged that he was aware of the dangers of smoking in the facility.

## CONCLUSIONS OF LAW

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

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

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-

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

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

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

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

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

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

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

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

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

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

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

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

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

> days before the resident is transferred or discharged. (ii) Notice may be made as soon as practicable before transfer or discharge when--
>
> (A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;...
>
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
> (i) The reason for transfer or discharge;
> (ii) The effective date of transfer or discharge;
> (iii) The location to which the resident is transferred or discharged...

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

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

The Findings of Fact show that the petitioner's behavior includes verbal abuse against the staff and failure to follow established smoking policy protocol. The facility has counseled with the family and the petitioner regarding the issue of smoking in the facility. In spite of the facility's efforts, the petitioner continued to be verbally abusive and smoked in unapproved areas such as the bathroom inside the facility.

The petitioner argued that the notice of discharge was invalid as the dates on the notice did not provide for 30 days to discharge the petitioner. The petitioner's argument is not persuasive as the above regulations state that Notice may be made as soon as

practicable before transfer or discharge when the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii). The petitioner acknowledged his understanding that smoking inside the facility could pose a hazard to him and the other residents and staff as there is oxygen in use and that he could have "blown up" the building.

The petitioner's representative argues that he advised the facility not to allow the petitioner to smoke, implying that the facility was at fault when the petitioner failed to abide by rules regarding smoking for "unsafe" residents. The above argument is not persuasive as the petitioner has a right to possess tobacco products, and has a right to have the facility assist and/or supervise him with his smoking to ensure that it is done without accident. The facility provides the resident a smoking apron as a preventive measure from potential accidental injuries due to his smoking. In addition, the facility has in place a written smoking policy and has, on numerous occasions, counseled with the petitioner regarding adherence with that policy. The respondent has provided a smoking schedule, which allows the petitioner approximately five times a day for 30 minutes at a time in a 24 hour period to pursue that activity. No resident or staff member is permitted to smoke inside the facility.

Based on the above findings, it is determined that the petitioner's behavior and continued violation of the smoking protocol have endangered the health and safety of other residents in the facility. Therefore, the respondent's proposed discharge of the

petitioner from the facility is in accordance with the reasons stated in the Federal Regulations.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of July, 2008, in Tallahassee, Florida.

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

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

APPEAL NO. 08N-00066

PETITIONER,

Vs.

RESPONDENT.
_____/

**FINAL ORDER**

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 11, 2008, at 9:30 a.m., in Pensacola, Florida. The petitioner was present. She was represented by District Ombudsman Manager, Florida Long Term Care Ombudsman Program (LTCOP) and certified LTCOP manager. Present as an observer was , chairperson for . Testifying on behalf of the petitioner were her friends, , and . The nursing home/respondent was represented by , nursing home administrator. Testifying on behalf of the respondent was , assistant direct of clinical services and staff development coordinator and , MDS coordinator. Also testifying on behalf of the respondent was , LPN, unit manager and , registered nurse practitioner.

The hearing was originally scheduled to be held on June 4, 2008 but was continued at the request of the petitioner. The hearing record was held open for 10 days or until June 21, 2008 to allow both parties to submit proposed orders.

## ISSUE

At issue is the facility's action of April 9, 2008, intending to discharge the petitioner due to the facility not being able to meet the petitioner's needs. The respondent bears the burden of proof.

## FINDINGS OF FACT

1. The petitioner is a resident of a nursing facility. She is wheelchair bound. She has Type II Diabetes and has suffered a stroke. During the course of her stay, the petitioner has refused to follow treatment recommendations, refused medication and medical advice. In addition, testimony presented by the respondent indicated the petitioner made several demands of the nursing home staff and that her behavior interfered with care required by other residents. She will not follow through with recommended treatment, refuses medication and has refused restorative therapy following a course of physical therapy. The nursing facility expressed concern that her continued refusal to follow recommended medical therapies will lead to her deterioration or to a medical incident which could lead to her death. She has been encouraged to follow treatment recommendations but continues to follow a course of self-treatment that may put her at risk medically and psychologically. It is the respondent's belief that another facility may be more successful in terms of assisting the petitioner with medical

intervention primarily for her well-being and in hopes that someone else can counsel with her and start the medical treatment she needs. The respondent has not been successful in its attempts to provide medical intervention and essentially recommends transfer to another facility for her medical condition.

2. The petitioner has refused medical care several times. This care includes taking a regimen of sliding scale insulin to regulate the petitioner's blood sugar, lasix to reduce swelling and control blood pressure, antidepressants, pain medication and bathing. The facility's goal is to keep a resident at the highest level of functioning possible. The nursing facility believes the resident's resistance to the care offered to her is hindering this process. The respondent requested a psychiatric consultation for the petitioner. The psychiatrist determined the petitioner was depressed and recommended anti-depressants. In addition, the petitioner's psychologist believed the petitioner needed antidepressants. The petitioner refused to take the anti-depressants because she did not believe she was depressed. The petitioner indicated she was diagnosed with obsessive compulsive disorder (OCD) and that anti-depressants were recommended to help with depression. She is acknowledged as a talented artist and prefers the "highs and lows" due to her artistic temperament rather than to take anti-depressants which she believe dulls her senses.

3. The petitioner is considered competent. It is her belief that insulin exacerbates or causes some of the symptoms of diabetes. She has lost 20 pounds over the past few months and her blood sugar readings have varied between 106 and

158 with the use of an oral agent. The petitioner's diabetes has improved in the past six months and she has been eating better. The respondent indicated that the petitioner's loss of weight could be attributed to uncontrolled diabetes rather than her improved eating habits. There was no medical evidence to support this belief. She does not wish to take pain medication, other than naprosin, as she is afraid she may become dependent on them and because a side affect is constipation. She refused to take lasix because it caused frequent urination and to accommodate the Certified Nursing Assistants (CNA) who complain about her frequent need for a bed pan. The petitioner began taking lasix when she began experiencing breathing difficulties.

4. The petitioner has called several state agencies and 911 to lodge complaints against the facility. The petitioner's family also called the respondent accusing the facility of failing to do all they could to provide medical care for the petitioner. The family's request for treatment required the petitioner to go to the emergency room as the medical treatment could only be done in a clinical setting such as the emergency room. The facility believes it cannot meet the petitioner's needs as she frequently complains about the care she receives and how quickly the nursing facility staff responds to meet her needs. Her frequent complaints and dissatisfaction with the services provided lead the respondent to believe that it cannot meet her expectations and needs. The respondent did not provide copies of the resident's clinical record or documentation made by the resident's physician to support its testimony or its belief that a transfer or

discharge of the resident from the facility was necessary or that they were unable to meet her needs regarding her medical care.

5. As a result of these events, the facility felt it could no longer meet the petitioner's needs. A Nursing Home Transfer and Discharge Notice was issued to the petitioner on April 9, 2008. Its effective date was May 9, 2008. The facility cited "your needs cannot be met in this facility" as the reason for the discharge (Respondent's Exhibit 1). A location to Alabama was listed for discharge. The facility's physician designee, ARNP signed the Notice of Nursing Home Transfer and Discharge Notice approving the transfer and discharge.

6. The ombudsman and petitioner objected to the discharge. When asked how the petitioner's needs could be better met at the other facility and why it was felt the petitioner would respond differently in another nursing home, the respondent explained it was their hope that being located nearer to her family who reside in and a new environment would improve the petitioner's emotional state. It is the respondent's belief that the petitioner has been very unhappy and depressed at its facility. The petitioner has frequently expressed her feelings of dissatisfaction.

7. The petitioner's representative requested an opportunity to submit a proposed order. The hearing record was held open until June 21, 2008 to allow for the submission of the proposed orders from both parties. No proposed orders were received from either party.

## CONCLUSIONS OF LAW

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

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (iii) The safety of individuals in the facility is endangered;
>
> (iv) The health of individuals in the facility would otherwise be endangered;
>
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
>
> (vi) The facility ceases to operate.
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.
>
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-
>
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and
(iii) Include in the notice the items described in paragraph (a)(6) of this section.

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

(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged...

42 C.F.R.§483.10 Resident rights, states in part:

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:...
(b)(4) The resident has the right to refuse treatment, or refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section...

42 C.F.R.§483.15(b) states in relevant part:

(b) Self-determination and participation. The resident has the right to (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;...(3) Make choices about aspects of his or her life in the facility that are significant to the resident...

The petitioner argued that Federal Regulations as outlined in 42 C.F.R. provide that residents have the right to refuse treatment and to make decisions regarding their physical and mental course of treatment. The respondent is charged with the responsibility to assure its residents are given the appropriate treatment and services to

promote or enhance the resident's quality of life and to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. There is no authority under the above regulations to support a discharge because the resident exercises his or her right to refuse treatment.

The respondent argued that the petitioner's medical and psychological well being would deteriorate if the petitioner continued to refuse prescribed therapies and treatment. There was no evidence to show that the respondent could not meet the petitioner's needs because of her refusal to take medication or participate in restorative care. The physician recommended skilled nursing care as evidenced by her presence in a nursing facility. There was no evidence submitted to show that the facility cannot provide the level of skilled nursing care needed by the petitioner or that another facility would be better prepared to meet her needs.

According to the above authorities, when the transfer or discharge of a resident is deemed necessary for the resident's welfare and because his or her needs cannot be met in the facility, the resident's clinical record must be documented by the resident's physician. The respondent did not present evidence to show the required documentation of the resident's clinical record in support of its testimony. Based on all evidence and testimony presented, the hearing officer concludes that the facility's action to discharge the resident is not justified according to Federal Regulations. The petitioner is to be allowed to remain at the nursing facility.

## DECISION

The appeal is granted. The respondent did not meet the burden of proof to show that it cannot meet petitioner's needs. The facility may not proceed with the proposed discharge.

## 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, 2008, in Tallahassee, Florida.

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

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

APPEAL NO. 08F-02164

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES (DCF)
DISTRICT: 07 Osceola
UNIT: 66032

CASE NO. 1011448807

RESPONDENTS

_____/

**FINAL ORDER**

Pursuant to notice, an administrative hearing was convened before the undersigned on May 1, 2008 at 1:05 p.m. and on May 15, 2008 at 1:30 p.m. in Kissimmee, Florida. On both dates the petitioner represented herself. On the first date, the respondent was represented by Sandra Villega, ACCESS senior specialist, with testimony available from Mickee Bonilla, operation management consultant, both with the Department of Children and Families (DCF). On the second date, DCF was represented by Sonia Colon, ACCESS supervisor and the Agency for Health Care Administration (AHCA) was represented by Lisa Sanchez, senior human service program specialist.

There were two dates of hearing and there were two separate issues as well as two separate but related agencies. On each occasion both issues were addressed, but on the first date, AHCA was not a participant. This order will address the Department of Children and Families matter and Final Order 08F-03066 addresses the AHCA concern.

## ISSUES

At issue is whether or not eligibility for Special Low Income Medicare Beneficiary (SLMB) Medicare Part B premium buy-in coverage, and Medically Needy share of cost enrollment are the most favorable options available based on income.

## FINDINGS OF FACT

1. The petitioner was concerned about Medicaid coverage options and the Medicare part B premium SLMB buy-in situation. She requested a hearing.

2. Her concern increased when the Department issued a "Statement of Matters" during April 2008, as a response to the hearing request. That document, Respondent's Exhibit 1, showed the petitioner had applied for Medicaid in October 2007 and "that her QMB changed to SLMB." At the second hearing date, the respondent's representative, who wrote the Statement, apologized for any confusion. The respondent's representative explained she was mistaken in that Statement, and the petitioner had never been a QMB recipient.

3. QMB means Qualified Medicare Beneficiary buy-in. It is a Medicaid coverage option. It results in the state paying for an individual's Medicare cost sharing expenses and Medicare premiums. QMB is a needs-based program based upon financial eligibility and income within financial standards.

4. SLMB means Special Low-Income Medicare Beneficiary buy-in. It is a Medicaid coverage option for individuals with slightly higher income than QMB standards. SLMB eligibility results in the state paying an individual's Part B Medicare premiums.

5. The petitioner submitted exhibits as numbered 1-6. While many Notices of Case Action from the Department were included in these exhibits, none of the notices showed official notification of QMB for any time period. The respondent submitted exhibits numbered 1-6 and these also included Notices of Case Action. None was a notice of QMB eligibility. The only reference to QMB eligibility was in the April 2008 Statement of Matters.

6. The petitioner's income is approximately $1011 from SSA benefits. With that income, the respondent determined the only Medicaid options were SLMB and enrollment in the Medically Needy Program with estimated share of cost at $881. Notice of share of cost was Petitioner's Exhibit 2, and the petitioner noted in the upper right hand corner "appealed on 3/21/08." Reason for the increased share of cost was "cost of living adjustment for SSI/SSA."

7. The budget showing computations was Respondent's Exhibit 6 pages 3-4. From income of $1011 was subtracted a $20 "unearned income disregard" and $180 "MNIL" (meaning Medically Needy Income Limit). Medically Needy Income Limit of $180 and the $20 disregard were also in the SSI-Related Programs – Financial Eligibility Standards chart (Respondent's Exhibit 5). That chart further showed the SLMB income maximum limit as $1045 and the QMB limit as $871. The chart was effective January 2008. Because income fell between the limits, the Department computed income too high for QMB but within SLMB limit and SLMB was authorized.

8. The SLMB buy-in for Medicare Part B premium payments began April 2006. Respondent's Exhibit 6, page 2 showed the effective date of buy-in as April 2006, with the current premium being paid at $96.40 monthly.

## CONCLUSIONS OF LAW

Florida Administrative Code **65A-1.702** addresses **Special Provisions** regarding Medicaid coverage options in relevant part as follows:

> (12) Limits of Coverage.
> (a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.
> (b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application.
> ...
> (13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual's or family's income.

Additional relevant rules appear at the Fla. Admin Code as follows:

> **65A-1.713 SSI-Related Medicaid Income Eligibility Criteria.**
> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> ...
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
> ...
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

The income standards for these coverage groups are at **Appendix A-9** of the **Florida Integrated Public Policy Manual 165-22**. The standard for QMB as of January 2008 was $871, the standard for SLMB was $1045 and the single person Medically Needy Income Limit was $180, plus a "$20 General Income Disregard."

Using these mandatory standards, it is concluded that SLMB was the proper coverage because the $1011 income was higher than the QMB limit and lower than the SLMB limit. Thus, the situation would qualify for the SLMB coverage with Medically Needy enrollment. As to the Medically Needy Income Limit or MNIL and the budget formula, with income of $1011, minus the MNIL of $180 and minus the $20 general disregard, the estimated share of cost was correct at $811. In the final analysis, it is concluded that SLMB was correct with Medically Needy enrollment and estimated share of cost as $811. The SLMB and share of cost as $811 were the most favorable options available.

## DECISION

The QMB eligibility and Medically Needy share of cost matters under challenge at hearing are denied.

## 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 1st day of July, 2008, in Tallahassee, Florida.

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

Copies Furnished

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

APPEAL NO. 08F-02934

PETITIONER,

Vs.

CASE NO. 1248296672

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 02 Leon
UNIT: 88510

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 16, 2008, at 9:30 a.m., in Tallahassee, Florida. The petitioner was not present but was represented by her daughter The Department was represented by Annie Jo Martin, supervisor, ACCESS Florida.

## ISSUE

At issue is whether the Department correctly determined the petitioner's Institutional Care Program (ICP) Medicaid patient responsibility. The petitioner bears the burden of proof.

## FINDINGS OF FACT

1. The petitioner is a resident of a nursing home in Tallahassee, Florida. The petitioner is 70 years old. The petitioner's income was a $250 pension.

2. Prior to entering the nursing home in September 2006, the petitioner received

Supplemental Security Income (SSI) of $373 and $250 Texas teacher retirement pension. The Social Security Administration terminated the SSI on November 1 2006 because she was a resident of an institution. The Department failed to budget her income from the Texas teacher retirement pension. When the SSI was terminated, the Department issued a $5 Personal Needs Allowance Supplement (PNAS). Rather than terminating SSI, the Department reduced the SSI to $30 as it was incorrectly determined that the only income available to the petitioner was SSI.

3. The petitioner continued to receive the pension of $250 and the $5 PNAS from at least September 2006 through January 2008. The Department discovered that the pension income was never included in the budget and determined the petitioner was not eligible for the $5 PNAS. The PNAS benefit was terminated effective February 1, 2008. The petitioner's ICP Medicaid was terminated effective February 29, 2008 because the petitioner did not verify unearned income.

4. The petitioner reapplied for the ICP Medicaid on February 19, 2008. The Department calculated the patient responsibility effective March 2008 as follows. The Department considered the petitioner's income from Texas teacher retirement pension of $250. The personal need allowance of $35 was subtracted from the total gross unearned income to arrive at a patient responsibility of $215.

5. The petitioner's representative disagrees with the amount of patient responsibility. The petitioner has life insurance with a premium of $31.80, she wants to continue to tithe to her church in the amount of $25 monthly, and she incurs expenses

for clothing of approximately $75 per month. In addition, the petitioner would like to be able to give small gifts to her grandchildren and other family members of approximately $25 per month. She had a Medicare Prescription Plan through AARP costing her approximately $4.97 per month. On January 8, 2008 the petitioner was notified that she would be disenrolled from the Medicare Prescription Drug Plan benefits through AARP due to overdue premiums. She had an outstanding balance of $75.32. In addition, the petitioner had an overdue bill of $198 owed to It was uncertain whether the medical bill could be covered under Medicaid. Finally, the nursing facility began billing the petitioner for her patient responsibility retroactive to February 2008. Her current balance as of May 31, 2008 was $860.

## CONCLUSIONS OF LAW

Federal Regulations at 20 C.F.R. §416.1123 in part states:

> How we count unearned income...
> (a) We count unearned income at the earliest of the following points: When you receive it or when it is credited to your account or set aside for your use....
> (b) Amount considered as income. We may include more or less of your unearned income than you actually receive.

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

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called 'post eligibility treatment of income'.
> (1) For Hospice and institutional care services, the following deductions

are applied to the individual's income to determine patient responsibility:
(a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance. ...
(g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.
1. The medical/remedial care service or item must meet all the following criteria:
   a. Be recognized under state law;
   b. Be medically necessary;
   c. Not be a Medicaid compensable expense; and
   d. Not be covered by the facility or provider per diem.
2. For services or items not covered by the Medicaid State Plan, the amount of the deduction will be the actual amount for services or items incurred not to exceed the highest of a payment or fee recognized by Medicare, commercial payers, or any other contractually liable third party payer for the same or similar service or item.

The Department's Integrated Policy Manual, 165-22, Section 1840.0905 states:

Annuities, pensions, retirement or disability payments are all included as unearned income. ...

The above regulations and rules require the Department to include the petitioner's gross Social Security and pension income in calculating her Institutional Care Program Medicaid patient responsibility. There is no provision to allow a deduction for clothing, life insurance premiums, tithing, and gifts. The intent of the personal needs allowance is to assist the petitioner to pay for her personal expenses. The patient responsibility is that portion of an individual's monthly income which the Department determines must be considered as available to pay towards the individual's institutional care, as Medicaid pays the balance.

The petitioner argued that she had a medical expense for Medicare Part D AARP Prescription Plan. However, the evidence submitted showed that there have been no payments made on the medical plan for over one year. In addition, the petitioner's representative presented a bill placed into collections that is unpaid. There was no indication when the medical bill was incurred or whether it is a Medicaid compensable bill. Further, there is no indication whether the petitioner's Medicare has made any payment toward the bill submitted into evidence. Therefore, the undersigned authority cannot find that the medical bills submitted can be used to offset the patient responsibility.

According to the above authorities and after a careful review of the Department's calculations, the undersigned authority concludes that the Department correctly determined the petitioner's patient responsibility of $215.

## 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 1st day of July, 2008, in Tallahassee, Florida.

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

Copies Furnished:

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

PETITIONER,

Vs.

APPEAL NO. 08F-02397

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 13 Marion
UNIT: ICP

CASE NO. 1270875353

RESPONDENT.
_____/

**FINAL ORDER**

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 11, 2008, at 12:00 p.m., in Ocala, Florida. The petitioner was not present. Present representing the petitioner was her daughter, ..... Present as witnesses for the petitioner were the petitioner's husband and friend, .... The Department was represented by Sandra Maxwell, ACCESS supervisor. Present as witnesses for the Department were Janice Rivers, ACCESS supervisor and Madelynn Young, public assistance specialist I.

The hearing was scheduled for May 8, 2008. However, at the request of the petitioner's daughter, a continuance was granted.

## ISSUE

The petitioner is appealing the Department's action of January 10, 2008, to deny her Institutional Care Program application because she did not provide information needed to establish her eligibility.

The petitioner had the burden of proof.

## FINDINGS OF FACT

1. The petitioner submitted an application for Institutional Care Program benefits on September 24, 2007. At the time of the application, the petitioner was a resident of Ocala, Florida.

2. On the above application, the petitioner listed that her husband, who was living in the community, had assets including stocks, bonds, income producing property, a checking account and that he sold liquid assets during July 2007. On October 19, 2007, the Department pended the application for verification of the above assets. The petitioner was given until October 29, 2007, to provide the information requested.

3. During the pending period, the petitioner's husband and another daughter contacted the Department numerous times as they were not sure as to what information they needed to provide. They also went to the Department's Wildwood Processing Center to inquire about the information that they needed to provide and were told that the only information needed was verification of the petitioner's income and a treatment order with a history physical from the nursing facility. According to the daughter, the information was faxed to the Department on October 26, 2007.

4. The petitioner's daughter made numerous calls to the Wildwood Processing Center and the Department's Tampa Call Center to inquire about the status of the

application and left messages for someone to return her calls. However, she did not receive a response to her calls.

5. On October 22, 2007, the Department received, from the petitioner, bank statements, a copy of a check for income received from real property, a level of care determination and a history and physical report completed by

The Department did not receive information related to the other assets listed on the application. Therefore, on January 10, 2008, the Department denied the application for Institutional Care Program benefits as eligibility could not be established.

6. The Department considered the petitioner's case to be a "red track" case due to the assets listed on the application. The "red track" cases require an interview to be held with the petitioner and/or the authorized representative. The eligibility specialist contacted the nursing facility where the petitioner was residing about the petitioner's application. The eligibility specialist believed that this contact satisfied the interview requirement. The nursing facility was not the petitioner's authorized representative. There was no interview scheduled or held with the petitioner and/or her authorized representative.

7. During the hearing, the Department acknowledged that an interview should have been scheduled with the petitioner's daughter who was her authorized representative. The Department also agreed to rescind the January 10, 2008, denial of the petitioner's application as an interview was not held. Additionally, the Department agreed to schedule an appointment with the daughter and to provide her with the opportunity to submit the necessary information needed to determine whether the petitioner was eligible to receive Institutional Care Program Benefits.

## CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.205 in part states:

(1) The individual receives a Request for Assistance and completes it to the best of the individual's ability. The eligibility specialist determines the potential eligibility of each household member for public assistance and prints out the data on the Common Application Form (CAF) or alternately, Form CF-ES 2327, Common Application Form and Eligibility Questionnaire, May 04, incorporated by reference, can substitute for the CAF. The individual then decides whether or not to apply for assistance. The Common Application Form or CF-ES 2327 is signed and dated by the individual to complete the process of applying. The applicant must be informed of the department's standards of assistance, penalties for fraud, right to appeal and to have a fair hearing, the civil rights provisions and other rights and responsibilities. An applicant may withdraw the application at any time without affecting their right to reapply at any time.

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

(d) If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, or that an assistance group member is required to register for employment services, the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated) or 30 days from the date of application whichever is later. In cases where medical information is requested the return due date is 30 calendar days following the request or 30 days from the date of application whichever is later. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day. 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. The eligibility specialist makes the decision of whether to grant the request for extension based on extenuating circumstances beyond the control of the individual, such as sickness, lack of transportation, etc. 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 Department agreed to rescind the denial of the petitioner's application and to provide the petitioner with another opportunity to submit the information needed to determine whether she was eligible to receive Institutional Care Program benefits. Therefore, the action of January 10, 2008, to deny the petitioner's Institutional Care Program benefits is reversed. The Department must provide the petitioner with an opportunity to provide the information necessary to determine her eligibility for Institutional Care Program benefits. Upon receipt of the information, the Department is to notify the petitioner, in writing, of its decision and the right to appeal if she disagrees with the Department's decision.

## DECISION

The appeal is granted. The Department's denial action is reversed.

## 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 25th day of July, 2008,

in Tallahassee, Florida.

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

Copies Furnished

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

APPEAL NO. 08F-2610

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 June 24, 2008, at 12:05 p.m., in Miami, Florida. The petitioner appeared telephonically, at her request. The respondent was represented by Maria Rodriguez, program specialist with the Agency for Health Care Administration (AHCA). Present telephonically, as witnesses for the respondent was Doug Harper, AHCA contract manager; Carol Mahdi, technical assistant with the Commission for Transportation for the Disadvantaged (CTD); Karen Summerset, CTD; Macy Mercado, former Medicaid supervisor with Miami-Dade Transit (MDT); Harry Rackard, MDT local coordinating board; Sharon De-Vlugt, supervisor with Logistic Care (provider); and George Duna, Logistic Care. Ainsly Barberena served as translator.

The hearing was previously scheduled for June 3, 2008, but was continued at the request of the petitioner. The record remained open for ten days in order for the petitioner

to provide additional documentation. The petitioner did not submit any documents to the hearing officer.

## ISSUE

The petitioner is appealing the March 21, 2008 denial of Medicaid Paratransit transportation services. The respondent has the burden of proof.

## FINDINGS OF FACT

1. The petitioner (83 years old) is a Medicaid recipient in the state of Florida who is eligible to receive Medicaid transportation services. The petitioner has continued to receive transportation services throughout the hearing process.

2. The Transportation Disadvantaged Program, governed by Chapter 427, Florida Statutes (F.S.) and Chapter 41-2, Florida Administrative Code (F.A.C.), is administered by the Commission for the Transportation Disadvantaged (CTD). This program designates a community transportation coordinator (CTC) in each county to assist those individuals who have been identified as transportation disadvantaged. Among other things, they evaluate eligibility for paratransit transportation and in Miami-Dade the CTC is Miami-Dade Transit Authority.

3. On September 20, 2006 the petitioner was mailed recertification documents in order to continue receiving transportation services. A Medicaid paratransit application form was required, along with current medical documentation from the petitioner's physician.

4. On October 22, 2006, a completed paratransit application was received from the petitioner, along with medical verification and certification from the petitioner's treating physician, Dr.

5. In the medical verification section of the application the treating physician certifies that the petitioner has "No limitations that would prevent the use of bus/rail service."

6. On October 30, 2006, a recertification follow up letter was faxed to the treating physician, requesting additional information on the petitioner's medical condition since he had previously certified that there were "No limitations that would prevent the use of bus/rail service." The respondent presented confirmation (Respondent's Exhibit 3) of the fax transmitted. A response was not received.

7. On December 7, 2006, a denial letter from the CTC was issued stating, "Based upon a review of your Medicaid Paratransit Eligibility Application Form, we have determined that you are ineligible ... We requested Medicaid documentation from your physician(s) and to substantiate your condition(s) and to assess your functional limitations. We have not received the requested documentation."

8. On March 11, 2007, an appeal to the local coordinating board (LCB) was received. The LCB is comprised of appointed representatives and normally meets on a quarterly basis. The petitioner would receive continued services while awaiting the next LCB meeting.

9. On February 7, 2008, the coordinator faxed (Respondent's Exhibit 5) a second request for additional information to the petitioner's treating physician. No response was received.

10. On March 3, 2008, the respondent issued to the petitioner a notice informing her that her appeal was scheduled to be reviewed by the Local Coordinating Board on March 18, 2008.

11. On March 18, 2008, the LCB reviewed the petitioner's appeal with no new information provided and they upheld the original denial. A notice of denial was issued on March 21, 2008 stating, "...A review of the medical documentation submitted indicates that you have a disability which does not prevent your ability to use the fixed route transportation system, ... Eligibility is based upon the condition preventing (making it impossible, not difficult) the individual from accessing and navigating the fixed route system." The respondent concludes that the petitioner's treating physician originally certified that she had "No limitations that would prevent the use of bus/rail service" and two additional requests for medical information were made to the physician, with no response received. Additionally, the petitioner was made aware of the physician not responding through the December 7, 2006 and again, no medical documentation was provided.

12. The petitioner appealed the denial through the Office of Appeal Hearings on April 11, 2008.

## CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct hearings pursuant to Chapter 120.80 F.S.

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

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible... Any service under this section shall be provided only when medically necessary and... Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.
>
> (12) TRANSPORTATION SERVICES--The agency shall ensure that appropriate transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for medically necessary and Medicaid-compensable services, provided a client's ability to choose a specific transportation provider shall be limited to those options resulting from policies established by the agency to meet the fiscal limitations of the General Appropriations Act...

Fla. Stat. 427.011 Special Transportation and Communications Services states in part:

> (1) "Transportation disadvantaged" means those persons who because of physical or mental disability, income status, or age are unable to transport themselves or to purchase transportation and are, therefore, dependent upon others to obtain access to health care, employment, education, shopping, ...
>
> (5) "Community transportation coordinator" means a transportation entity recommended by a metropolitan planning organization, or by the appropriate

designated official planning agency as provided for in ss. 427.011-427.017 in an area outside the purview of a metropolitan planning organization, to ensure that coordinated transportation services are provided to the transportation disadvantaged population in a designated service area.

(7) "Coordinating board" means an advisory entity in each designated service area composed of representatives appointed by the metropolitan planning organization or designated official planning agency, to provide assistance to the community transportation coordinator relative to the coordination of transportation services.

(9) "Paratransit" means those elements of public transit which provide service between specific origins and destinations selected by the individual user with such service being provided at a time that is agreed upon by the user and provider of the service. Paratransit service is provided by taxis, limousines, "dial-a-ride," buses, and other demand-responsive operations that are characterized by their nonscheduled, nonfixed route nature.

Fla. Stat. 427.013 explains Special Transportation and Communications Services and states in part:

The Commission for the Transportation Disadvantaged; purpose and responsibilities--The purpose of the commission is to accomplish the coordination of transportation services provided to the transportation disadvantaged...

Fla. Admin. Code at 59G-4.330, Transportation Services states in part:

(1) This rule applies to all entities which provide transportation services to Florida Medicaid recipients.

(2) All non-emergency transportation services providers who provide transportation to Medicaid recipients must comply with the provisions of the Florida Medicaid Transportation Coverage, Limitations and Reimbursement Handbook, July 1997, incorporated by reference. ...

The Florida Medicaid Transportation Coverage, Limitations and Reimbursement Handbook, states in part:

Requirements To Receive Services

Introduction-Medicaid may reimburse for transportation services furnished to eligible Medicaid recipients only when they are for the purpose of transporting a recipient to receive a Medicaid-compensable service, such services are medically necessary, and...

Medical Necessity-Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's services, and are:

- individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

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

Selection and Coordination of Transportation

The Coordinator must implement a transportation assessment screening process to determine the most appropriate and cost effective means for transporting recipients. The assessment must be based on recipient needs as well as the recipient's mental capacity. The Coordinator may require medical provider certification to justify exceptions to the mode considered most appropriate.

Prior Authorization Requirements

Introduction-All transportation services, except for emergency ambulance, must be prior authorized by the local transportation coordinator. For the purposes of this handbook, the entity responsible for authorizing transportation is referred to as the "Coordinator."

The petitioner states that she has multiple medical problems and has difficulties in getting to the bus stop and is unable to pay for a taxi. She states that the physician did send in the requested information and would obtain a copy for the hearing officer. This official did not receive any medical documentation from the petitioner's physician.

The hearing officer finds that based on the only medical evidence presented during the recertification process, the physician's certification of "no limitation" in using bus or rail service justifies the respondent's denial. There was no medical evidence to show that given the petitioner's medical conditions, she would be unable to access and navigate the fixed route system.

The respondent's original denial of December 7, 2006 and the reconsideration of March 21, 2008 that upheld the original decision, is affirmed.

## DECISION

The 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 29th day of July, 2008,

in Tallahassee, Florida.

A. G. Littman

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

Copies Furnished To:

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

APPEAL NO. 08F-2421

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 June 3, 2008, at 12:50 a.m., in Miami, Florida. The petitioner, , was present and represented himself. Present, as witnesses for the petitioner was his mother, and his friends, and . The respondent was represented by Maria Rodriguez, program specialist with the Agency for Health Care Administration (AHCA). Present telephonically, as witnesses for the respondent was Doug Harper, AHCA contract manager; Carol Mahdi, technical assistant with the Commission for Transportation for the Disadvantaged; Karen Summerset, transportation coordinator assistant director with Miami-Dade Transit; Macy Mercado, former Medicaid supervisor with Miami-Dade Transit; Ainsly Barberena, contract operations with Miami-Dade Transit; Sharon De-Vlugt, supervisor with Logistic Care (provider); and Willie Digioia, certification specialist with Logistic Care. Blanca Alvarez served as translator.

## ISSUE

The petitioner is appealing the March 21, 2008 denial of Medicaid Paratransit transportation services. The respondent has the burden of proof.

## FINDINGS OF FACT

1. The petitioner (33 years old) is a Medicaid recipient in the state of Florida who is eligible to receive Medicaid transportation services.

2. The Transportation Disadvantaged Program, governed by Chapter 427, Florida Statutes (F.S.) and Chapter 41-2, Florida Administrative Code (F.A.C.), is administered by the Commission for the Transportation Disadvantaged (CTD). This program designates a community transportation coordinator (CTC) in each county to assist those individuals who have been identified as transportation disadvantaged. Among other things, they evaluate eligibility for paratransit and in Miami-Dade the CTC is the Miami-Dade Transit Authority.

3. On November 29, 2005 the petitioner was mailed recertification documents in order to continue receiving transportation services. A Medicaid paratransit application form was required, along with current medical documentation from the petitioner's physician was required.

4. On December 22, 2005, a completed paratransit application was received from the petitioner, along with medical verification and certification from Dr. .

5. On the application the petitioner answers questions presented and states that he has friends that can transport him; and that he has another program (STS) that will provide transportation "but it's more expensive so why take it."

6. Dr. [redacted] (neurologist) in his certification states that the petitioner's primary disability is epilepsy. He certifies that the petitioner is ambulatory; that he finds it "impossible" for the petitioner to walk more than seven blocks; endure warm weather; and wait for thirty minutes. The treating physician finds that these limitations "usually" applies, as opposed to "always" applies to the petitioner.

7. A letter (dated December 12, 2005) from Dr. [redacted] was also received in the recertification packet on December 22nd where it states in part, "The patient was last seen October 6, 2005. Denies having any seizures since I last saw him. He has been, otherwise, doing quite well. ... Assessment: Seizure disorder and bipolar disorder, stable. Plan: Continue current drug regimen. The patient has been seizure-free now for well over 6 months. Continue with vagal nerve stimulator, which he has in place..."

8. On December 28, 2005 a denial letter from the CTC was issued stating, "This determination is based on a transportation decision of functional ability to use the available fixed-route public transportation system," and "Your physician has certified that you disorder does not fall within the guidelines for Medicaid paratransit service eligibility. Keep in mind that just the diagnosis of a potentially limiting illness or condition is not sufficient. The impairment related condition must prevent the individual from traveling to/from a boarding or disembarking location and/or navigating the public fixed-route system."

9. Testimony received by the CTC stated that medical evidence provided showed that the petitioner could walk no more than seven blocks, and the bus stop was three blocks from his home; the neurologist documented that the petitioner had not reported a

seizure in months and was doing well; the petitioner's physician indicated that the limitations listed for the petitioner applied as "usually" and not as "always" limiting; and the petitioner had alternative transportation available to him and therefore, was unable to approve.

10. The petitioner filed a complaint locally on the denial, which was not resolved. The complaint was now forwarded to the Local Coordinating Board (LCB) as the next step in the grievance procedures and would wait for the next LCB meeting. The LCB is comprised of appointed representatives and normally meets on a quarterly basis.

11. In February 2006, the petitioner provided a letter from his neurologist Dr. stating, "...Despite multiple medications his seizures have not been controlled. A Vagus Nerve Stimulator has also been implanted. Since his seizures are not under control he requires assistance when he uses the STS and Florida Medicaid Transit."

12. On June 26, 2006, as part of the grievance process Dr. was sent (via fax) a second request for additional information on the petitioner's disability. The CTC maintained a fax confirmation receipt on file, showing the correct fax number in which it was sent. The fax informed the informed the physician that the previous request had been denied and that it was being appealed. No additional information was received.

13. On March 18, 2008, the LCB reviewed the petitioner's appeal along with information provided and upheld the original denial. A notice of denial was issued on March 21, 2008 stating, "...A review of the medical documentation submitted indicates that you have a disability which does not prevent your ability to use the fixed route

transportation system, ... Eligibility is based upon the condition preventing (making it impossible, not difficult) the individual from accessing and navigating the fixed route system." The respondent concludes that the petitioner can navigate the transportation system.

14. The CTC notes that the LCB delayed in holding their quarterly meetings as they usually did, due to difficulties. However, the petitioner has received transportation throughout the entire grievance and appeals process.

15. The petitioner appealed the denial through the Office of Appeal Hearings on April 1, 2008.

## CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct hearings pursuant to Chapter 120.80 F.S.

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

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible... Any service under this section shall be provided only when medically necessary and... Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.
>
> (12) TRANSPORTATION SERVICES--The agency shall ensure that appropriate transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for medically necessary and Medicaid-compensable services, provided a client's ability to choose a

specific transportation provider shall be limited to those options resulting from policies established by the agency to meet the fiscal limitations of the General Appropriations Act...

Fla. Stat. 427.011 Special Transportation and Communications Services states in part:

(1) "Transportation disadvantaged" means those persons who because of physical or mental disability, income status, or age are unable to transport themselves or to purchase transportation and are, therefore, dependent upon others to obtain access to health care, employment, education, shopping, ...

(5) "Community transportation coordinator" means a transportation entity recommended by a metropolitan planning organization, or by the appropriate designated official planning agency as provided for in ss. 427.011-427.017 in an area outside the purview of a metropolitan planning organization, to ensure that coordinated transportation services are provided to the transportation disadvantaged population in a designated service area.

(7) "Coordinating board" means an advisory entity in each designated service area composed of representatives appointed by the metropolitan planning organization or designated official planning agency, to provide assistance to the community transportation coordinator relative to the coordination of transportation services.

(9) "Paratransit" means those elements of public transit which provide service between specific origins and destinations selected by the individual user with such service being provided at a time that is agreed upon by the user and provider of the service. Paratransit service is provided by taxis, limousines, "dial-a-ride," buses, and other demand-responsive operations that are characterized by their nonscheduled, nonfixed route nature.

Fla. Stat. 427.013 explains Special Transportation and Communications Services and states in part:

The Commission for the Transportation Disadvantaged; purpose and responsibilities--The purpose of the commission is to accomplish the

coordination of transportation services provided to the transportation disadvantaged...

Fla. Admin. Code at 59G-4.330, Transportation Services states in part:

(1) This rule applies to all entities which provide transportation services to Florida Medicaid recipients.

(2) All non-emergency transportation services providers who provide transportation to Medicaid recipients must comply with the provisions of the Florida Medicaid Transportation Coverage, Limitations and Reimbursement Handbook, July 1997, incorporated by reference. ...

The Florida Medicaid Transportation Coverage, Limitations and Reimbursement Handbook, states in part:

Requirements To Receive Services

Introduction-Medicaid may reimburse for transportation services furnished to eligible Medicaid recipients only when they are for the purpose of transporting a recipient to receive a Medicaid-compensable service, such services are medically necessary, and...

Medical Necessity-Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's services, and are:

• individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

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

Limitations and Exclusions

Introduction-Medicaid transportation services are only available to eligible Medicaid recipients who are unable to obtain transportation or make arrangements through any other available means, such as family, friends or community resources. ...

Prior Authorization Requirements

Introduction-All transportation services, except for emergency ambulance, must be prior authorized by the local transportation coordinator. For the purposes of this handbook, the entity responsible for authorizing transportation is referred to as the "Coordinator."

How the Requests are Processed

The Coordinator:

• determines if the recipient has access to transportation resources other than Medicaid-funded transportation;

• determines whether the transportation is for the purpose of receiving a Medicaid-covered service;

• selects the appropriate mode of transportation based on the recipient's physical and mental condition;...

Mode of Transportation Restrictions-The Coordinator must screen the recipient to determine the most appropriate and cost-effective mode (i.e., mass transit, volunteer, multiload van) to use based on the recipient's physical and mental condition. The recipient may appeal the Coordinator's decision on the mode of transportation through the Local Coordinating Board (LCB) grievance process.

Documentation Requirements

The Coordinator may require medical provider certification when the recipient or the recipient's representative requests:

• exception to the Coordinator's evaluation on the most appropriate mode of transportation; ...

Types of Transportation Service

Types of Medicaid Reimbursable Transportation-There is a wide variety of types of transportation covered under the Medicaid transportation program. The following information describes each type of transportation covered by Medicaid, gives the criteria for use of each type and guidelines for their selection as the most appropriate mode of transportation based on the recipient's mental and physical condition at the time of transport. The Coordinator will implement an eligibility screening process by which recipients are screened as to the most appropriate and cost effective mode of transportation to be used.

> Fixed-Route Transit (Mass Transit)-Fixed-route transportation should be selected for recipients who have access to a bus system and can reach their medical appointment by bus in a reasonable time period. ...

The petitioner states that he continues to be treated for seizures, neck/back/knee pain; sleep apnea; vision problem; and he sees a psychologist. He is on several different medications and he continues to receive STS (special transportation services). The petitioner states that he can walk 4 ½ to 5 blocks, that currently his limitations presented in the application are "usually" limiting and did not consider them to be "always" limiting. The petitioner states that he is no longer seeing Dr.

The petitioner argues that if the request for additional information would have been sent to him, he could have tried to have the physician provide more information. He feels that the request for additional medical information should have been sent to Dr.

The respondent stated that the communication for medical information is with the medical providers and that two letters (Dr. & Dr. had been received, but given the information contained, could not approve.

This was an additional request for Dr. since a previous application in March 2005 resulted in a denial, due to the petitioner's treating physician (Dr. ) documenting that the petitioner had no limitations for the use of bus rail. That letter was not considered in the review conducted for the December 2005 application. The petitioner had then submitted another application, with a letter from Dr. and had been approved back in early 2005.

The petitioner presented witnesses which stated that the petitioner is "dangerous" as he can fall asleep when driving and starts swerving left and right. They feel that he is

in danger of falling asleep when crossing the streets and needs someone to hold on to. They feel that he needs the transportation service.

At the hearing, the petitioner presented the following on his behalf: A prescription from an eye care center dated April 17, 2008 and has written, "Strabismus-Exutropia, Interminet Diplupia." A prescription note dated April 15, 2008 from an otolaryngolist stating, "Pat c [with] mild sleep apnea and nasal obstruction." A letter dated April 3, 2008 from his psychologist stating, "He has been told not to drive by his physicians and would benefit from special transportation arrangements." A prescription and letter signed by the petitioner on letterhead from his pulmonologist dated March 13, 2008 stating, "I , Promise that I won't drive or be driving until I'm cleared to do so by my Pulmonologist: Dr. regarding my Sleep Apnea. That I will be using the CPAP machine as instructed. ..." A prescription note dated April 11, 2008 from Dynamic Medical Services stating, "...Has been Tx in this office from 2006-Dec. 2007 for low back pain and knee pain." A prescription note from an orthopedist dated December 19, 2007 stating, "Medicare exemption, Low back exercise program, lumbar traction, massage and deep ... lumbar spine Daily x 2 wks-3wks." A prescription note from Advanced Health Services dated April 21, 2008 stating, "...currently being treated in this office for lumbar disk problems, low back pain and neck pain." A copy of a prescription on medication prescribed on March 4, 2008 was also presented.

The hearing officer finds that given the evidence presented with the December 2005 application, the respondent correctly denied the application based on "The

impairment related condition must prevent the individual from traveling to/from a boarding or disembarking location and/or navigating the public fixed-route system."

In this case, the information provided by the petitioner and the physician warranted a denial of the service, as there was no evidence to show that the petitioner was not able to access and navigate the fixed route system.

As a *de novo* hearing is conducted, the hearing officer considered all evidence newly presented by the petitioner at the hearing. The petitioner's own testimony was that he was able to walk 4 ½ to 5 blocks and he continues to have STS transportation available to him. The hearing officer finds that evidence from his own medical providers do not indicate that given his medical conditions, he would be unable to access and navigate the fixed route system.

The petitioner highlights his seizure disorder and sleep apnea as the main concern for the need of paratransit transportation. However, no medical evidence was provided nor testimony on any possible seizures that he has had, since the application in December 2005 to the present. The petitioner only claims that he is being "treated" for seizures, not that he has had any within the last 24 months.

Additionally, medical evidence does not support the petitioner's statement of falling asleep, when his own doctor's statement is that he has "mild sleep apnea" and was instructed to use the CPAP machine in March 2008. The petitioner has been repeatedly instructed not to drive. There was no mention on his inability to use public transportation based on his limitations, due to his medical condition.

Lastly, one of the physicians states that the petitioner would "benefit" from special transportation, there was no mention that from a medical standpoint he would be unable to navigate the fixed route system.

The respondent's original denial of December 28, 2005 and the reconsideration of March 21, 2008 that upheld the original decision, is affirmed.

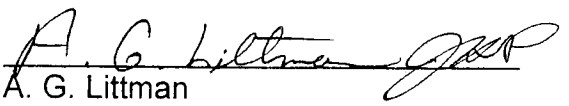
## DECISION

The 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 25th day of July, 2008, in Tallahassee, Florida.



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