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

APPEAL NO. 07F-1226

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 April 25, 2007, at 12:10 p.m., in Miami, Florida. The petitioner was not present but was represented by his mother, provider was present. Representing the agency was Erica Woodard, registered nurse specialist with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the agency was Teresa Ashey, reviewer with KēPRO South; Dr. Robert Buzzio, KēPRO physician reviewer; and George Smith, KēPRO reviewer. Present telephonically, only at the beginning of the hearing, was Brevin Brown, attorney for AHCA. Carlos Rodriguez served as translator. was present as an observer. The hearing was previously scheduled for March 27, 2007, but was continued at the request of both parties.

ISSUE

At issue is the agency's action of February 8, 2007, in approving 868 hours and denying 196 hours of private duty nursing instead of the requested 1,064 hours. The certification period is for January 7, 2007 through March 7, 2007. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is four years old and a Medicaid beneficiary in the state of Florida. The petitioner's medical condition as reported to the agency was of "disorders relating to extreme immaturity of infant; 500-749 grams, obstructive hydrocephalus, other convulsions, and attention to gastrostomy." The provider requested on January 12, 2007 1,064 skilled nursing hours for the petitioner, for the certification period of January 7, 2007 through March 7, 2007.

The agency has contracted Keystone Peer Review Organization (KēPRO South) to perform medical reviews for Private Duty Nursing and Personal Care Prior Authorization Program for Medicaid beneficiaries. This prior authorization review determines medical necessity of the hours requested, under the terms of the Florida Medicaid Program. The request for service is submitted by the provider as well as the information, in order for KēPRO to make a determination on medical necessity.

On January 15, 2007, a preliminary screening of the request was completed by the registered nurse reviewer. The provider was requested to submit additional information and clarification, which were ultimately provided.

On February 7, 2007, a second physician consultant (board-certified pediatrician) reviewed the request, as part of the reconsideration process for a previous (February 6, 2007) denial. The physician considered among other information, "4 yr. old with VP shunt; gtube, nebs, suction, CPT, 02, attends PPEC, mother works FT m-f, has a 3 year old... trach has been removed, and ...mother is apprehensive on being alone with child." The provider informed KēPRO, "This child has been hospitalized 6 times since 01/2006. He deteriorates rapidly, had apnea and had to be taken 911 during one episode..." and they provided the petitioner's medical history.

The physician consultant determined, "Requested hours for cert period, 1-7-07 – 3-7-07 is 1064 hours, 4p-8a for 16 hour shifts, 20 hours 8a-10pm and 12a-6a on Saturdays and 24 on Sundays. Patient also attends PPEC. Patients trach was removed. It would seem reasonable after other sibling goes to sleep early in the evening that mother (PCG) could provide more independent care for this patient. Suggest that PCG should be responsible for four (4) hours each evening between 8pm and 12 am this would reduce PDN service to only 16 hour shifts. There is no indication why there are 20 hour shifts, and no indication on what particular days that is needed..." The petitioner attends PPEC from 7 a.m. to 4 p.m.

It was then determined by the physician consultant based on the information provided, that 868 skilled nursing hours were approved for certification period of 1/7/07 through 3/7/07, and 196 hours were denied out of the 1,064 requested. The petitioner and provider were notified.

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 Florida Statute, Chapter 120.80.

Florida Statute 409.905 addresses Mandatory Medicaid services and states as follows:

> 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 on the dates on which the services were provided. Any service under this section shall be provided *only* when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. 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 adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.
>
> (4)(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services...The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents...

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;
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-4.130 *Home Health Services* states in part:

(1) This rule applies to all home health agencies licensed under Chapter 400, Part IV, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.

(2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. ...

The Home Health Services Coverage and Limitations Handbook (October 2003), pages 2-15 and 2-16 states in part:

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

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.

CMAT Referrals
A recipient who is medically able to attend a PPEC and whose needs can be met by the PPEC, should have PPEC services recommended by the CMAT. Private duty nursing may be provided as a wraparound alternative for an individual needing additional services when PPEC is not available.

Limitations
Private duty nursing services are limited to a minimum of two continuous hours and a maximum of 16 continuous hours per day.

Exception Authorization, 16 Hours Per Day, Greater Than 30 Days
When the plan of care indicates that private duty nursing services will exceed the maximum of 16 hours per day for more than 30 consecutive days, Medicaid may reimburse those services only if they are recommended by the Children's Multidisciplinary Assessment Team (CMAT).

Private duty nursing services must be reviewed at each staffing to determine continued medical necessity.

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

The petitioner's mother states that she does not want the hours reduced, as she has another child, will start working at night and she will start going to school and cannot do it all. She also confirmed that the petitioner attends the Prescribed Pediatric Extended Care (PPEC) Center from 7 am through 4 pm.

The Findings of Fact shows that the petitioner requested private duty nursing service in the amount of 1064 hours, for the certification period of January 7, 2007 through March 7, 2007. This would equal to 20 hours daily of private duty nursing service. The request was reviewed by the contracted agency that conducts the reviews of medical necessity. The physician consult (reviewed by two separate consultants) determined that according to the information provided, 686 or 16 hours daily of private duty nursing would be approved for the certification period. The physician consultant concluded that it was "reasonable for mom to be responsible" for four hours daily of care. After careful consideration, it is determined that the agency's action to reduce the private duty nursing services, is upheld.

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 13th day of June, 2007,

in Tallahassee, Florida.

A. G. Ramos
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. 07F-2425

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 22, 2007, at 10:50 a.m. in Miami, Florida. The petitioner, represented herself at the hearing. The respondent was represented by Donna Pollins, program specialist with Agency for Health Care Administration (AHCA). Appearing telephonically was Dr. Frank Castrina, medical director with KePRO; Debbie Parthemore, RN, operations manager with KePRO; and Katharine Peters, RN, team leader with KePRO. Dora Rawlins served as translator.

ISSUE

At issue was whether or not the agency's action of March 16, 2007, to deny home health aide services due to medical necessity was correct. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner (sixty years-old) is a Medicaid recipient in the state of Florida and has a diagnosis of osteorthrosis, osteoporosis, other anxiety and abnormality of gait. On behalf of the petitioner , a home health care provider requested authorization for home health aide visits one time a day. The certification period was for March 1, 2007 through April 29, 2007.

The review of this request is performed by KePRO (Keystone Peer Review Organization) an organization contracted by AHCA to perform prior authorization reviews, of private duty nursing and personal care services for home health care. The review determines if under Medicaid criteria, medical necessity has been demonstrated according to the information submitted by the provider.

On March 9, 2007 a physician consultant reviewed the petitioner's request. The agency stated that the request for daily service was made by the provider in order to assist with meals, dressing, shower and general activities. The petitioner's limitations as described by the provider, was pain and rigid left leg (previous tumor removed one year ago) with a diagnosis of severe generalized pain. The only medication listed was ibuprofen every eight hours for pain. The physician consultant denied the request for service as medical necessity had not been demonstrated.

The provider requested a reconsideration and submitted additional medical information, which included a diagnosis of "osteochondroma (tumor) 12 yrs ago on the left leg" and medication for pain and other medical information.

On March 15, 2007, a different physician consultant reviewed the information and denied the request stating: "There is little in this application, the patient's diagnoses or medication list that would support the need for HHA visits. This is a relatively young, alert, ambulatory female with minimal medications. Medical necessity is not supported in this case." The agency denied the request and issued a Notification of Denial on March 16, 2007 stating: "...because documentation submitted by the agency (provider) does not support the medical necessity for the visit frequency of the services requested." A hearing request was received by the Officer of Appeal Hearings on April 13, 2007.

CONCLUSIONS OF LAW

Pursuant to the Florida Administrative Code at 59G-1.010 *Definitions,* states in part:

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

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

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

The Home Health Services Coverage and Limitations Handbook (October 2003) explains service requirements for Home Health Aide Visit Service on page 2-14, stating in part:

Home health aide services may be reimbursed only when they are:

- Ordered by the attending physician;
- Documented as medically necessary; ...

Home Health Aide Services

Home health aide services help maintain a recipient's health or facilitate treatment of the recipient's illness or injury. The following are examples of home health aide services reimbursed by Medicaid:

- Assisting with the change of a colostomy bag;
- Assisting with transfer or ambulation;
- Reinforcing a dressing;
- Assisting the individual with prescribed range of motion exercises that have been taught by the RN;
- Assisting with an ice cap or collar;
- Conducting urine test for sugar, acetone or albumin;
- Measuring and preparing special diets;
- Providing oral hygiene;
- Bathing and skin care; and

- Assisting with self-administered medication.

The petitioner states that she takes medication for pain, but for her other conditions as well. She states that the doctor recommended the service because of her back problem (spine deterioration); her osteoarthritis; her osteochondoma; severe pain; circulatory problem and a kidney problem. The petitioner states that she lives in an apartment with her adult son that is disabled. She states that she does what she can around the apartment and only has the assistance of a sister that works and sometimes does house work for her. The petitioner provided no medical evidence or testimony on her physical limitations.

The agency argued that the information submitted by the provider, did not include all of the conditions mentioned. The agency was aware of all medications being taken and noted that the petitioner had not been hospitalized (within last 60 days), had not been seen in the emergency room and they still have no information on her limitations. Therefore, medical necessity for the service was not demonstrated.

After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action of March 16, 2007, to deny the request for home health aide of one time a day for the period of March 1, 2007 through April 29, 2007.

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 15th day of June, 2007,

in Tallahassee, Florida.

A. G. Ramos
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. 07F-01981

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 02 Leon
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 23, 2007, at 9:30 a.m., in Tallahassee, Florida. The petitioner was present and was represented by her mother. Testifying on behalf of the petitioner was Medicaid Waiver Support coordinator, Present was

The respondent was represented by Deborah Jamski, RNS, Agency for Health Care Administration (AHCA) Medicaid, Area 2B. Testifying on behalf of the agency, by telephone, was Dr. Robert Buzzeo, physician reviewer, KePRO, Teresa Ashey, review operations supervisor, KePRO, and George Smith, review operations specialist, KePRO. Observing the proceeding was Vern Hamilton, program administrator, AHCA Medicaid, Area 2B.

ISSUE

The petitioner is appealing AHCA's action of February 28, 2007 to reduce Private Duty Nursing and Personal Care Services from a request of 720 hours to 648 for the months of March 10 through May 8, 2007 based on the contention that the intensity or level of medical care requested was not medically necessary. The respondent bears the burden of proof.

FINDINGS OF FACT

The petitioner (date of birth is a Medicaid recipient. The petitioner is also receiving Home and Community Based Care Services of waiver support coordination and respite services. The petitioner's care is medically complex. The petitioner has been receiving private duty nursing services under Medicaid. A request for 720 hours of private duty nursing was submitted by the provider, Interim Healthcare of NW Florida, for the period of March10, 2007 through May 8, 2007.

The petitioner is residing with her mother and father and 14 year old brother. Prior to the action under appeal, the parents were authorized to receive 12 hours/7 days a week private duty nursing care (PDN). The parents work 12 hours/day, Monday through Friday from 7 a.m. to 7 p.m. The father is on 24/7 call. The parents provide for the remaining 12 hours/day, 7 days/week.

The mother is employed full time Monday through Friday and the father works as a coach/manager for persons with disabilities Monday through Saturday, 9 a.m. to

9 p.m. He is on call 24 hours per day/7 days per week and needs to leave if called.

Requests for private duty nursing are reviewed with a contract provider who completes prior authorization for the requested service. That contract provider is KePRO. The request for services is submitted by the home health care provider, in this case, Interim Health Care of Northwest Florida. The requests are for 60 day time periods. All communication is sent between KePRO and the provider until a decision is reached. KePRO reviews the written request for services to determine if the number of hours requested are medically necessary. If additional information is needed, KePRO contacts the provider. Once services, as in this case, were rejected or modified, a notice is sent to the recipient's family.

KePRO received the request for 720 hours of private duty nursing submitted by the provider . A KePRO Registered Nurse Reviewer (RNR) completed a screening of the Plan of Care submitted in February 2007. At AHCA's direction, the RNR used modified InterQual Criteria and a Pediatric Home Care Guide for Private Duty Nursing (PDN) Hourly Utilization to review the request for PDN services. Using that documentation, a Utilization Form was developed. The Utilization Form assigns point values to physical conditions of the petitioner and level of care that is anticipated. KePRO concluded that based on the points the petitioner was scored, a physician's review was required.

The case was then referred to a Board Certified Pediatric Specialty Physician Consultant. A Board Certified Pediatrician reviewed the case and made the following

determination: "Underlying diagnosis not described. ?GT tube feeds. Mother works 12 hour/day, Monday-Friday. Father on call 24 hours/7 days a week but not clear how many hours spent or how often on average father called to work... Will approve 12hr/day Monday through Friday but parents could cover more weekend hours. Approve 8 hours/day Saturday and Sunday. Approve 648 hours" (Respondent's Composite Exhibit 2, Section C). The determination of the physician consultant was sent to Interim Healthcare of Northwest Florida on February 28, 2007. Based on the documentation, the pediatric consultant denied 72 hours and approved 648 hours of the 720 requested hours of private duty nursing.

The documentation indicated a request for the petitioner with convulsions, cerebral degeneration, unspecified delay in development, closed fracture of lower end of femur, unspecified part, congenital quadriplegia, and neuromuscular scoliosis. She has cerebral palsy, cannot walk or talk and has minimal muscle tone requiring total support physically requiring lifting and moving throughout the day. The petitioner requires oral suctioning as needed to clear secretions. She requires medication administration, tube feedings, and monitoring for seizure activity as well as oxygen as indicated applied via nasal cannula. The petitioner often requires oxygen, especially at night.

The petitioner's physician submitted correspondence to KePRO dated March 1, 2007 indicating the "petitioner has chronic lung disease, reactive airway disease, severe gastro esophageal reflux, severe developmental delay, severe seizure disorder that is

intractable and scoliosis. She is subject to frequent pneumonias unless her pulmonary toilette and airway maintenance are immaculate." The treating physician urged continuation of the 12 hours a day, 7 days a week as essential in order to keep the petitioner out of hospital and/or institutional care.

A request for a Reconsideration review was submitted to KePRO by Interim Healthcare of Northwest Florida. For the Reconsideration, a second, different Board Certified pediatrician, Dr. Robert Buzzeo, reviewed the request on March 14, 2007. The determination by the second physician consultant was based both on the patient's clinical medical state as well as the level of intensity needed to provide for her care. The program is operated with the understanding that parents or caregivers will be able to participate in providing care as they are trained in providing for the child's care.

In addition, the second physician consultant's decision took into consideration the parents' work schedule Monday through Friday. "Dad as an counselor and is on call 24 hours, 7 days/week. Location of Private Duty Nursing services, Home and School. Taking into account that father may be called any time... for his work would not factor in, since this could occur as well when mother is providing independent care Monday through Friday, so eight hours on weekends, is a reasonable proposal by physician consultant." KePRO determined it to be reasonable that the caregivers could provide at least eight hours of independent care especially on the weekends. Eight hours on Saturday and on Sunday was approved to allow some coverage during the evening so that the caregivers could sleep. On March 15, 2007,

the second physician reviewer upheld the initial decision and authorized 12 hours per day 5 days per week Monday through Friday and 8 hours per day Saturday and Sunday for the 60 day certification period at issue.

A hearing request was received by KePRO on March 23, 2007. As the request for Fair Hearing was submitted within the 10 day time frame from the date of the Reconsideration letter, administrative approval of 72 hours for the certification period for a total of 720 hours was approved for the certification period.

The petitioner's parents do not agree with the decision by KePRO. At the hearing, the mother stated that her daughter weighed approximately 51 pounds. The mother indicated that both parents have medical issues which limit their ability to lift any significant weight. The father had recent quadruple heart bypass surgery in November 2006 and has continuing coronary disease. She has four herniated cervical discs with degenerative arthritis in her back and neck. The mother presented correspondence from her physician stating that "she is medically prohibited from lifting anything over twenty pounds. The father has severe coronary artery disease with recent bypass graft and multiple complications including diabetes and intermittent heart failure. He is prohibited from strenuous physical activities" (Petitioner's composite exhibit 1).

The mother is concerned with the petitioner's medical needs and their medical limitations which impact their ability to lift or move the petitioner should an emergency occur. Currently, the parent administers medication to the petitioner which allows her to sleep through the night. The petitioner's representative indicated the nursing hours on

Saturday and Sunday are 9 a.m. to 9 p.m. "This gets her through her developmental day with constant support. The time at night without a nurse from 9 p.m. until the petitioner goes to sleep for the evening is manageable" for the caregivers (Petitioner's Composite Exhibit 1). The mother is concerned that she will not be able to assist the petitioner if she is in crisis. The primary caregiver is also concerned that her husband cannot help her when he is called away on his job.

CONCLUSIONS OF LAW

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

Florida Statutes § 409.919 Rules (2006) states:

> The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906, as they relate to these responsibilities, and any other provisions related to responsibility for the determination of Medicaid eligibility.

Florida Statute 409.905 addresses Mandatory Medicaid services with section (4) informing that Home Health Care Services can be covered. Under subsection (b) the following information is relevant:

> The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services...The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep and care for other family dependents...

It is concluded that the agency needed to review need for nursing service.

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

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

The Home Health Services Coverage and Limitations Handbook defines private duty nursing (at page 2-15):

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.

The Home Health Services Coverage and Limitations Handbook , Chapter 2, p.2-16, states in part:

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 that 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 Home Health Services Coverage and Limitations Handbook , Chapter 2, p.2-16, states in part:

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

The Home Health Services Coverage and Limitations Handbook provide that for private duty nursing, prior authorization must be received (at page 2-17):

> **Service Authorization:** All private duty nursing services must be prior authorized by a Medicaid service authorization nurse prior to the delivery of services.

In accordance with the provider manual (CMS 1500) prior authorization requests must be submitted by the provider (at 2-2):

> **Who Submits the Request** The request for prior authorization must be submitted by the provider who plans to furnish a service, except for out-of-state prior authorization.

As a result of the reduction in private duty nursing services paid for by Medicaid, the petitioner, through her representatives, appeal this action, asserting that 12 hours per day, seven days per week of private duty nursing services are necessary. In weighing the evidence, the following conclusion is reached by the undersigned: AHCA presented evidence from the pediatric physician consultant of the number of hours deemed medically necessary. This is a medical expert who routinely determines medical necessity for Medicaid services. The physician's statement submitted by the petitioner did not show that the petitioner's condition would deteriorate as a result of the current plan. The petitioner's physician does not routinely determine medical necessity for Medicaid services and is not as familiar with the term as used in the governing authorities, therefore, greater weight was given to the agency's expert witness.

In addition, the agency's Registered Nurse Specialist and two Board Certified Pediatric physicians who are considered medical experts, determined that the reduction

of private duty nursing care is appropriate for the petitioner. The decision was based upon a review of the petitioner's clinical medical state and the needs of the family. The respondent acknowledges that the petitioner is medically complex. However, according to the above authorities, 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. In addition, according to the above authorities, private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care.

The representative's statement that she and her husband have medical issues that make it difficult for the family to provide for the child's care was considered. The mother stated that the hours she worked and the petitioner's father needed to be on call, required 12 hours seven days per week PDN. The mother indicated that she provides the remaining 12 hours care per day/ seven days per week. The evidence sets forth that the parents provide care 12 hours per day, seven days per week.

According to the above authorities, the agency is the final arbiter of medical necessity. In making the determination of medical necessity, the agency followed its procedure to have a professional registered nurse practitioners and the opinion of a physician as the reviewing physician. Such determination was based upon the information available at the time the goods or services were provided.

The petitioner's caretakers, who are her parents, play an important role and according to the above authorities, their involvement is strongly encouraged in taking care of her. The evidence submitted indicated that the caretakers have been providing care for the petitioner when private duty nurses were unavailable 12 hours per day, seven days per week. In addition, the evidence indicated that the mother has been able to provide for the petitioner's care during times when the father was called away. After careful consideration, it is determined that the action to reduce the private duty nursing hours from 720 to 648 hours or from 12 hours per day, seven days per week to 12 hours per day, Monday through Friday and 8 hours per day on Saturday and Sunday, is in accordance with the above authorities.

The evidence did not support a greater amount of nursing hours under the circumstances. Continuing the additional hours would help to achieve parental relief on a daily basis, but the additional hours cannot accurately be described as medically necessary. Based on the above cited authorities, the respondent's action to deny 72 hours of private duty nursing for the period of March 10, 2007 to May 8, 2007 was within the rules of the Program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20th day of June, 2007,

in Tallahassee, Florida.

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

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

APPEAL NO. 07F-02154

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on May 2, 2007, at 11:15 a.m., in Tampa, Florida. The petitioner was not present, but was represented by his grand-mother, ... also testified. The respondent was represented by Betty Williams, behavioral health specialist with the Agency For Health Care Administration (AHCA). Ms. Wiiliams also testified. The petitioner's case manager with ... , appeared as a witness. director of clinical operations with , also appeared as a witness.

The petitioner's witnesses from appeared by telephone. These witnesses are clinical case manager;

therapist; psychiatrist; , contact teacher; unit manager.

The respondent witnesses from also appeared by telephone. These witnesses are , supervisor of behavioral case managers; child psychiatrist and consultant; registered nurse and behavioral case manager. , notary, administered the oath to and

ISSUE

At issue is the respondent's decision of February 26, 2007 to terminate approval of the petitioner's inpatient psychiatric hospitalization services under a Medicaid Waiver Program at effective March 30, 2007. The petitioner wants to remain at

FINDINGS OF FACT

1. The fifteen year-old petitioner resides at since July 31, 2006. is a provider of the Statewide Inpatient Psychiatric Program (SIPP). The petitioner receives mental health treatment and case management planning services at under SIPP.
2. The petitioner was admitted to from his grand-mother's care in the community. In the original case management plan, the petitioner was to be discharged back to his grandmother's care upon successful treatment. However, the petitioner is not ready to be discharged to his grandmother's care

due to continued aggressive inappropriate behaviors, per agreed expert testimony. The petitioner also is not ready to be transferred to a less intensive level of treatment in a group home.

3. The petitioner's symptoms at the time of admission to , have stabilized. However, the treatment at ..., has not improved the petitioner's chronic behaviors, nor is future improvement expected. The respondent's contracted reviewer, First Health Services of Florida, terminated inpatient hospitalization under the SIPP effective March 30, 2007, because behaviors are not expected to improve via treatment at

4. The petitioner needs another plan of care or treatment approach at a different, perhaps more structured SIPP facility, than what has given, per expert testimony. The parties discussed the possibility of the petitioner's placement at another SIPP facility. However, there was no SIPP facility transfer location established as of the hearing date.

CONCLUSIONS OF LAW

The Florida Administrative Code 65A 1-702(16) defines services under the SIPP Medicaid Waiver Program, in relevant part as follows:

> (16) Statewide Inpatient Psychiatric Program (SIPP) waiver. This program provides inpatient mental health treatment and comprehensive case management planning to enable discharge to

> less restrictive settings in the community for children under the age of 18 who are placed in an inpatient psychiatric program.

The Code of Federal Regulations at 42 C. F. R. 441.152, Inpatient Psychiatric Services, sets forth the determination of need for inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs, in part as follows:

> Certification of need for services.
>
> (a) A team specified in Sec. 441.154 must certify that—
> (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

The Florida Administrative Code Rule 59G-1.010(166) addresses relevant definitions within the Medicaid Program, which apply to this specific Medicaid Waiver decision of continued residential treatment under the SIPP. Services provided under SIPP must be defined as "medically necessary." Subsection (166) of the Florida Administrative Code Rule defines "medically necessary" care, goods or services, as follows:

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

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

Paragraph 2. of the above-cited Administrative Code Rule shows that goods or services must be consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the individual's needs. Paragraph 4. of the F.A.C. Rule shows that needed goods or service must be provided in an effective, but least costly manner. The Findings of Fact show that the petitioner's continued treatment at , is not expected to improve continuing chronic problem behaviors. Therefore, continued services under the SIPP at are not effective to improve such behaviors. Since these continued services are no longer effective, the services do not meet medical necessity criteria set forth in Paragraphs 2 and 4.

Findings show that the respondent, through its contracted entit , terminated continuing SIPP services provided by because continued treatment is not expected to improve the petitioner's problem behaviors. The above-cited Code of Federal Regulations 42 C. F. R. 441.152 and the medical necessity criteria defined in Florida Administrative Code Rule 59G-1.010(166) show that continued SIPP treatment must be expected to improve the petitioner's condition as a pre-requisite to continued authorization. Since the present SIPP treatment at is not expected to

improve the petitioner's conditions, the respondent is correct to terminate authorization for SIPP services.

Findings show that the petitioner might benefit from other SIPP services, perhaps at a more structured SIPP facility, since he is not ready to be transferred to less intensive levels of treatment at a group home or his grand-mother's residence in the community. The parties explored the possibility of this type of transfer during the hearing, though such possible location was not then established. This hearing authority's jurisdiction is limited to review the merit of the respondent's specific termination action at issue, and does not encompass review of the merits of a possible transfer or discharge location, as per the following Florida Administrative Code Rule:

> 65-2.056. Basis of Hearings.
> The Hearing shall include consideration of:
> (3) The Hearing Officer shall determine whether the action by the agency was correct at the time the action was taken.

Even though this hearing authority's jurisdiction is limited to a review of the specific termination action at issue, the parties are encouraged to continue to explore alternative placement at another appropriate SIPP facility.

DECISION

This appeal is denied in that the respondent's action to terminate SIPP services under the Medicaid Program is a correct action. However, the parties are encouraged to continue to explore the possibility of the petitioner's alternative placement at another appropriate SIPP facility.

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 June, 2007,

in Tallahassee, Florida.

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

Copies Furnished T

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

APPEAL NO. 07F-02279

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
DISTRICT: 12 Volusia

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 1:37 p.m. on May 11, 2007. The petitioner was not present but was represented by her mother, . The respondent was represented by Gwen Mathis, registered nurse specialist.

ISSUE

At issue was whether or not skilled nursing services could be provided at a Prescribed Pediatric Extended Care (PPEC) services setting rather than at home for four full days per week. The burden of proof is upon the agency.

FINDINGS OF FACT

1. The petitioner was born prematurely on ; twenty-seven weeks gestation. She received skilled nursing hospital services until late February 2007. She was discharged with nursing service. Eligibility for Medicaid is undisputed.

2. When she was initially discharged, her treating doctor recommended PPEC services for up to "5 full days/week x 6 months" as shown in Respondent's Exhibit 3. She did not eat well by mouth, had a G-tube for feeding and had some respiratory distress. She also had an apnea monitor and oxygen.

3. Following hospital discharge, the petitioner was rehospitalized for about a week (Petitioner's Exhibit 1) starting March 5, 2007.

4. Her mother works Tuesdays through Saturdays and PPEC is not available on the weekend. Therefore, the respondent planned to authorize one day per week for private duty nursing. AHCA concluded that adequate nursing services for the other days could be achieved under PPEC. Notification and review occurred during March 2007 (Respondent's Exhibit 1, 2, 4 and 5). Dates of service authorization were planned as February 26 through August 26, 2007.

CONCLUSIONS OF LAW

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

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.

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 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 fragile or technologically dependent;
- 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
...Medicaid has the right to deny more costly services such as private duty nursing ordered by an attending physician when PPEC services are medically appropriate for the child.

Under appropriate statute and administrative authorities, AHCA is charged with determining whether medical necessity has been adequately established and AHCA must assess whether the Medicaid reimbursement criteria have been met. While the mother argued that medical necessity standards would best be met in the family home with one-on-one nursing available as it had been, substantive evidence did not support such a contention. Moreover, the attending physician specifically authorized PPEC services rather than private duty nursing service at home. Evidence supported the determination made by the agency to achieve less costly but effective and less restrictive prescribed care.

Based upon the evidence it is concluded that the respondent's plan to authorize skilled nursing services at a PPEC for four days a week, with one day of private duty nursing due to unavailability of PPEC, is a reasonable determination. Thus, it is concluded the agency action has been justified.

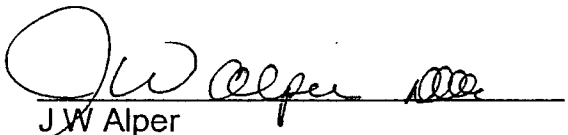
DECISION

The appeal is denied and the agency action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of June 2007, in Tallahassee, Florida.



J W Alper
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. 07F-01134

PETITIONER,

Vs.

CASE NO. 1243578963

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 15 St. Lucie
UNIT: 88508

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on April 25, 2007, at 9:55 a.m., in Fort Pierce, Florida. The petitioner was not present. Her daughter, represented her. Erika Delgado, economic specialist supervisor, represented the Department.

The petitioner requested and received a continuance for a prior scheduled hearing.

ISSUE

At issue is whether the Department completed a Medicaid determination for May and June 2006 from the petitioner's May 24, 2006 application. The petitioner holds the burden.

FINDINGS OF FACT

On May 24, 2006, the Department received a web application requesting Medicaid benefits and nursing home care for the petitioner according to The Common Application Form and Eligibility Questionnaire (Respondent's Exhibit 3). The petitioner's representative does not recall asking for nursing home care at the time of application because her mother was in the hospital, not a nursing home at that time.

The petitioner's date of birth is : . On May 9, 2006, she had a medical emergency and required emergency surgery for an infracted small intestine and obstructing distal colon mass (Petitioner's Exhibit 1). The petitioner was in the hospital from May 9, 2006 to May 30, 2006. She returned to the hospital on May 31, 2006 and placed in a nursing home on July 3, 2006. She stayed in the nursing facility for one week. She returned to the hospital on July 15, 2006 and went to live with her daughter on July 23, 2006 upon her discharge. She is seeking Medicaid benefits to cover her hospital stays beginning in May 2006.

On March 21, 2007, the petitioner had reconstructive surgery to reverse the colostomy, and now alleges new conditions. She needs rehabilitation and physical therapy.

At the time of the petitioner's application, she had not yet reached her 65th birthday. Because of her age, not having any children under the age of 18 years old, and because she was not pregnant, she did not meet the technical requirements to receive Medicaid benefits without a disability determination

The Department gathered information and submitted it to the District Medical Review Team (DMRT) for review. On November 15, 2006, the DMRT returned a

decision indicating the petitioner did not meet the program criteria. The reason cited is Code 34, which means the impairment will not last 12 months. In order to qualify for nursing home care, an individual must meet a level of care and be determined disabled if under 65 years of age. The petitioner met the level of care on July 3, 2006 (Respondent's Composite Exhibit 2).

The Department issued Notices of Case Action for Institutional Care Program and Medicaid denials for the months of July 2006 through December 2006. The issue date of the notices is November 21, 2006 (Respondent's Exhibit 1). The Department's representative asserts the Department determined eligibility for nursing home coverage. There is no indication that the Department determined Medicaid eligibility for May and June 2006.

The petitioner applied for Social Security benefits in July 2006 based on the contention that she is disabled. Social Security denied disability benefits in November 2006 and the petitioner is appealing the decision. There is no evidence of what months Social Security denied in its decision or what impairment it considered.

CONCLUSIONS OF LAW

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

> The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental

impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy...

The Code of Federal Regulations at 42 C.F.R. § 435.541 in part state:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability... (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility...(b) Effect of SSA determinations. (1)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA... (c) *Determination made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and... (i) Alleges a disability condition different from, or in addition to, that considered by SSA in making its determination; (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and--

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

The Department's Integrated Public Assistance Policy Manual defines the time standards in which an application must be processed and states at passage 0640.0400

APPLICATION TIME STANDARDS (MSSI, SFP):

> The time standard begins upon receipt of a signed application. Process applications and determine eligibility or ineligibility within the following time frames:
> 1. 45 calendar days after the date of the application (without a disability determination), or
> 2. **90 calendar days after the date of the application for individuals who claim a disability.**

The Findings of Fact show the petitioner applied for Medicaid benefits on May 24, 2006. There is no evidence that the Department determined any Medicaid eligibility prior to July 2006. The petitioner is still seeking Medicaid benefits effective May 2006. The above-cited passage from the Department's manual shows applications for disability must be completed within 90 days from the date of application. The Department has exceeded that processing time standard.

The hearing officer concludes that in the absence of a receipt of a Notice of Case Action for Medicaid benefits for May and June 2006, the months at issue are still in a pending status. The notices concerning nursing home care also include Medicaid eligibility, but the notices are effective July 2006. The petitioner only resided in a nursing facility for a week. The petitioner argues that she was seeking regular or community Medicaid effective May, the month of application, since she was in the hospital in May, June, and part of July 2006.

The record is devoid of any information that would allow the hearing officer to make a decision concerning the petitioner's allegation of disability. The record also lacks any information the Social Security Administration considered in rendering a decision of not disabled.

The appeal is remanded to the Department to determine Medicaid eligibility for May and June 2006. The Department is to then issue a notice of the determination, to include appeal rights. If Social Security made a decision that includes the months of May and June 2006, the Department must consider that decision and follow established policy.

DECISION

The appeal is granted and remanded to the Department for an eligibility determination for May and June 2006. The Department is to begin this determination within 10 days of receipt of this order to prevent any further delay in processing.

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 12th day of June, 2007, in Tallahassee, Florida.

Margaret Poplin

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

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

APPEAL NO. 07F-1673

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 29, 2007, at 1:35 p.m., in Miami, Florida. The petitioner, appeared telephonically at her request. The agency was represented by Mara Perez, program specialist and Marian Browne, physical therapist both with the Agency for Health Care Administration (AHCA). The hearing was originally scheduled for May 2, 2007, but was continued at the request of the petitioner.

ISSUE

At issue is the agency's February 12, 2007 denial, of an initial prior authorization request for a Merits Heavy-Duty Power Wheelchair for the petitioner. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is forty-nine years old (date of birth June 6, 1957) and a Medicaid recipient. The petitioner has multiple medical conditions and has been diagnosed with diabetes and is morbidly obese.

On January 11, 2007, the agency received a prior authorization request from the Durable Medical Equipment provider (DME) to Medicaid for a heavy duty power wheelchair. Along with the request, was an evaluation that was performed on December 15, 2006 by a licensed physical therapist.

On January 31, 2007, a review of the documentation submitted on behalf of the petitioner was initiated. According to documentation provided by the physical therapist, the petitioner is able to "ambulate 300-500 feet with a gait aid." It also documents that the petitioner needs the power wheelchair because, "lacks the ability to go grocery shopping, or any kind of shopping, due to her inability to walk more than 500 feet."

The agency states that the primary purpose of Medicaid funding for power mobility, is to accomplish basic activities of daily living (ADL) within the home. In the petitioner's case, the physical therapist through the evaluation completed, documents that the petitioner does ambulate within the home. Therefore, the criteria on medical necessity had not been met and on February 12, 2007 the request was denied.

CONCLUSIONS OF LAW

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

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

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

(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

The Fla. Admin. Code Rule section 59G-4.070 states in part:

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

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

The Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, dated April 2001, page 2-57, states in part:

> *Customized Wheelchair Documentation*-Medicaid may reimburse for a customized wheelchair that is specially constructed (K0008, K0013, K0014). Prior authorization is required.
> Medicaid will not approve a customized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established.
>
> For a customized wheelchair, the following information must be submitted with the prior authorization request:
>
> - medical necessity;
> - written documentation describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive abilities, coordination, and activity limitations;
> - wheelchair evaluations performed by either a registered physical or occupational therapist or a certified physiatrist;
> - what physical improvement(s) can be anticipated;
> - what physical deterioration can be prevented;
> - a list of each customized feature required for unique physical status;
> - specify the medical benefit of each customized feature; ...

The petitioner states that she would like to be independent but because of her obesity, is unable to. She wants to go out into the community, as she feels confined being at home. The petitioner states that washing dishes is difficult and she can walk about 100 feet or less and is able to stand for about five minutes. The petitioner states that she is unable to push a manual wheelchair as she gets out of breath. She feels that the physical therapist completed the evaluation, the best he could.

The Findings of Fact show that the petitioner requested through the prior service authorization, that Medicaid pay for a heavy duty power wheelchair. In order to approve the request, the petitioner must demonstrate medical necessity. In this case, the

petitioner is with difficulties, performing her activities of daily living and is able to ambulate within the home. The petitioner's desire to go out into the community is understandable, but would still require assistance in order to do so. The hearing officer concludes that the petitioner did not demonstrate medical necessity for the requested heavy duty power wheelchair and therefore, the agency's denial is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 12th day of June, 2007,

in Tallahassee, Florida.

A. G. Ramos
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. 07F-0859

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 April 19, 2007, at 9:05 a.m., in Miami, Florida. The petitioner, , was present and was represented by attorney. Representing the agency telephonically was Brevin Brown, attorney for the Agency for Health Care Administration (AHCA). Present, on behalf of the agency was Oscar Quintero, program specialist with AHCA. Appearing telephonically, as witnesses for the agency, was Dr. Marcelino Oliva, MD, acting medical director with KēPRO South; Dr. Heidi Flynt, obstetrics/gynecology consultant with KēPRO; Diane Weller, RN, KēPRO contract manager; Teresa Ashey, KēPRO operations review supervisor; and George Smith, KēPRO review specialist. Hector Gutierrez served as translator. The hearing was previously scheduled for March 7, 2007 and April 4, 2007, but was continued at the request of both parties.

ISSUE

The petitioner is appealing the January 5, 2007 denial of a prior authorization request for two-days (01/05/07 through 01/07/07), inpatient hospital medical services. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is forty-five years old and a Medicaid beneficiary in the state of Florida. The petitioner has been diagnosed with "uterine fibroids and chronic pelvic pain." The petitioner had a previous hearing (appeal 06F-7796) that was denied, on the same issue, with different dates and a different physician provider.

On December 16, 2006, a prior authorization request was received for the petitioner, from the provider , of a pending "Total Abdominal Hysterectomy with possible Bilateral Salpingo Oophorectomy" procedure, with inpatient hospitalization for two-days. The procedure would be scheduled for January 5, 2007.

The request was reviewed by Keystone Peer Review Organization (KēPRO), an organization under contract with AHCA to perform medical reviews of Medicaid prior authorization requests, for the Inpatient Hospital Medical Services Program for Medicaid beneficiaries in the state of Florida. This review is only for determining medical necessity, under the terms of the Florida Medicaid Program and is based on information submitted to KēPRO.

The provider submitted to KēPRO the following information: "Presenting Signs and Symptoms/Treatment Plan: Severe pelvic pain, pelvic severely tender. Uterus irregular (12 weeks) left adnexal tender and fullness. Prior Treatment: N/A. Status:

Premenopause. Childbearing: Not desired future childbearing. Conservative Surgery: Left Blank. Symptoms: Left Blank. History: Gravadia G:1 PARA: P1. Physical Exam: Uterus: 12 Weeks size irregular. Diagnostic Evaluations: Left Blank. Abnormal Findings: LABS: Urinalysis 12/07/06 all negative. IMAGING: Ultrasound on 11/20/06 multiple fibroids."

The initial screening completed by a registered nurse reviewer, using the InterQual® criteria (procedures criteria used by the first level reviewer) determined that the information provided did not meet the criteria to determine necessity for acute inpatient care.

The request was then reviewed by a board certified physician consultant, which denied the request stating: "Therefore is little info (information) presented and not enough info to meet AHCA/Medicaid criteria for hysterectomy. All that is presented is that the pt (patient) has pain and fibroids. Need a more detailed history with more information on the pt's symptoms, need the U/S (Ultrasound) report with the uterine dimensions, number and size of fibroids. Need to know what conservative medical management has been tried; such as progestins or continuous or extended cycling OCPs (Oral Contraceptive Pills). [Need to know] What are [the] results of endometrial sampling? Pain is generally not a primary symptom of a 12 weeks uterus, rather it is generally bleeding. What else has been done to evaluate the pain? Has pt ever been scoped? Is there a possibility she has endo (endometriosis)? Adhesions? Has she been anemic? All days denied."

On December 28, 2006, a reconsideration request was received from the petitioner's physician along with the following information: "Presenting Signs and

Symptoms: Reconsideration DX: 218.9 Leiomyoma of Uterus, unspecified, SX: 58150-Total Abdominal Hysterectomy (Corpus and Cervix), with or without removal of Tube(s), Severe!!! Pelvic Pain not Responding to medical treatment, Multiple Uterine Fibroids-Adenoyosis, Abnormal Pap Smear, Cone Biopsy, Pain Meds-Ibuprofen, Patient has been on Medical Treatment for Several Months without Relief. Abnormal Findings: Labs: Pap Smear Abnormal (ASCUS), Pelvic Ultrasound, Multiple Uterine Fibroids, Adenoysis."

The information was reviewed by a different physician consultant, who upheld the denial and stated the following: "...The previous reviewer requested specifics on the ultrasound such as the size of the uterus and fibroids and what specific medical therapy has been tried. Those still were not answered and no mention of symptoms other than pain which is generally not a/w (associated with) fibroids. Adonomyosis cannot be diagnosed on ultrasound and the symptom of this is generally dysmonorhea and menorrhagia which are not mentioned. There is also now an ASCUS pap reported with no info on the follow-up (Colpo). Denied due to the above lack of info."

On January 5, 2007, additional information was received from the physician provider, "Severe pelvic pain-on 'disability' due to pain with inability to work-dyspareunia. U/S shows multiple fibroids 2cm in size. No progestins or OCP's as no menorrhagia and will not help pain. Ibuprofen and Percocet however side effects from Percocet causing other problems such as constipation. Initial abnormal PAP done in 8/06 and repeat PAP showed ASCUS. Cone biopsy of cervix showed chronic cervicitis. Colposcopy not done as plan removal of cervix with procedure."

The information was reviewed by a third physician consultant as a re-reconsideration and the denial was upheld, with the following determination: "44 yo (year old) G1P1 (Gravida1, Para1) 12 wk size uterus. Pain. Percocet had GI (side effects). Did pt have laparascopy done yet. I am not sure that fibroids are the cause of the pain." Nurse reviewer contacted the provider's office and requested information to clarify discrepancies in information and response to last reviewing physician's concerns. No response was received and a denial was issued to the petitioner and the provider notified. The provider had not demonstrated medical necessity for the inpatient admission for medical services, for the requested two-days from January 5, 2007 through January 7, 2007.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

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

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

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

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

The petitioner states that she continues to have constant pain and nothing that has been done to take the pain away. She continues with abnormal bleeding and it's affecting her activities of daily living. The petitioner feels that information submitted from previous prior authorization requests, should be made available to the current reviewers. The petitioner argues that she cannot control what the physician submits and is willing to sign an authorization for her medical records. She disagrees with the process utilized in which past medical information is not shared.

At the hearing, the petitioner provided some medical documentation from doctors visits (4/2004, 6/2004, 10/2006, 11/2006); abdominal and pelvic ultrasound results (7/2006); lab test results (7/2006, 8/2006); doctor's prescriptions (7/2006, 11/2006) with diagnosis; hospital admission history (7/2006), operative report (8/2006); physician statement form (9/2006); surgical orders (10/2006); temporary disability certificate(11/2006); and report of radiologic consultation (1/5/2007).

Testimony and evidence shows that the agency received limited past medical information on the petitioner. Attempts were made in order to secure sufficient documentation, demonstrating medical necessity for the petitioner. The review of the request is conducted individually and past requests are not accessed. In this case, some of the prior doctor's information was in conflict with the current doctor's information.

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 final decision to deny the prior authorization request on January 5, 2007 due to insufficient documentation on medical necessity was correct. However, given the new medical information provided

during the hearing and the physician consultant's response to hearing the information during the hearing, stating that the petitioner "probably does meet medical necessity criteria" the case is being remanded to the agency for further consideration of the new medical information.

DECISION

The appeal is remanded to the agency for further consideration of new medical information provided.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11th day of June 2007,

in Tallahassee, Florida.

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

Copies Furnished To:

11

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

APPEAL NO. 07F-02301

PETITIONER,

Vs.

CASE NO. 1108924301

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES (DCF)
DISTRICT: 07 Orange
UNIT: 66292

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Orlando, Florida, at 11:15 a.m. on May 14, 2007. The petitioner represented herself and the respondent was represented by Reginald Schofield, ACCESS supervisor for the adult payment unit.

ISSUE

At issue was whether or not patient responsibility was determined correctly as related to life insurance premium.

FINDINGS OF FACT

1. The petitioner receives Institutional Care Program (ICP) benefits under the SSI (Supplemental Security Income) – Related Medicaid Program. Her patient responsibility is $546 effective January 1, 2007 (Respondent's Exhibit 1).

2. The respondent determined patient responsibility based on gross income minus a $35 personal need allowance. The respondent gave no further deduction for the cost of the petitioner's life insurance premium.

CONCLUSIONS OF LAW

The facts are not disputed. The petitioner would prefer recognition of her life insurance premium so that her patient responsibility would be less and she could better afford her insurance premium. The respondent declared that uncovered medical expenses could be deducted from one's income, but life insurance premiums were not such a deductible expense and could not be deducted. The respondent declared that Fla. Integrated Pub. Policy Manual 165-22 passage 2640.0125.01 was used.

Fla. Admin. Code 65A-1.7141 addresses **SSI-Related Medicaid Post Eligibility Treatment of Income** and establishes at (1)(a) the "$35...personal need allowance..." At subsection (1)(g) the rule further "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..." The list of such expenses includes a provision that the expense be "medically necessary..." The state rule refers to 42 C.F.R. § 435.725 where the list is confirmed and at subsection (c)(1) the *Personal needs allowance* requirement is set as "at least...$30 a month..." Thus, it can be seen that the Florida personal need allowance is greater than what is required at federal level. Additionally, however, no deduction is permitted for the cost of life insurance.

Federal regulation 20 C.F.R. § 416.1103 further addresses **What is not income?** and informs at subsection (a) that "*Medical care and services*...are not income if they are...(6) Direct payment of your medical insurance premiums by anyone

on your behalf..." Life insurance premiums are not medical insurance and there is no federal or state authority which permits a deduction for life insurance expenses. Thus, it must be concluded the respondent correctly omitted such an expense from the ICP budget. While the petitioner's financial predicament is evident, there is no regulatory remedy for the problem at hand.

DECISION

The appeal is denied and the agency 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 19th day of June, 2007, in Tallahassee, Florida.

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

Copies Furnished To:

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

APPEAL NO. 07N-00072

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 23, 2007 at 3:25 p.m. in the nursing facility. The petitioner was not present but was represented by guardians of her property and personal affairs and (who is also daughter of the petitioner), respectively. Present on her behalf were , hospice resource specialist; , hospice social worker; and State Guardianship Association. The respondent was represented by administrator, with testimony from , financial director.

ISSUE

At issue was whether or not notice of intent to discharge was correct due to nonpayment following reasonable and appropriate notice to pay. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner has resided at the nursing facility since at least summer 2006, due to ill health and need for nursing care. Initially, payment for care was through a Health Maintenance Organization. Hospice became involved on July 21, 2006.

2. The petitioner filed a Medicaid application with Department of Children and Families (DCF). Medicaid approval was anticipated but did not occur. DCF denied the Institutional Care Program (ICP) application. The petitioner filed a Medicaid ICP appeal and it is currently pending with DCF.

3. On March 10, 2007, hospice ended and on March 11, 2007, private pay status began. Rate was $170.00 per day and the guardian of property was informed. The facility required customary payment in advance. Medicaid "pending" status was fiscally unacceptable to the facility and staff was unsure Medicaid approval would occur. The private pay status resulted in a March 2007 charge of $3570, shown on Billing Activity record and Statement of Account (Respondent's Exhibits 2 and 3, respectively). The Statement of Account also showed a semiprivate room charge of $5100 was expected in advance, for the month of April 2007. There were a few additional charges such as continence care items and March 31, 2007 Statement of Account showed the "Amount Now Due..." as $8,711.60.

4. Facility staff determined there was neither sufficient payment nor payment guarantee. They issued notice and clarification of intent to discharge on March 16, 2007 with discharge planned for April 15, 2007 (Respondent's Exhibit 1). A timely appeal was filed and the petitioner has remained at the facility.

5. Agency for Health Care Administration (AHCA) conducted a survey at direction of the undersigned. AHCA did not find a violation. Survey results are Hearing Officer Exhibit 1 and were shared with the parties.

6. The petitioner's expenses continued at $170 per day. Payments of $947.20, $947.20 and $598.80 occurred on or about May 3, 2007. These did not satisfy facility staff and intent to discharge remained. Balance was $11,844.87 for care through May 2007. Medicaid eligibility was not approved.

7. The petitioner used her Social Security checks toward payment of her nursing facility charges. These payments did not mitigate the facility's intent to discharge.

CONCLUSIONS OF LAW

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

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
> ...
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...
> ...
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
> ...

> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State;
> (v) The name, address and telephone number of the State long term care ombudsman;
> ...

Findings of fact show the facility issued billing statements and notified proper parties of charges. While recognizing that some payments have occurred, and personal income of the petitioner was used toward bill payment, facility staff does not wish to continue providing care under current financial circumstances. There is no regulation that would require a facility to retain a resident under such circumstances.

Difficulties achieving Medicaid coverage as well as obstacles encountered by the petitioner do not provide remedy for the problem at hand. Based upon findings, it must be concluded that sufficient payment simply has not occurred. Under regulations, adequate payment for continuing stay at a nursing facility is required. It is concluded that reasonable and appropriate notice to pay was followed by insufficient payment for services rendered. Despite the unfortunate circumstances and the understandable desire to remain where she is, discharge has been justified under regulatory requirements, so long as discharge proceeds to a safe location following proper guidelines.

DECISION

The appeal is denied. Intent to discharge is upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is

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

DONE and ORDERED this 6th day of June, 2007, in Tallahassee, Florida.

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

Copies Furnished Tc

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ɪministration

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

APPEAL NO. 07N-00040

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 4, 2007, at 3:45 p.m., at , in North Miami, Florida. The petitioner was not present, but was represented at the hearing by her daughter, . Also present on behalf of the petitioner was ombudsman. The respondent was represented at the hearing by administrator, . Also present on behalf of the facility was , fiscal service manager. A continuance was granted on behalf of the petitioner for a hearing previously scheduled on April 23, 2007.

ISSUE

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

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

FINDINGS OF FACT

The facility provided this hearing officer on March 7, 2007, a notice the petitioner on or about January 27, 2007 was to be discharged by March 1, 2007. The discharge location that was given was: " " The petitioner does not currently reside at the , but another nursing home.

The above reference notice was not provided to the petitioner or her representative prior to this hearing. The petitioner's treating physician had discharged the petitioner to the hospital approximately on January 29, 2007, based on an acute medical problem. The petitioner's representative was advised by the facility at about that time that the petitioner was not going to be allowed back at the facility, as there was an outstanding nursing home bill.

Based on the above, the petitioner's representative had the petitioner admitted to another nursing home.

The petitioner was approved for ICP benefits in January 2007 by the Department of Children and Families and incurred a patient responsibility. Part of the patient responsibility apparently was not paid to the facility, thus an overdue bill.

The respondent; after listening to the petitioner's representatives arguments; offered or stipulated that the facility is willing to take the petitioner back as a patient if the petitioner's representatives are willing to settle the outstanding facility bill of about $2,500. The petitioner's representatives did not agree with this offer or "stipulation".

CONCLUSIONS OF LAW

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

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

This regulation continues and states in part:

> (4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident... (6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following:...(iii) The location to which the resident is transferred or discharged...
>
> (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.
>
> (ii) Notice may be made as soon as practicable before transfer or discharge when-
>
> (A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;
>
> (B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;
>
> (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;
>
> (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or

As shown in the Findings of Fact, the facility discharged the petitioner on or about January 29, 2007 to the hospital. The facility provided a notice of the discharge to this

hearing officer on March 7, 2007 that the petitioner was to be discharged by March 1, 2007 to: " ." The petitioner's representative was not provided a copy of the above notice until the hearing. The petitioner's representative was verbally told of the petitioner's discharge approximately around the date of the discharge. The discharge reason is: "Your bill for services at the facility has not been paid after reasonable and appropriate notice to pay...". The petitioner's representative had placed the petitioner in another nursing facility based on being told that the petitioner would not be allowed back at the facility.

The respondent had argued that the facility had been advising the petitioner's representative that the facility bill at the facility for the petitioner was outstanding and overdue. The respondent argued that they understood that the petitioner's representative did not want to pay the overdue bill and that the petitioner's representative did not want the petitioner returned to the facility. The respondent also argued and stipulated that the petitioner can return to the facility if the outstanding bill is paid to the facility.

The petitioner's representative argued that the facility had not correctly followed the pertinent federal regulation regarding the notice and discharge. The petitioner's representative argued that she was not aware that the petitioner's bill was outstanding. She also argued that she may want her mother back at the facility. She argued that she wanted the hearing officer to make a decision for this case and that she did not accept the facility's offer or stipulation. The hearing officer agrees with the petitioner's representatives first argument noted above.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the facility's action to

discharge the petitioner is not appropriate as the notice of discharge was not in compliance with the above noted federal regulation. The facility has not met its burden of proof and is not in compliance with the appropriate federal regulation noted above for the discharge of January 29, 2007 or the discharge as noted on the supplied notice of discharge. This decision does not act to alter or change any outstanding facility bill for the petitioner.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 1st day of June, 2007,

in Tallahassee, Florida.

Robert Akel

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

Copies Furnished T

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

APPEAL NO. 07N-00056

PETITIONER,

Vs.

CASE NO. 1254629203

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 24, 2007, at 9:05 a.m., in Plantation, Florida. The petitioner was not present. She was represented by her husband The respondent was represented by director of the facility. Also present from the facility was director of social services, Medicaid consultant, and business manager.

ISSUE

At issue is the action of March 2, 2007, to discharge the petitioner for not paying the cost of care in the facility. The respondent has the burden of proof.

FINDINGS OF FACT

As of the time of the hearing, the petitioner resided at the Center in Plantation, Florida. The petitioner was provided with a Nursing Facility Transfer and Discharge Notice, dated March 2, 2007, informing her that she would be discharged from the facility due to non-payment of care in the facility. This notice lists the location to which the petitioner is transferred or discharged to, and states the following, will arrange transfer to another facility of our choice". The petitioner has been in this facility since September 2006.

Included in the evidence is a copy of a Trust Agreement done by the petitioner's attorney, ... from November 27, 1987. This agreement was set up so that in the future, an income trust account would be set up for the petitioner. An income trust account is set up so that the individual's income can be diverted to qualify for the Institutional Care Medicaid Program.

Included in the evidence is a copy of a Notice Of Case Action form, dated March 16, 2007, stating that the petitioner was approved for Institutional Care Program Medicaid benefits effective December 2006. It states that the petitioner is obligated to pay $599.90 monthly to the facility. According to the respondent's representative at the hearing, the petitioner has not paid this or anything to the facility.

The petitioner has been provided with statements of how much she owes the facility. Included in the evidence is a copy of a statement requesting the petitioner to pay $8,647.30 by December 26, 2006. Included in the evidence are copies of statements showing that as of March 31, 2007, the balance due was $18,208.10, and as of May 1, 2007, the balance due was $18,808.00.

CONCLUSIONS OF LAW

The jurisdiction to conduct these hearings is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. These hearings differ from most hearings conducted by the Department's hearing staff, as the Department is not party to the proceedings. The matter is a private dispute between two parties and not a circumstance where the individual's substantial interest has been affected by the Department's action.

In accordance with the Federal Regulations at 42 C.F.R. § 483.12 (a):

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

The facility provided the petitioner with a transfer and discharge notice because she has not been paying for the cost of her care. According to a Department's notice dated March 16, 2007, she should be paying $599.90 monthly to the facility. According to the respondent's representative at the hearing, the petitioner has never paid this or anything to the facility.

The notice lists the location to which the petitioner is transferred or discharged to, and states that the _____ will arrange transfer to another facility of their choice. This is not in accordance with the cited regulation, which states that the notice should list the location to where the resident is transferred or discharged to, therefore it is determined that this notice is inadequate. After careful consideration, although it is agreed that the petitioner should pay what she is obligated to pay to the

facility, since the transfer and discharge notice is inadequate, it is determined that the action to discharge the petitioner is not upheld.

DECISION

This appeal is granted, and the action of March 2, 2007, to discharge the petitioner is not upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 1st day of June, 2007, in Tallahassee, Florida.

Stuart Imberman

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

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

APPEAL NO. 07N-00066

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 5, 2007, at 8:33 a.m., at the in St. Petersburg, Florida. The petitioner was not present. The petitioner was represented by her daughter, Present on behalf of the petitioner was the petitioner's grandson, , and ombudsman, The respondent was represented by , business office manager. Present on behalf of the respondent were social services director and , admissions director. , administrator, was observing.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of April 2, 2007 is in accordance with the requirements of 42 C.F.R. § 483.12(a):

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

FINDINGS OF FACT

The respondent gave the petitioner's representative a Nursing Home Transfer and Discharge Notice on April 2, 2007. The reason stated in the notice was "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".

1. The petitioner entered the facility on November 1, 2006. The petitioner receives Medicare through the WellCare HMO plan.

2. The petitioner has incurred expenses for her residence in the facility. The bill was not paid. The petitioner was notified on April 2, 2007 advising her of the facility's decision to discharge the petitioner on May 2, 2007. The basis of that discharge was that there had been lack of payment of her bill for services and after reasonable and appropriate notice.

3. The respondent stated that the current amount due is over $45,000. Evidence submitted was Medicare billing and correspondence regarding Medicare. The respondent stated that monthly bill's were mailed to the petitioner's representative at the representative's address. The respondent did

not provide copies of the monthly billing, proof of the monthly billing or proof of mailing to the petitioner.

4. The petitioner's representative stated that she has not received monthly bills. She was handed paperwork in April 2007 that indicated "Balance forward" and billing sent to Medicare. She disputes the amount of the current balance as stated by the respondent of over $45,000. She opined that Medicare should pay the first 100 days.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255 F.S. Matters that are considered at this type of hearing is the decision by the facility to discharge the patient. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. The hearing officer has not been conveyed jurisdiction for issues regarding payment by Medicare.

In this case, the petitioner was sent notice indicating that she would be discharged from the facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a):

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless...
> (v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

The respondent has the burden of proof. As the petitioner disputed receiving any monthly billing statements, the respondent would have the burden to prove that monthly billing statements were sent. The respondent did not

provide copies of the monthly billing, proof of the monthly billing or proof of mailing to the petitioner. The evidence did not demonstrate that the petitioner and her family were sent reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility. The facility has not met their burden of proof. Based upon the above cited authority, the hearing officer finds that the respondent's April 2, 2007 action to discharge the petitioner is not in accordance with federal regulations. As reasonable and appropriate notice has not been demonstrated, the respondent must permit the petitioner to remain in the facility and the respondent may not proceed with the discharge for the notice of April 2, 2007. This Final Order is solely for the discharge notice of April 2, 2007 and does not dismiss the debt or preclude the respondent from any further discharge action.

DECISION

This appeal is granted. Based on the notice of April 2, 2007, the respondent must permit the petitioner to remain in the facility and the respondent may not proceed with the 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 12th day of June, 2007,

in Tallahassee, Florida.

Linda Jo Nicholson
Hearing Officer
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h Care Admin

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

APPEAL NO. 07N-00085

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 6, 2007, at 8:24 a.m., at in St. Petersburg, Florida. The petitioner was not present. He was represented by his sister, Present on behalf of the petitioner was ombudsman. The respondent was represented by administrator, and director of nursing and risk management.

ISSUES

I. The representative requests the petitioner's return to the facility on the basis of the late receipt of written discharge notice, late notification to ombudsman or lack bed hold notice with the discharge notice.

II. The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge dated May 7, 2007 is in accordance with the requirements of Code of Federal Regulation at 42 C.F.R. § 483.12(a):

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

FINDINGS OF FACT

The respondent sent a notice to the petitioner's representative on May 7, 2007. The notice informed the representative that the petitioner was discharged from the facility. The reason stated in the notice was "The safety of other individuals in this facility is endangered."

1. The petitioner was admitted to the facility in December 2006. The petitioner had both medical and psychiatric problems.

2. The petitioner was discharged from the facility under Baker Act on February 6, 2007. The petitioner was discharged for striking another resident and a staff member. The petitioner's psychiatrist signed that discharge indicating that the petitioner met the criteria for Baker Act due to paranoid schizophrenia. The petitioner returned to the facility. The facility was working with the petitioner regarding his paranoid schizophrenia.

3. On May 5, 2007, the petitioner was in his room partially disrobed with the door open. Another resident was wandering around the facility. She looked into the petitioner's room. The petitioner was observed to be agitated about the invasion of his privacy and space. Later at about 6:45 p.m., the petitioner was sitting in a chair in the common area. As that other resident approached him, he struck her.

5. The respondent gave the petitioner medication, Adivan, for his agitation. The respondent contacted the Agency for Health Care, abuse line and the police, as required. The respondent contacted the police at 9:30 p.m.

6. The police officer arrived at the facility and spoke to the petitioner. The police officer completed the Report of Law Enforcement Officer Inititating Involuntary Examination at 10:30 p.m. The police officer attested in that report that the petitioner met the criteria for involuntary examination. The police office opined that there was substantial likelihood that without care or treatment the petitioner would cause serious bodily harm to another person. The petitioner had told the police officer that he was going to kill that female resident and how he would kill her would be with the knife he had in his room. The petitioner was transported to

7. The facility contacted the petitioner's representative and the petitioner's treating physician on May 5, 2007 that the petitioner was transported to . The treating physician indicated by telephone order at 11:30 p.m. orders to discharge the petitioner to .

8. On May 7, 2007, the respondent sent the petitioner's representative a discharge notice. On May 8, 2007, the petitioner's representative requested a hearing.

9. On May 8, 2007, a licensed psychologist completed psychological determination and progress notes on the petitioner. This psychologist opined that the petitioner was not able to be managed in the facility setting due his

unpredictable episodes of aggressive outbursts and that the petitioner's needs would be better met in another type of facility.

10. On May 9, 2007, the petitioner's psychiatrist opined that due to the petitioner repeated aggressive acts against others, including residents, that the facility was unable to meet the petitioner's needs.

11. Based on the opinion of the petitioner's psychiatrist, the respondent did not allow the petitioner to return to the facility when the petitioner was discharged from the . The petitioner is currently residing at another nursing facility.

12. The representative did not dispute that the petitioner struck another resident. The representative opined that the petitioner should be returned to the facility based on the delay of receiving written discharge notice and the failure for the respondent to provide notification of bed hold with the discharge notice. The respondent also indicated that the respondent did not notify the Long Term Care Ombudsman Office in a timely manner.

CONCLUSIONS OF LAW

I. For issues regarding late receipt of written discharge notice, late notification to ombudsman or lack of bed hold notice.

The Florida Statutes at 400.0255 set forth that a resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge and implementation of emergency transfers:

> (10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge...

> (11) Notwithstanding paragraph (10)(b), an emergency discharge or transfer may be implemented as necessary pursuant to state or federal law during the period of time after the notice is given and before the time a hearing decision is rendered. Notice of an emergency discharge or transfer to the resident, the resident's legal guardian or representative, and the local ombudsman council if requested pursuant to subsection (9) must be by telephone or in person. This notice shall be given before the transfer, if possible, or as soon thereafter as practicable. A local ombudsman council conducting a review under this subsection shall do so within 24 hours after receipt of the request. The resident's file must be documented to show who was contacted, whether the contact was by telephone or in person, and the date and time of the contact. If the notice is not given in writing, written notice meeting the requirements of subsection (8) must be given the next working day.

Jurisdiction to conduct this type of hearing is conveyed to the Department by Federal Regulations appearing 42 C.F.R. § 431.200. The regulation at 42 C.F.R § 431.241, "Matters to be considered at the hearing", sets forth what a hearing must cover:

> (c) A decision by a skilled nursing facility or nursing facility to transfer or discharge a resident

The jurisdiction conveyed to the Office of Appeal Hearings is for the decision by the skilled nursing facility to transfer or discharge the petitioner. Jurisdiction for the issues of delay in receiving written discharge notice, notification to ombudsman or bed hold have not been conveyed to the hearing officer. The facility did call the representative the day the petitioner was discharged and two days later notified the representative in writing. The petitioner was discharged on May 5, 2007 and the hearing was requested on May 8, 2007. The ombudsman was notified of the hearing request and was present at the hearing. Therefore, the delay of receiving the written notice and

notice to the ombudsman did not prejudice the petitioner's due process. The representative's issues regarding delay of written notice, delay of notification to ombudsman and lack of bed hold notice are referred to the Agency for Health Care Administration.

II. For the issue of the respondent's decision to discharge the petitioner.

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

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

The petitioner struck another resident. The petitioner continued to make threatening remarks regarding that other resident to the police officer. The police officer initiated the discharge under the Baker Act. The petitioner's treating physician discharged the petitioner from the facility to by telephone order. Therefore, the discharge is consistent with the recommendation of the treating physician. The petitioner had previously struck another resident and a staff member. Striking other individuals in the facility endangers the safety of other individuals in the facility. Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner was in accordance with Federal Regulations.

DECISION

I. The representative's issues regarding delay of written notice, delay of notification to ombudsman and lack of bed hold notice are referred to the Agency for Health Care Administration.

II. This appeal is denied as the respondent's action to discharge the petitioner is correct and in accordance with Federal Regulations.

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 12th day of June, 2007,

in Tallahassee, Florida.

Linda Jo Nicholson

Linda Jo Nicholson
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01773

PETITIONER,

Vs.

CASE NO. 1113248513

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 14 Polk
UNIT: 88581

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 19, 2007, at 11:40 a.m., in Lakeland, Florida. The petitioner was not present. She was represented by . Medicaid specialist. The respondent was represented by Gail Crews, economic self-sufficiency specialist supervisor.

The respondent was allowed 10 days to return further information. No further information was received.

ISSUE

At issue is the February 2, 2007 action by the respondent denying the petitioner's request for Institutional Care Program benefits for the months of October 2006 through December 2006. The petitioner has the burden of proof as the applicant for benefits.

FINDINGS OF FACT

1. The petitioner filed a Request for Assistance to apply for Institutional Care Program benefits on January 4, 2007. The petitioner requested retroactive benefits for the months of October 2006 through December 2006. On February 2, 2007, the respondent approved the petitioner's request for Institutional Care Program benefits beginning January 1, 2007.
2. The petitioner has three sources of income; a pension ($656), an annuity ($603) and a monthly social security benefit of $759. The $656 monthly pension is received by the petitioner's daughter who makes it available for the petitioner. The $603 annuity is being held by the Federal Retirement Office pending certain requirements.
3. The three incomes totaled $2,018. This amount exceeded the $1,809 monthly income limit for the Institutional Care Program. The petitioner formed and funded an income trust beginning with the month of January 1, 2007.
4. The respondent denied the petitioner's request for retroactive benefits through the Institutional Care Program for the months of October 2006 through December 2006. The respondent considered all three sources of income for the retroactive months. Since the petitioner did not form and fund the income trust until January 2007, she was over the income limit for the Institutional Care Program for the months of October 2006 through December 2006.

5. Over a year ago, the petitioner left her home to live with her granddaughter temporarily. In that move her three benefit checks were misrouted. Two of the benefits have been resolved and any withheld payments have been forwarded to the petitioner or her representative (social security of $759 and pension of $656). The petitioner has since been committed for a nursing facility.
6. The latest information from the Office of Personnel Management Retirement Programs that manages the $603 annuity was on December 11, 2006 when that agency verified the amount of the annuity. Information was forwarded from that agency regarding the necessity of determining the petitioner's competency and who is managing her business affairs and the instructions for providing this information. The funds are being withheld pending this determination.
7. The respondent sought clarification from their District Program Office on January 5, 2007. The program specialist determined that the funds must be considered as available since the petitioner had the "legal ability to make the funds available."

CONCLUSIONS OF LAW

Fla. Admin Code 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria, states in part:

> 1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:...
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit

> may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C...
> (f) For hospice services, income cannot exceed 300 percent of the SSI federal benefit rate or income must meet Medically Needy eligibility criteria, including the share of cost requirement. Effective October 1, 1998, institutionalized individuals with income over this limit may qualify for institutional hospice services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(14)(a), F.A.C...
> (3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individuals account, or when it is set aside for their use, whichever is earlier...

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

> (15) Trusts. (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

The Department's Florida Integrated Public Assistance Policy Manual, 165-22, Appendix A-9, April 2006, set forth the ICP income limit at $1809 for an individual for the time period at issue.

The Florida Integrated Public Assistance Policy Manual states in relevant part at passage 1640.0505.04 regarding retirement funds:

> Retirement Funds (MSSI, SFP)
>
> Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., retirement plans administered by an employer or union, disability, or pension). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals (sometimes referred to as Keogh plans).
>
> Retirement funds must be considered as an asset or as income, unless they are considered unavailable. Retirement funds purchased on or after April 1, 1995, may be regarded as a transfer of assets under certain conditions (see special policy on ICP, etc., below).

If an individual is eligible to receive regular periodic payments from a retirement fund, the payments are considered unearned income and the fund is not considered an asset to the individual. (If the individual is eligible to receive payments but elects not to, he is ineligible due to failure to file for other benefits to which he is entitled.)

If the individual is NOT eligible to receive periodic payments from the fund, the funds are considered an asset in the amount that is currently available. Any penalty imposed due to early withdrawal can be deducted when computing the value of the funds, but any taxes due are not deductible.

A retirement fund is not an asset if an individual must terminate employment in order to obtain any payment.

The Integrated Public Assistance Policy Manual states in relevant part at the following passages:

1840.0106 Availability of Income (MSSI, SFP)
Some types of income are readily available to the individual and must be included; however, the individual may have limited or no access to income in certain situations. Some unavailable income may still be included as income.

1840.0108 Available Income (MSSI, SFP)
Income must be available to meet the SFU's needs to be considered, except in the case of lump sum income. Generally, income is considered available when it is actually available and/or when the individual has the legal ability to make the income available.

The evidence establishes that the petitioner has monthly income from three different benefits sources. Two of the three benefits sources are paid to her or her representative. The third source is being held pending the resolution of her competency and legal representative. The issue is the petitioner's eligibility for the retroactive months of October 2006 through December 2006 for Institutional Care Program benefits.

The petitioner argues that the monies were inaccessible/unavailable to the petitioner in the months requested. She argues that they were unavailable due to circumstances beyond the petitioner's control. The petitioner falls below the monthly institutional care income standard if the $603 benefits are considered unavailable.

The respondent argues that the funds are temporarily unavailable. The $603 pension will be directed to the petitioner when the competency and representative issues are resolved. According to the above-cited policy material, retirement income is considered unearned income if regular monthly distributions occur. If not, the funds are considered an asset.

The evidence establishes that the funds were not unavailable. They were being held in an account for the petitioner until the petitioner's competency and legal representation could be established. The petitioner has the burden of proof as the applicant for benefits. There is no reason to believe that the funds will not be refunded once the above issues are resolved. The hearing officer does not conclude that the funds should be excluded. Therefore, the respondent's action was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days

of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20th day of June, 2007,

in Tallahassee, Florida.

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

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

APPEAL NO. 07F-01385

PETITIONER,

Vs.

CASE NO. 1182797288

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Duval
UNIT: 88369

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 3, 2007, at 11:10 a.m., in Jacksonville, Florida. The petitioner was not present. However, she was represented by her son [redacted] and her daughter, [redacted]. The Department was represented by Rycha Redden, Department of Children and Families supervisor and Viola Dickinson, eligibility specialist. Audrey Edwards, Benefit Recovery Unit appeared as a witness for the Department. Ms. Edwards participated in the hearing by telephone.

ISSUE

At issue is the Department's action of December 21, 2006 to establish an inadvertent household error Medicaid overpayment claim for $35,386.44 for the period beginning December 1, 2005 through October 31, 2006. The Department has the burden of proof.

FINDINGS OF FACT

1) The petitioner was previously approved to receive ICP Medicaid benefits based on income of $844. On August 22, 2005, the petitioner's husband died and she became eligible for additional Social Security benefits totaling $1920 a month. In January 2006, the Social Security amount was increased to $1998 and in January 2007, the Social Security amount increased to $2064. The amounts of income received by the petitioner were not disputed.

2) The additional Social Security benefits caused the petitioner's income to exceed the ICP Medicaid income limit. The ICP Medicaid income limit in effect in December 2005 was $1737. Effective January 2006 the ICP income limit was $1809.

3) An entry made on November 9, 2005, in the Department's computer "Running Record Comments" stated that the case was holding for verification of income trust and now a review was due. The entry also indicated "I tried to call the daughter at . . . and left a message. The case is now red due to the trust. I have sent the family the passive packet." The Department's benefit recovery specialist believes this supports the fact that the Medicaid Qualifying Income Trust fact sheets were included to inform the family of how and why a Qualified Income Trust must be established. There were no further entries made on "Running Record Comments" until February 14, 2006 just stating that the Medicare number had changed and nothing again until November 29, 2006 documenting the error and explanation of how to correct it.

4) The Department submitted notice history from its computer system to show that a "continued" notice was issued on November 9, 2005 to . . ., and two "reduction" notices were sent on November 28, 2005 to both and the

nursing home and finally one "increased" notice was sent on November 28, 2005 showing a reduction in the patient responsibility to the facility.

5) It was unclear why the Department continued the ICP Medicaid coverage until November 2006, when it was known that the petitioner's income exceeded the limit and eligibility had not yet been achieved by properly funding a Qualified Income Trust.

6) The petitioner's representatives do not believe that a packet explaining the Qualified Income Trust was ever sent. The petitioner's son found out about the need for a trust through a phone call made by Gail Burton, a worker with the Department, shortly after his father's death. He believes the only information she gave him was to quickly set up the trust and fund it with $300. He did so with $300 of his own money although he did not understand the purpose or why that amount was chosen. Nothing further was deposited into the trust until November 2006, when he was contacted by the worker, Ms. Dickinson, who completely explained the eligibility and trust details. The petitioner's son discussed the trust with his probate attorney who advised it was useless and did not see the need for it.

7) The Department made a referral to Benefit Recovery Unit to determine if Medicaid overpayment had occurred. The Benefit Recovery Unit reviewed the case and determined that beginning in December 2005 through October 2006 the petitioner was totally ineligible for ICP Medicaid due to excess income. The Benefit Recovery Unit determined that all Medicaid benefits paid out on behalf of the petitioner during this period constituted the Medicaid overpayment of $35,386.44.

8) The petitioner's representatives disagreed with the overpayment claim because they had not been informed about the policy related to establishing and properly funding a

Qualified Income Trust. The petitioner's representatives also noted that the petitioner did not benefit from the overpayment situation in that her entire income except for $35 monthly was retained by the nursing home.

10) The petitioner's representative believed that if he had been properly informed of the Departmental policy and procedures related to Qualified Income Trusts, he would have achieved eligibility for the months of overpayment.

CONCLUSIONS OF LAW

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

> (26) Qualified Income Trust: A trust established on or after October 1, 1993, for the benefit of an individual whose income exceeds the ICP income standard and who needs institutional care or HCBS. The trust must consist of only the individual's pension, Social Security and other income. The trust must be irrevocable and provide that upon the death of that individual the State shall receive all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of that individual pursuant to the state's Title XIX state plan.

Fla. Admin. Code 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, in part states:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.

Fla. Integrated Pub. Policy Manual, Appendix A-9, sets forth the ICP income limit for an individual at $1869 beginning January 2007, $1809 was effective January 2006 and $1737 was effective January 2005.

Fla. Integrated Pub. Policy Manual, 165-22, Section 1840.0110 describes the prerequisites for creating a qualified trust and states in part:

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

The Findings show that the petitioner's income exceeded the ICP limit when her Social Security Income was increased due to her spouse passing away in September 2005. The Findings show that the petitioner was over the ICP Medicaid income limit for at least December 2005 through October 2006. It can not be determined that the Department sent any information on the Qualified Income Trust to the family. The Department relied on an entry in its "Running Record Comments" that a passive packet was sent on November 9, 2005, when the Department realized the income exceeded the limit. A passive packet is not proof that income trust information was included. There was no evidence that the case was ever pended for the Qualified Income Trust documentation and proper funding. The Department continued the ICP Medicaid for another year with no action on the known income information.

The petitioner's son had a telephone discussion with a Department employee shortly after his father's death in September 2005 of the need for a Qualified Income Trust. He created a trust in accordance with the verbal direction provided by the Department and funded it with $300 of his own money. Therefore, the petitioner complied with information given by the Department related to the income trust. There

was no evidence of any further direction from the Department related to the income situation until November 2006.

While the Department argues the ineligibility came out of the insufficient funding of the trust, it can not be determined that the petitioner was overpaid in accordance with *Forman v. State of Florida Department of Children & Families*, 4D06-1770 (Fla. 4th DCA 2007). Therefore, the Department is to void the ICP Medicaid overpayment claim at issue.

DECISION

This appeal is granted and the Department is hereby ordered to void the overpayment claim at issue.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 07F-01836

PETITIONER,

Vs.

CASE NO. 1251741819

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Pinellas
UNIT: 88498

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 10, 2007, at 8:15 a.m., in St. Petersburg, Florida. The petitioner was not present. The petitioner was represented by her sister . The respondent was represented by Suzi Jackson, economic specialist supervisor. Witness for the respondent was David Hicks, Program supervisor Department of Elder Affairs.

ISSUE

The petitioner is appealing the respondent's action to deny Institutional Care Program benefits as the petitioner did not meet the eligibility criteria for the applications of January 26, 2007 and March 8, 2007.

FINDINGS OF FACT

The petitioner's January 16, 2007 application for Institution Care Program benefits was denied as the petitioner did not meet a level of care. The petitioner reapplied on March 8, 2007. A Notice of Case Action was sent to the petitioner on March 16, 2007. The notice informed the petitioner that the respondent had denied the petitioner's application for Institutional Care Program benefits for the reason stated in the notice of "no eligible members in the assistance group".

1. The petitioner had been hospitalized in [redacted] on August 25, 2006. The diagnosis was abdominal pain and weakness with a secondary diagnosis of post traumatic stress disorder. The petitioner was placed in a nursing home on October 24, 2006. The nursing home applied for Institutional Care Program benefits for the petitioner on January 16, 2007. The petitioner was 54 years old at the time of application.

2. The respondent contacted the Department of Elder Affairs for a level of care assessment of the petitioner by the CARES Unit.

3. On February 9 and 16, 2007, a Department of Elder Affairs CARES Unit assessor evaluated the petitioner at the nursing home. The petitioner required assistance with care and rehabilitation when she entered the nursing home. At the time of the assessment, the petitioner was not received any nursing care, needed occasional assistance with showering and otherwise was independent with activities of daily living. The petitioner was no longer receiving rehabilitation. Based on the medical evidence, the CARES assessor determination was "no level of care". The "no level of care" determination was

made by CARES physician consultant, Thiam Lie, M.D., on February 22, 2007. The CARES Unit notified the respondent that the petitioner did not meet a level of care.

4. As the petitioner did not meet the criteria for Institutional Care Program benefits, the respondent denied the January 26, 2007 application.

5. The petitioner reapplied on March 8, 2007. The CARES Unit contacted the petitioner's attending physician, Dr. ' for additional information. Dr. was the petitioner's attending physician from her admission to the nursing home until the petitioner left the nursing home. The petitioner left the nursing home when she was removed to ., a psychiatric hospital, under Baker Act on March 22, 2007. The petitioner's diagnosis was GERD, post traumatic stress disorder, osteoarthritis without major abnormalities, chronic constipation, osteoporosis, history of narcissistic personality disorder, conversion disorder, psychosis and delusional disorder. The petitioner's impairments are primarily mental health issues. The CARES Unit notified the respondent that the petitioner did not meet a level of care.

6. As the petitioner did not meet the criteria for Institutional Care Program benefits, the respondent denied the March 8, 2007 application.

7. The petitioner has not been found disabled by the Social Security Administration. No evidence was submitted that demonstrated that the petitioner's medical condition was at a level of severity that required 24 hour skilled nursing care.

CONCLUSIONS OF LAW

SSI-Related Medicaid non-financial eligibility criteria is set forth in the Florida Administrative Code at 65A-1.711:

> (2) for ICP benefits, an individual must be:
> (a) Living in a licensed nursing facility, or confined to a hospital swing bed or to a hospital-based skilled nursing facility bed, or in an ICF/DD facility that is certified as a Medicaid provider and provides the level of care that the client needs as determined by the department; or living in a Florida state mental hospital and be age 65 or over; and
> (b) Determined to be in medical need of institutional care services according to Rules 59G-4.180 and 59G-4.290, F.A.C., for nursing facility, hospital swing bed placements and placements in a hospital-based skilled nursing facility bed according to Rule 10D-38, F.A.C., for ICF/DD facilities or according to Rule 59G-4.165, F.A.C. for state mental hospitals.

The criteria for Intermediate Care Services and Skills Services is defined in the Florida Administrative Code at 59G-4.00. If the individual does not meet the Skilled Service criteria then the criteria for Intermediate Care Services are reviewed. The Florida Administrative Code at 59G-4.180 "Intermediate Care Services" states in relevant part:

> (1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitation services to qualify as intermediate care services and clarifies the criteria that must be met in order for such services to qualify as an intermediate level I or intermediate level II service under Medicaid...
> (3) Intermediate Services criteria.
> (a) To be classified as requiring intermediate care services, level I or level II in the community or in a nursing facility, the applicant or recipient must require the type of medical, nursing or rehabilitation services specified in this subsection.
> (b) Intermediate Care Services. To be classified as intermediate care services, the nursing or rehabilitation service must be:
> 1. Ordered by and remain under the supervision of a physician;
> 2. Medically necessary and provided to an applicant or recipient whose health status and medical needs are of sufficient

seriousness as to require nursing management, periodic assessment, planning or intervention by licensed nursing or other health professionals;
3. Required to be performed under the supervision of licensed nursing or other health professionals;
4. Necessary to achieve the medically desired results and to ensure the comfort and safety of the applicant or recipient;
5. Required on a daily or intermittent basis;
6. Reasonable and necessary to the treatment of a specific documented medical disorder, disease or impairment; and
7. Consistent with the nature and severity of the individual's condition or the disease state or stage...
(e) To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services including 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital or that meets the criteria for skilled services...

The evidence does not support that the petitioner's physical impairments demonstrate the need for rehabilitative services, skilled nursing care, intermediate care or require 24 hour medical supervision. The petitioner does not meet the level of care criteria for skilled nursing care or intermediate care. Based upon the above cited authorities, the respondent's actions to deny Institutional Care Program benefits on March 16, 2007 for the applications of January 26, 2007 and March 8, 2007 were within the rules of the Program. The petitioner has a right to reapply at any time and be reevaluated based on any changes that have occurred since the denial on March 16, 2007.

DECISION

This appeal is 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 12th day of June, 2007,

in Tallahassee, Florida.

Linda Jo Nicholson
Hearing Officer
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Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 07F-03063

PETITIONER,

Vs.

CASE NO. 1057697401

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 09 Palm Beach
UNIT: 88626

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 15, 2007, at 11:28 a.m., at the Lake Worth Service Center, in Palm Beach County, Florida. The petitioner was not present, but was represented at the hearing by Hospice billing supervisor, l . The petitioner is deceased. The Department was represented by Martha Stollberg, economic self sufficiency specialist supervisor. The hearing was left open for three additional days in order for the respondent to submit additional information. The respondent submitted additional information within the time frame allotted.

ISSUE

At issue is the Department's action not to approve December 2006 as a retroactive request month for Hospice Related Medicaid benefits, based on a May 2007 application for these benefits.

FINDINGS OF FACT

The petitioner was in a nursing home up until December 2006. She was under Hospice care starting in March 2006 and passed away in December 2006.

In September 2006, the Department mailed an appointment letter to the nursing home where the petitioner resided, for the petitioner's yearly eligibility review for the Hospice or ICP benefits. No one appeared at the set appointment with the Department for the petitioner in October 2006. Based on this, the Department, on October 31, 2006, cancelled the petitioner's Hospice Related Medicaid benefits starting December 2006.

In May 2007, the local Hospice center applied for retroactive Hospice Related Medicaid benefits for the petitioner for December 2006. As December 2006 is not within the three months prior to application for benefits months, the Department denied the petitioner's representatives request for the benefits.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.710 sets forth the SSI-Related Medicaid coverage groups and states in part:

> (3) Hospice Program. A coverage group for terminally ill individuals (or couples) who elect hospice services and who meet all categorical or Medically Needy eligibility criteria, and who also meet special Medicaid hospice requirements as provided in 42 U.S.C. § 1396d(a), subsection 65A-1.711(3) and Rule 65A-1.713, F.A.C.

Fla. Admin. Code 65A-1.702 sets forth special provisions of the Florida Medicaid Program that includes Hospice Related Medicaid coverage and states in part:

> (2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the

> three months immediately preceding the month of application (called the retroactive period)....
>
> (9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
>
> (a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance.

As shown in the Findings of Fact, the Department denied the petitioner's representative's request for Hospice Related Medicaid coverage for the retroactive request of December 2006 for an application submitted in May 2007. December 2006 was beyond three months prior to May 2007.

The petitioner's representative did not dispute the facts of the case. She argued that they should have been provided the eligibility redetermination notice (in September 2006) along with the nursing home. She argued that was in need of the requested benefits for December 2006.

After considering the evidence, the Florida Administrative Code Rule and all of the appropriate authorities set forth in the Findings above, the hearing officer finds the Department's action to deny the petitioner's May 2007 application request for the Hospice Related Medicaid request for the retroactive month of December 2006, is correct, as the month of December 2006 was previous to three months prior to May 2007.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29th day of June, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
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Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 07F-02519

PETITIONER,

Vs.

CASE NO. 1191038467

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned-hearing officer convened an administrative hearing in the above-matter on May 24, 2007, at 9:50 a.m., in Orlando, Florida. The petitioner did not appear. [redacted], petitioner's daughter and authorized representative, appeared for the petitioner. Reginald Schofield, economic self-sufficiency specialist supervisor, appeared and represented the respondent-Department.

ISSUE

At issue is the respondent's action of February 2, 2004, denying the petitioner's application for Institutional Care Program (ICP) Medicaid for failure to verify value of assets and unearned income as well as failure to follow through in establishing eligibility. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

1. The petitioner's representative submitted an application on the petitioner's behalf for ICP Medicaid on December 24, 2003.
2. The respondent placed the application into a pending status awaiting the submission of verification of assets and unearned income.
3. The petitioner's representative believed that the nursing facility caring for the petitioner was assisting in the application process. She was unaware that this was not true.
4. The respondent did not receive the requested information by the assigned deadline date. As a result, the respondent's eligibility specialist denied the petitioner's application.
5. The respondent issued a Notice of Case Action dated February 2, 2004, informing of the denial and the reasons for it.
6. At the hearing, the petitioner's representative stated that her current mailing address was the same as that listed on the notice dated February 2, 2004. She did not deny receiving the notice in February 2004. She believed the facility was handling the application process and as a result, did not follow through on the notice's request.
7. The representative requested a hearing in this matter on April 18, 2007.
8. The respondent stated that it received no returned mail from the petitioner's representative's address.
9. The respondent argued that the time limit for filing a hearing request expired and that the hearing officer lacks jurisdiction.

CONCLUSIONS OF LAW

Fla. Admin. Code 65-2.046 states in relevant part:

(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following: (a) The date on the written notification of the decision on an application...

The evidence shows that the petitioner's representative did not request a hearing until three years after the respondent's denial of the application for ICP Medicaid. Unfortuntately, the hearing officer lacks jurisdiction to rule on this matter because the hearing request was untimely.

DECISION

The appeal is denied and dismissed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of June 2007,

in Tallahassee, Florida.

Jeannette Estes

Jeannette Estes
Hearing Officer
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850-488-1429

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

APPEAL NO. 07F-02727

PETITIONER,

Vs.

CASE NO. 1253860076

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 11 Dade
UNIT: 66257

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 24, 2007, at 10:48 a.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was not present, but was represented at the hearing by _____, Medicaid specialist. The Department was represented by Cathy Mugarra, economic self sufficiency specialist II. Also present on behalf of the Department was Enrique Bascuas, economic self sufficiency specialist. The hearing was left open for eight additional days in order for the Department to submit additional information. The Department, while the hearing was left open, requested and was granted another seven additional days for the hearing to be left open, for a total of fifteen additional days. The Department submitted additional information within the time frame allotted.

ISSUE

At issue is the Department's action of April 16, 2007 to deny the petitioner's December 12, 2006 application for Institutional Care Program and Medicaid benefits (ICP) for the month of October 2006 (only) based on: "Asset value exceeds Program eligibility limits." The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner or her representative had filed an application for ICP benefits with the Department on December 12, 2006 to include the retroactive request for October 2006. The petitioner was previously admitted to the nursing home as a private pay from about March 2006.

During the month of October 2006, the petitioner or her representative had spent down the petitioner's remaining funds on home improvement (of the petitioner's home). The petitioner started out with nearly $5,000 in her bank account in October 2006. By October 28, 2006, she had spent down to under $2,000 in her bank account. The Department determined that the petitioner's "spend down" in October 2006 was an improper spend down, not occurring in the admitting month of her placement in a nursing home and thus; the Department denied the petitioner's ICP request for the retroactive month of October 2006, based on: "Asset value exceeds Program eligibility limits."

The Department requested the hearing be left open for additional time, in order to submit additional information, notably a copy of pertinent policy related to the Department's action. While the hearing was left open, the Department verbally informed the hearing officer that the Department's above noted decision was not correct and that benefits would be approved for the month in question. The Department provided the

hearing officer with a copy of a new Notice of Case Action; indicating that ICP benefits were approved for the petitioner for October 2006.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.712 sets forth the SSI-Related Medicaid resource eligibility criteria that includes the ICP and Medicaid Program

As shown in the Findings of Fact, the Department initially denied the petitioner's request for ICP benefits for October 2006, based on an alleged improper spend down of resources. The Department, though not providing an explanation, "stipulated" that the Department will approve the petitioner for ICP benefits for October 2006.

After considering the evidence, the Florida Administrative Code Rules and all of the appropriate authorities set forth in the findings above, the hearing officer as per Department stipulation, orders the Department to provide the petitioner with the ICP benefits for October 2006.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 27th day of June, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-01503

PETITIONER,

Vs.

CASE NO. 1249294720

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 04 Duval
UNIT: 88365

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 20, 2007, at 10:00 a.m., in Jacksonville, Florida. The petitioner was not present. However, she was represented by her daughter,

The respondent was represented by Deborah Stoller, economic services self-sufficiency specialist supervisor.

ISSUE

At issue is the respondent's action to deny Institutional Care Program (ICP) Medicaid benefits for the retroactive month of November 2006, due to excess income. The petitioner has the burden of proof.

FINDINGS OF FACT

1) The petitioner's representative submitted an application for ICP Medicaid in September 2007. That application was denied due to failure to follow through in establishing eligibility.

2) On December 7, 2006, the petitioner reapplied for ICP Medicaid benefits. The respondent acted on this application as to include a request for retroactive payment for the month of November. The maximum income limit to receive ICP Medicaid is $1809. The petitioner's income in November 2006 consisted of $1315 in Social Security benefits and a pension of $604.88 for a total monthly income of $1919.88. The petitioner's Social Security income increased to $1358 in December 2006, making her total monthly income $1962.88. The petitioner's income was not disputed. Since the petitioner's income exceeded the maximum income limit, an income trust had to be set up and properly funded before the petitioner could be approved for ICP Medicaid benefits.

3) The petitioner's representative established and funded a Qualified Income Trust (Respondent's Exhibit 4) on December 3, 2006. The Income Trust placed the petitioner's income below the maximum income limit, so ICP Medicaid was approved for December 2006 and ongoing on January 26, 2007.

4) All parties acknowledged at the hearing that during the month of November 2006, the income trust had not been properly funded and as a result, the petitioner's income was over the ICP Medicaid income limit of $1809. As such, ICP Medicaid was denied for the month of November 2006 due to excess income.

5) The petitioner's representative acknowledged that she had not established and properly funded the income trust required to achieve ICP eligibility during the month of November 2006 because she was waiting to get an appointment with an affordable attorney.

CONCLUSIONS OF LAW

All policy criteria must be fulfilled before ICP Medicaid benefits can be authorized and there are no provisions in the agency policy to make exception to meeting such criteria.

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

> (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).
>
> (b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal."

Fla. Admin. Code **65A-1.713 SSI-Related Medicaid Income Eligibility Criteria**, in part states:

> "(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:...(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in Rule 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in Rule 65A-1.702(13)(a), F.A.C."

The respondent published Transmittal number I-06-03-0006 on March 10, 2006 which includes Appendix A-9 to the Department's Integrated Policy Manual, 165-22 for the time period at issue. This chart sets forth the ICP income limit for an individual at $1809, effective April 2006.

Fla. Integrated Pub. Policy Manual, 165-22, Section 1840.0110 further states:

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

> To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust...
>
> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.** (emphasis added)"

The above authorities provide for the establishment of an income trust by an Institutional Care Program applicant in order to reduce monthly income below the state income limitations. The petitioner's income exceeded the maximum income limit for ICP Medicaid of $1809 during the month of November 2006. The Findings of Fact show that an income trust was established and properly funded in December 2006, thereby reducing the petitioner's income to below the maximum income limit for the ICP Medicaid Program.

Since the petitioner's income for November 2006 exceeded the maximum limit, the respondent denied ICP Medicaid benefits for that month. The respondent's action is consistent with the above cited authorities and there were no grounds presented to make an exception to this policy.

DECISION

This appeal is 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 8th day of June, 2007,

in Tallahassee, Florida.

James Abdur-Rahman

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