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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 08F-01674

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 03 Levy
UNIT: AHCA

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 27, 2008, at 11:30 a.m., in Chiefland, Florida. The petitioner was present. Present representing the petitioner were her parents [redacted] and [redacted]. Present as a witness for the petitioner was her home care nurse, [redacted] The respondent was represented by Alice Reshard, senior human services program specialist. Present as a witness for the respondent was Kelly Loveall, RN with the Agency For Health Care Administration. Testifying by telephone on behalf of the respondent were Dr. Robert Buzzeo, associate medical director, Keystone Peer Review Organization (KePRO), and Theresa Ashey, RN, review operations supervisor, KePRO.

## ISSUE

The petitioner is appealing the respondent's action of February 24, 2008, to terminate her private duty nursing services. The respondent had the burden of proof.

## FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving private duty nursing services through Medicaid from 7:00 a.m. to 3:00 p.m. Monday through Friday. The petitioner requested the continuation of private duty nursing services at the same level for the period of January 26, 2008 through March 25, 2008.

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

3. A prior authorization review was completed by (KePRO). On February 8, 2008, KePRO denied the petitioner's request for private duty nursing services from 7:00 a.m. to 3:00 p.m. Monday through Friday because information requested from the provider was not received and medical necessity for the services could not be determined. A reconsideration was requested. A reconsideration review was completed by KePRO after additional information was received from the provider. The reconsideration was denied on February 24, 2008 because medical necessity was not established for the private duty nursing services during the day and the services were terminated. The private duty nursing services have been continued pending the outcome of this hearing.

4. The petitioner is 14 years old. The petitioner has been diagnosed with Dandy Walker syndrome, seizure disorder, Spastic Quad, Cerebral Palsy with profound motor disability, profound mental retardation, developmental delays, chronic respiratory disease, trachea, GT and constipation. The petitioner lives with her father and a 12 year old sibling. The father is a single parent and does not have any health problems. The father takes care of the petitioner during the night and during the hours that a nurse is not in the home. The father is up frequently during the night checking on the petitioner. He provides monitoring of her respiratory status, frequent suctioning, trachea care, turning and repositioning, diapering, monitoring of the GT feeding and monitoring her safety. The petitioner sleeps all night and the father gives her medication during the day. The petitioner has not had any recent seizures. The father is also responsible for making sure that his other daughter is cared for. The father home schools the other daughter and she stays home during the day. The petitioner's mother does not live in the home. She works odd hours and stops in to see the petitioner once or twice each day and at times takes her out during the day.

5. The father requested private duty nursing during the day so that he could go to the store, run errands and pick up medication for the petitioner when the nurse was caring for the petitioner.

6. KePRO denied the private duty nursing services from 7:00 a.m. to 3:00 p.m. Monday through Friday because the father is at home during the day and can take care of her during the day. KePRO determined that there was no medical necessity for the private duty nursing services during the day. However, KePRO determined that the petitioner requires private duty nursing services in the evening and at night. KePRO

was willing to approve private duty nursing services during the evening and at night so that the father could sleep at night and take care of the petitioner during the day.

## CONCLUSIONS OF LAW

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

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

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

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

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

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

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

The petitioner's father lives with the petitioner. He does not have any health problems and is capable of taking care of her during the day. The private duty nursing services were requested during the day so that the father could go to the store, run errands and pick up medication for the petitioner when the nurse was caring for the petitioner. The evidence presented did not establish that it was medically necessary for the petitioner to have private duty nursing services during the day because the father was able to care for her during the day. Therefore, it is determined that the respondent correctly terminated the petitioner's request for private duty nursing services from 7:00 a.m. to 3:00 p.m. Monday through Friday.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the respondent. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, 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 respondent has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 2nd day of June, 2008,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To: [redacted] Petitioner
Marilyn Schlott, Area 3 Medicaid Adm.

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

[redacted]

PETITIONER,

APPEAL NO. 08N-0059

Vs.

[redacted]

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 22, 2008, at 9:23 a.m., in Miami, Florida. The petitioner, [redacted], was present and represented himself at the hearing. Representing the facility was [redacted] nursing home administrator. Present as witnesses for the respondent were: [redacted] facility physician; [redacted] director of nursing; [redacted], therapist; and [redacted] social services.

## ISSUE

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

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

## FINDINGS OF FACT

1. The petitioner (47 years old) is a resident of [redacted] in Miami-Dade County. The petitioner had an accident in 2005 and as a result was hospitalized and was admitted to the facility. The facility has been providing the petitioner with required medical care and therapies.
2. On March 24, 2008, the treating physician authorized the facility to initiate the discharge process for the petitioner, as he was found medically ready for discharge.
3. A Notice of Discharge was issued to the petitioner with a discharge date of April 23, 2008. The petitioner filed for an appeal of that action on March 31, 2008.
4. At the hearing the physician stated that the petitioner is totally independent and from a medical standpoint, able to live on his own. The petitioner spends half the time away from the facility and out in the community.
5. The petitioner agrees with the physician and states that he is ready to leave, but needed four to five weeks to be able to do so.

## CONCLUSIONS OF LAW

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

(a) *Transfer and discharge*- (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plants or not. (2) Transfer and discharge requirements. The facility must permit each resident to remain in

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

The petitioner agreed with the facility that he is able to leave, but just needed additional time in which to do so.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner on March 24, 2008. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The notice, as required, noted the reason for the discharge as "your health has improved sufficiently so that you no longer need the services provided by this facility". The petitioner agreed with the facility's physician that his health has improved sufficiently, where nursing home care is no longer needed. The notice provided a location, to which the petitioner was to be discharged. All requirements have been met by the nursing facility.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 26th day of June, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
[redacted] Resp.

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

[redacted]

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

APPEAL NO. 08N-00051

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 21, 2008, at 9:10 a.m., in Lauderdale Lakes, Florida. The petitioner was present and she represented herself. Also present was [redacted] her friend, and [redacted], from the Broward County Long Term Care Ombudsman Council. The respondent was represented by [redacted] director of the facility. Also present from the facility was [redacted] director of nursing; [redacted] physician assistant; [redacted] director of social services; [redacted] wound care nurse; and [redacted] medical records director.

## ISSUE

At issue is the [redacted] March 31, 2008 action to discharge the petitioner from the facility, because her needs cannot be met there. The respondent has the burden of proof.

## FINDINGS OF FACT

1. The petitioner resides at the [redacted] in Lauderdale Lakes, Florida. Included in the evidence is a copy of a Nursing Facility Transfer and Discharge Notice, dated March 19, 2008, stating that the petitioner was being discharged from the facility because her needs cannot be met there.

2. Included in the evidence is a copy of a Nursing Facility Transfer and Discharge Notice, dated March 31, 2008, stating that the petitioner was being discharged from the facility because her needs cannot be met there. This notice has a location to where the petitioner is being discharged.

3. Present at the hearing from the facility was [redacted] who agrees with the discharge of the petitioner from the facility. Attached to the discharge notice is a statement written by [redacted], physician assistant for [redacted]. It states that the facility cannot meet the petitioner's needs. The following is part of this statement.

4. The petitioner compiled a list of over 17 physicians who are caring for her outside of the facility. This interferes with the services that the facility provides for her. She is also non compliant with doctor's orders concerning her wound care for a wound on her right buttocks. She should be in a wheelchair for about two hours daily; however she spends the entire day in the wheelchair.

5. The petitioner writes on progress notes from outside specialists that she sees, after being told that this is unlawful and would not be tolerated. At the hearing, [redacted] explained the importance of proper communication and coordination with physicians outside the facility and in the facility, due to proper dosage of medications.

6. Since there is not proper communication with the doctors in the facility and outside the facility, her medications are not properly coordinated, and the petitioner's needs cannot be met there. Also, the petitioner smokes cigarettes against doctor's orders, and as the petitioner asserted in the hearing, she is a social drinker. As explained at the hearing, alcohol interferes with medications, and smoking interferes with her wound care.

7. The petitioner asserted at the hearing that she has 23 doctors outside of the facility, and that she tries to control her smoking with a rubber band attached to her wrist that she snaps to encourage her not smoke. She also asserted that when she drinks alcohol, she does not take her medications, to avoid any problems.

8. Even though the petitioner should not write on doctor's notes for doctors outside of the facility, according to the respondent's employees, she continues to do this. As described in the statement from [redacted], the petitioner recently saw an urologist outside of the facility, and she wrote on the doctor's notes again.

9. According to the petitioner, there is a misunderstanding about her writing on doctor's notes. She states that she does this to inform the facility about the care that she receives from doctors outside of the facility.

10. According to the petitioner, and [redacted], they accused staff members of the facility of physically and mentally abusing her. According to the petitioner, even though she is being abused, she does not want to be discharged. She asserted that she will have surgery in the future, and it is more convenient for her to stay in the facility. She also asserted that there are staff members that treat her well.

## 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 a 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):

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

The petitioner, a resident of the [redacted], was being discharged from the facility because her needs could no longer be met there. According to the petitioner, she has 23 doctors outside of the facility. Since there is not proper communication with the doctors in the facility and outside the facility, her medications are not properly coordinated, and the petitioner's needs cannot be met there. Also, the petitioner smokes cigarettes against doctor's orders, and as the petitioner asserted in the

hearing, she is a social drinker. As explained at the hearing, alcohol interferes with medications, and smoking interferes with her wound care.

The petitioner is non compliant with doctor's orders concerning her wound care for a wound on her right buttocks. She should be in a wheelchair for about two hours daily; however she spends the entire day in the wheelchair. The petitioner writes on progress notes from outside specialists that she sees, and she should not be doing this. According to the facility's staff that was present at the hearing, including the administrator, and a physician, the petitioner's needs cannot be met there. After careful consideration, it is determined that the action to discharge the petitioner from the facility is upheld.

## DECISION

This appeal is denied, and the [redacted] action to discharge the petitioner from the facility is affirmed.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9th day of June, 2008,

in Tallahassee, Florida.

Stuart Imberman

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

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

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

[redacted]

APPEAL NO. 08N-00035

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on May 6, 2008, at 1:45 p.m., at [redacted] in Melbourne, Florida. The petitioner was present and was represented by [redacted] Esquire. Present as witnesses for the petitioner were: [redacted] power of attorney; [redacted] therapist; and [redacted] friend. [redacted] Ombudsmen, Florida Long-Term Care Ombudsman Program, were present. [redacted] nursing home administrator, represented the respondent. Present as witnesses for the respondent were: [redacted] facility physician; [redacted] LPN; [redacted] LPN; [redacted] director of nursing; [redacted] regional nurse consultant; [redacted] CNA; [redacted] medical director; and [redacted] LPN.

A continuance was granted to the respondent for a prior scheduled hearing.

## ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of Federal Regulation at 42 C.F.R. §483.12(a)(2)(iii).

## FINDINGS OF FACT

1. On February 25, 2008, the respondent issued a Nursing Home Transfer and Discharge Notice to inform the petitioner that he was being discharged from the facility to [redacted] A copy was sent registered mail to his power of attorney on that day. She received it on February 28, 2008. The reason stated in the notice was "The safety of other individuals in this facility is endangered." (Respondent's Exhibit 1) A hearing was requested on March 4, 2008.

2. The petitioner was admitted to the respondent's facility on October 25, 2006. Because of an accident, he is blind and suffered some brain damage. He also has other medical conditions, but he is very independent and able to perform his activities of daily living.

3. The petitioner was Baker Acted on February 11, 2008. [redacted], medical facility director, signed the Certificate of Professional Initiating Involuntary Examination Baker Act Form, citing the petitioner was and had previously demonstrated extremely aggressive behavior including yelling at staff, hitting a female nurse in the chest after calling her names, cursing at other staff members, and lunging at another nurse. On February 10, 2008, the petitioner was agitated by his roommate turning the sound up on his television rather than turning it down. The nurses' notes show there was an incidence of aggressive behavior with the petitioner's roommate. A staff member

entered the room after she heard shouting coming from the petitioner's room. A staff member witnessed the petitioner yelling obscenities and hitting a roommate while holding him up by his diaper. The roommate was removed from the room (Respondent's Composite Exhibit 2). The police were called. The petitioner went to the emergency room the following day and was sent back to the respondent's facility.

4. There was also an incident on January 8, 2008 concerning an incident about a privacy curtain with a roommate, and hitting the nurse in the chest. Law enforcement was contacted, the petitioner was not Baker Acted at that point, and no charges were pressed. In March 2008, two compliant investigations were completed by the Agency for Health Care Administration. The allegations were not substantiated and the facility was in compliance with 42 CFR 483.12 (Respondent's Composite Exhibit 2).

5. The petitioner spent 73 days at [redacted], a mental health facility, as a result of the Baker Act. [redacted] pined that at the time the petitioner was Baker Acted, the facility could no longer meet his needs and signed the discharge notice on February 25, 2008. The petitioner is currently residing at another facility but he wants to return to the respondent's facility. He denies all of the allegations against him and wants his name cleared. His witnesses describe him as polite, a perfect gentleman, and only gets angry when he thinks he is not being respected. He believes that the staff member he is accused of hitting in the chest provoked him.

6. The Ombudsman believes that the state should force the respondent to take the petitioner back. They believe that the facility made late entries in the petitioner's records to have records to support the reasons for the Baker Act. [redacted] explained that late entries are allowed; altered entries are not.

## CONCLUSIONS OF LAW

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

The Code of Federal Regulations at 42 C.F.R.§ 483.12 Admission, transfer and discharge rights states:

(a) Transfer and discharge--

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

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

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

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

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

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

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

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

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

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

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

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

(5) Timing of the notice.

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

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

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

Florida Statutes 400.022, Residents' rights, states in relevant part:

(p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act.

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 petitioner was a resident in the respondent's facility up until being Baker Acted on February 11, 2008 after several episodes of violent or disruptive behaviors.

The undersigned has jurisdiction to review if the discharge was appropriate and within the guidelines set forth in the federal regulations. The petitioner was discharged on an emergency basis, as determined by [redacted]. [redacted] also signed the discharge notice.

Witnesses for the petitioner argued that the timing of the notice was two weeks after the discharge. The regulations at 42 C.F.R. §483.12(a)(5) provide that the notice should be filed "as soon as practicable before transfer or discharge when – (A) the safety of individuals in the facility would be endangered..." The above cited Florida Statute sets forth residents' rights and states the resident has the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home. The resident can only be discharged for medical reasons or for the welfare of other residents.

Although there was no advance notice, the undersigned finds that the respondent's failure to provide an advance notice does not invalidate the discharge, as the discharge was an emergency and was for a reason stated within the controlling federal regulations. Based on the above findings, it is determined that the petitioner's behavior and outbursts have endangered the safety of other residents in the facility and the discharge action was proper as it is within the controlling state and federal statutes.

## DECISION

The appeal is denied for the reasons stated in the conclusions.

## 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 13th day of June, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner

[redacted] Respondent

Agency for Health Care Administration

[redacted]

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

[redacted]

APPEAL NO. 08N-00081

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

## FINAL ORDER

Per notice, a nursing home discharge hearing was held before the undersigned hearing officer on May 23, 2008, at 2:55 p.m., at the respondent nursing facility. The facility was represented by [redacted] business office manager. The facility administrator, [redacted] appeared as a witness for the respondent. The petitioner was not present, but was represented by her daughter, [redacted] who also testified.

## ISSUE

At issue is the correctness of the facility's discharge action of April 11, 2008 to discharge the petitioner based on non-payment. The nursing facility has the burden of proof.

## FINDINGS OF FACT

1. The petitioner was admitted to the respondent nursing facility on November 20, 2006. The petitioner has been a continuous facility resident since she was admitted. The petitioner was eligible for Medicare for two months after admission.
2. The petitioner has been approved for Institutional Care Program and Medicaid (ICP) benefits for all the months of her stay at the nursing facility. Under the ICP Program, the petitioner owes the facility a patient responsibility portion. This patient responsibility portion was $748.72 in December 2006. The patient responsibility portion was $766.72 from January 2007 through January 2008. This amount increased to $779.72 monthly effective February 2008 and ongoing.
3. No payments were made toward the patient responsibility portion until February 2008. The petitioner receives Social Security of $589 monthly. The nursing home arranged for these monthly Social Security funds to be paid to the facility effective February 2008 and ongoing.
4. The petitioner also receives a $26.00 monthly [redacted] pension, and a $190 monthly pension from [redacted] The petitioner's representative believes that she signed over responsibility to the nursing facility to collect all the funds in the petitioner's behalf at the time of admission. The petitioner's representative believes that the nursing facility received all the petitioner's funds. The nursing facility asserted that they were only authorized to receive the Social Security funds beginning in

February 2008 and ongoing. The petitioner's representative, as power of attorney, has a joint bank account with the petitioner. The petitioner's representative did not present any of the joint bank account statements as evidence of receipt or non-receipt of funds. Based on the available evidence, it is not established that the nursing facility received the petitioner's Social Security funds prior to February 2008, nor any of the petitioner's other pension funds.

5. The petitioner had an outstanding balance owed the facility of $11,304.54 as of the date of hearing. The petitioner received monthly billing notices from the respondent as reflected in Respondent Exhibits 4 and 5.
6. On April 11, 2008, the petitioner received a thirty-day discharge notice due to non-payment. The discharge notice lists the petitioner's daughter's residence in as the intended discharge location. The petitioner's daughter is unable to care for the petitioner at her home, per testimony. The nursing facility will work to discharge the petitioner to a safe setting, per testimony.

## CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42C.F.R.§431.200. Federal Regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility because of non-payment. Federal

Regulations do permit a discharge for this reason, as set forth at 42C.F.R. §483.12(a)(2)(v), as follows:

> 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...

The Findings of Fact establish that the petitioner was determined eligible for ICP Medicaid benefits for all the months of her stay at the facility. Findings establish that the petitioner received billing notices to pay her patient responsibility owed the nursing facility. Findings establish that the nursing facility has only received partial payment of the patient responsibility portion beginning February 2008. Further, the petitioner had an outstanding balance of $11,304.54 owed the facility as of the hearing date.

The Code of Federal Regulations at 42 C.F.R.§483.12(a)(6)(iii) requires the content of the discharge notice to include "the location to which the resident is transferred or discharged." Further, paragraph (a)(7) entitled "Orientation for transfer or discharge" shows that the facility "must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility." The Findings of Fact show that the facility intends to facilitate the petitioner's transfer to a safe location.

In summary, the respondent nursing facility has valid reason to discharge the petitioner based on non-payment. However, the nursing facility must provide the petitioner sufficient preparation and orientation to a suitable discharge location before proceeding with this discharge action. Therefore, the nursing

facility is concluded to have met its burden of proof in this specific discharge action based on non-payment.

## DECISION

The appeal is denied. The facility is concluded to have met its burden to discharge the petitioner based on non-payment, as stated in the above conclusions. However, the respondent facility must provide the petitioner sufficient preparation and orientation to a suitable discharge location before proceeding with this discharge action.

## 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 13th day of June, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner

[redacted] Respondent

[redacted]
Agency for Health Care Administration

[redacted]

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

[redacted]

APPEAL NO. 08N-00043

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on April 30, 2008, at 2:35 p.m., at [redacted] Florida. The petitioner was not present. Her daughter, [redacted] represented her. [redacted], nursing home administrator, represented the respondent. [redacted] director of nursing; [redacted] west wing manager; [redacted] risk manager, and [redacted] social services director, appeared as witnesses for the respondent.

## ISSUE

At issue is the March 3, 2008 action taken by the respondent to discharge the petitioner for endangering the safety of other individuals in the facility. The respondent will have the burden to prove by clear and convincing evidence that the petitioner's

discharge is in accordance with the requirements of the Code of Federal Regulation at 42 C.F.R. §483.12(a).

## FINDINGS OF FACT

1. Prior to the action under appeal and while the appeal is pending, the petitioner has been a resident of the [redacted] nursing facility since her admission on May 5, 2006. On March 3, 2008, a Nursing Home Transfer and Discharge Notice was issued, signed by a physician, informing the petitioner that the respondent wished to transfer her to another facility because it determined that "The safety of other individuals in this facility is endangered". The discharge location was listed originally as [redacted] r, but later changed to [redacted] (Respondent's Exhibit 1). Subsequent to the issuance of the discharge notice, the discharge location changed several times. The final discharge location is listed as [redacted] in St. Petersburg, Florida (Respondent's Exhibit 2).

2. The respondent entered into evidence records of incidents of the petitioner's physically abusive behavior to staff members of the facility. In addition, testimony was given concerning an incident that occurred on September 25, 2007, when the petitioner kicked a pregnant CNA in the stomach. She ultimately lost the baby. Other incidents occurred on the following dates: March 3, 2008, April 4, 2008, April 5, 2008, and April 24, 2008. The behaviors exhibited on these dates can involve among other actions, either hitting or kicking staff members or other residents to tipping a bedside table of another resident and pouring water on her (Respondent's Exhibits 3 & 4). The petitioner's daughter stipulates that the report of all of the incidents is correct.

3. The facility staff tried to redirect the petitioner's behavior. They changed her medication, moved her roommate out of the room, sent her to the emergency room, and tried to Baker Act her on two occasions without success. Calling the petitioner's daughter is used to calm her down when she was in an agitated state. The facility reports that the only time she is calm is when her daughter is visiting her.

4. The facility reports that the petitioner has thrown the phone, thrown her dinner on the floor, and ripped the clothes of a CNA. When her agitation level is increased, she needs increased supervision. The respondent opines that the petitioner needs to be stabilized but it cannot be done at their facility. They believe that it can be done in a psychiatric treatment facility. They have been unsuccessful in getting her into a local psychiatric facility, partially because she cannot ambulate, but also because she was discharged from the emergency room without being Baker Acted.

5. The petitioner's daughter does not want her to remain in the respondent's facility. She wants her to go to a hospital or a rehabilitation center to get off the drugs she is currently taking to detoxify and then back to a nursing facility. She believes that her mother's behavior is a direct result of the medication. She did not act out like this when she was admitted to the facility. She explains that she acts like a zombie from the psychotropic drugs she takes. She is afraid that if she goes to the facility in St. Petersburg, she will never come out of there.

6. The respondent explains that [redacted] specializes in geriatric psyche patients. They can evaluate her, treat her, and then she can return to [redacted]

## CONCLUSIONS OF LAW

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

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:

> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (iii) The safety of individuals in the facility is endangered...
>
> (iv) The health of individuals in the facility would otherwise be endangered;
>
> This regulation continues and states in part:
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.
>
> (4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident... (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...
>
> (5) Timing of the notice.

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

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

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

(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;

The findings show that the petitioner's behavior includes physical abuse to other residents and staff members. The facility tried unsuccessfully to redirect her, change her medication and Baker Act her to get her stabilized. In spite of the facility's efforts, the petitioner continued to act out when agitated.

The petitioner's daughter wants the undersigned to transfer the petitioner to a hospital to detoxify. It is not within the undersigned's jurisdiction to order such a placement. Jurisdiction is limited to determining if the facility's planned discharge is within the federal guidelines.

Based on the above findings, it is determined that the petitioner's behavior has endangered the safety of other individuals in the facility. Therefore, the respondent's proposed discharge of the petitioner from the facility is in accordance with the reasons stated in the federal regulations.

## DECISION

The appeal is denied. The respondent met the burden of proof to show the discharge reason meets the reasons stated in the federal regulation and may proceed with the proposed discharge. The facility may discharge to an appropriate location in accordance with the Agency for Health Care Administration's guidelines.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 4th day of June, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
[redacted] AHCA

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

[redacted]

PETITIONER,

APPEAL NO. 08N-0068

Vs.

[redacted]

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 22, 2008, at 8:45 a.m., in Miami, Florida. The petitioner, [redacted] was present and represented herself at the hearing. Representing the facility was [redacted] nursing home administrator. Present as witnesses for the respondent were: [redacted], facility physician; [redacted] director of nursing; [redacted] physical therapist; and [redacted] social services.

## ISSUE

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

## FINDINGS OF FACT

1. The petitioner (34 years old) is a resident of [redacted] in Miami-Dade County. The petitioner had a stroke in 2003 and as a result was hospitalized and was admitted to the facility. The facility has been providing the petitioner with required medical care and therapies.
2. On March 28, 2008, the treating physician authorized the facility to initiate the discharge process for the petitioner, as she was found medically ready for discharge.
3. A Notice of Discharge was issued to the petitioner with a discharge date of April 30, 2008. The petitioner filed for an appeal of that action on April 8, 2008.
4. At the hearing the physician stated that the petitioner has become independent in her activities of daily living (ADL) and still does use a wheelchair, although she can walk short distances. The petitioner has reached a level of independence, that allows her to live in the community.
5. Upon discharge, [redacted] can be used for outpatient services. The respondent has contacted an adult living facility (ALF) that would be appropriate for the petitioner.
6. The petitioner states that she has already found a place to live, but just needed a few more days in order to complete making it wheelchair accessible for her.

## CONCLUSIONS OF LAW

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

(a) *Transfer and discharge*- (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility

> whether that bed is in the same physical plants or not. (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident ... (iii) Include in the notice the items described in paragraph (a)(6) of this section. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for the transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; ...

The petitioner agreed with the facility that she is able to leave, but just needed additional time in which to do so.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The notice, as required, noted the reason for the discharge as "your health has improved sufficiently so that you no longer need the services provided by this facility". The petitioner agreed with the facility's physician that her health has improved sufficiently, where nursing home care is no longer needed. The notice provided a location, to which the petitioner was to be discharged. All requirements have been met by the nursing facility.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 26th day of June, 2008,

in Tallahassee, Florida.

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

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

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 08F-02313

CASE NO. 1277935301

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 21, 2008, at 2:15 p.m., in Port St. Joe, Florida. The petitioner was not present but was represented by his wife, [redacted]. The Department was represented, via speakerphone, by Nancy Riley, supervisor, ACCESS FLORIDA.

The hearing record was held open for 10 days or until May 31, 2008 to allow the respondent to present additional evidence. This was received and entered as Respondent's Exhibit 2.

## ISSUE

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

## FINDINGS OF FACT

1. The petitioner is residing in a nursing facility. An application for Institutional Care Program (ICP) and Medicaid benefits were submitted on his behalf on January 16, 2008. The petitioner's income consisted of Social Security (SSA) of $1,241.60, Veterans compensation of $398, a pension from ABB Benefits Service Center of $537.28 and Florida State Retirement of $591.52. As the total income of $2,767.80 exceeded the ICP income limit of $1,911 the petitioner was required to establish and fund an irrevocable Medicaid income trust account. This was accomplished in March 2008.

2. The patient responsibility assigned to the petitioner was $1,618.80 according to the Notice of Case Action dated March 27, 2008 (Respondent's Composite Exhibit 1).

3. The petitioner's wife is 71 years old and resides in the community. She will be referred to as the community spouse. The Department determines the community spouse allowance by a budgeting procedure that considers shelter and utility expenses as well as the community spouse's income. At the time of the application, the Department determined her mortgage was $726, homeowner's insurance was prorated to $225 monthly and annual real property taxes including fire assessment fee prorated to $14.58. The Department uses the standard utility allowance of $198. Total shelter cost allowed was $198. The Department was unable to explain why the petitioner's community spouse was not allowed a shelter deduction for her mortgage, household

insurance or property taxes. The record was held open to allow the Department to further explore the budgeting procedure and to evaluate the patient responsibility and spousal allowance. The Department completed its reconsideration and submitted copies of amended budgets and notices allowing credit for shelter expenses including mortgage, taxes, and homeowners insurance (Respondent's Exhibit 2). The amended patient responsibility effective March 1, 2008 is $969.22 and the community spouse maintenance need allowance is $1,763.58. Beginning May 2008, the petitioner's SSA benefit was increased to $1,242 because the State of Florida began paying the Medicare premium. As a result, the patient responsibility increased to $970.22 and the maintenance need allowance for the community spouse remained the same.

4. Subsequent to the Department's review of the budget and amended notification to the petitioner and his community spouse, the undersigned authority received correspondence from the community spouse dated May 28, 2008 stating in part: "I am satisfied with the new assessment for my husbands care after my hearing with you on Wednesday, May 21 2008 here in Port St. Joe." The undersigned authority concludes the correspondence to mean that she no longer disputes the issue under appeal and is requesting a withdrawal of the matter.

## CONCLUSIONS OF LAW

The Findings of Fact show that the Department has correctly amended the patient responsibility and community spouse maintenance need allowance that is at issue. The undersigned authority received correspondence from the petitioner's spouse

and representative indicating her satisfaction with the Department's corrective action. Therefore, the issue at hand is considered to be moot and the appeal is hereby dismissed.

## DECISION

The appeal is denied as the issue before the hearing officer is moot; there is no corrective action necessary.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, 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, 2008, in Tallahassee, Florida.

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

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

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

[redacted]

APPEAL NO. 08F-01985

PETITIONER,

Vs.

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

RESPONDENT.
_____/

**FINAL ORDER**

Per notice, a hearing was held before the undersigned hearing officer on April 16, 2008, at 10:18 a.m., in Lakeland, Florida. The minor petitioner was present but was represented by her mother, [redacted] who also testified. David Beaven, fair hearing coordinator and health care program analyst with the Agency For Health Care Administration (AHCA), represented the respondent and testified. Sue Langston, licensed practical nurse with Maxim Health Care, observed.

Two persons with Kepro appeared as witnesses for the respondent by telephone: Teresa Ashey, registered nurse reviewer, and Dr. Rakesh Mittal, pediatrician and physician reviewer.

## ISSUE

At issue is the respondent's decision of February 22, 2008 to terminate private duty nursing (PDN) hours paid by Medicaid. The respondent previously paid for eight hours daily, five days weekly. The respondent has the burden of proof.

## FINDINGS OF FACT

1. The petitioner is five years old. The petitioner lives with and receives care from her mother, [redacted]. The petitioner lives with her three other children, ages 13, 10, and 4. The petitioner's mother and the other three children are healthy.
2. The petitioner has diagnosis of Cockayne Syndrome. The petitioner has flaccid upper extremities and rigid lower extremities. The petitioner moves around on her back when lying on the floor. The petitioner will not sit in a wheelchair that binds her shoulders. The petitioner rides in a regular baby stroller.
3. The petitioner receives gastro-intestinal tube feeds every four hours with feedings by mouth two times daily. The petitioner has a history of seizure disorder, but seizures are now mostly controlled with medication. The petitioner has no breathing problems.
4. The petitioner's 4 year-old sibling presently stays home with her mother. The petitioner's mother plans to seek work if and when the four year-old child attends school. The petitioner's mother is not presently employed nor attends school. There is no father in the

home. The petitioner's grand-mother occasionally watches the four year old child when the petitioner's mother does errands.

5. The petitioner's mother is generally able to provide needed care for the petitioner. However, the petitioner's mother expresses a need for two persons to give the petitioner a bath. Further, the petitioner expresses a need for help with shopping errands and occasional doctor visits. The petitioner's mother has difficulty getting the petitioner and her four year-old sibling out of a car seat when doing errands. The petitioner's two older siblings have helped with bathing even though it is difficult for the older siblings.
6. The petitioner received eight hours daily PDN hours, five days weekly. The respondent's reviewing medical physicians at Kepro believe that it is not medically necessary to continue any ongoing nursing hours. Kepro believes that occasional nursing hours could be approved, if requested, for the mother to run needed errands or doctor visits, on a case-by-case basis.

## CONCLUSIONS OF LAW

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

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

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

The petitioner's mother and caregiver is generally capable to provide needed care to the petitioner. Findings show that the older siblings can assist with bathing, even though it is difficult. The language of the cited "Home Health Services Coverage and Limitations Handbook," on page 2-15, shows that parents and caregivers must participate in care "to the fullest extent possible," to provide care as in the following excerpt:

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

can be offered to parents and caregivers to enable them to provide care they can safely render.

It is concluded that the respondent decision to terminate ongoing nursing hours is reasonable, given the petitioner's mother's ability and responsibility to provide care to the fullest extent possible. The respondent has agreed to review any episodic need for care when errands or doctor visits are needed. If the petitioner's and/or her caregiver's circumstances warrant a request for occasional PDN hours, the petitioner may request such hours. However, the evidence does not show that the petitioner requires eight hours daily of professional PDN care, given the petitioner's health condition and the mother's ability to provide needed care. In sum, the respondent has met its burden to prove that ongoing PDN hours are not medically necessary, based on the definition of medical necessity.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 4th day of June, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Sue McPhee, Area 6 Medicaid Field Manager

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

[redacted]

APPEAL NO. 08F-01173

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 Clay
UNIT: AHCA

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 16, 2008, at 2:05 p.m., in Orange Park, Florida. The petitioner was present. The petitioner was represented telephonically by [redacted] insurance advocate with [redacted]. Present as witnesses for the petitioner were [redacted] petitioner's grandfather, [redacted] petitioner's grandmother, [redacted], petitioner's pre-school Teacher [redacted] and [redacted], petitioner's speech language pathologist [redacted] Representing the agency was Michelle Manor, program administrator and Rebecca Amidon, senior human services program specialist. Appearing telephonically as agency witnesses were Dr. James Brooks, medical director for Access Health Solutions, Donald Lucas, director of quality improvement for Access Health Solutions and Ralph Medina, director of customer service for Access Health Solutions.

## ISSUE

At issue is the agency's denial of a second cochlear ear implantation device for the petitioner. The petitioner has the burden of proof.

## FINDINGS OF FACT

1. The petitioner is a beneficiary of the Florida Medicaid Program. The petitioner is a four year old child who suffers from bilateral sensory neural hearing loss. Hearing aids are of no auditory benefit to the petitioner. Her treating physician recommended cochlear implantation. In 2006, the petitioner's representatives requested and The Agency for Health Care Administration (AHCA) approved unilateral cochlear ear implantation. The petitioner was unilaterally implanted with a Nucleus Freedom cochlear implant in her right ear in January 2007.

2. The unilateral implantation was successful and has provided the petitioner with some access to sound. The petitioner remains deaf in her left ear. The petitioner's pre-school teacher and speech pathologist asserted that the petitioner hears loud sounds only and cannot always localize sound, she cannot always determine from where the sound is coming. The witnesses believe this puts the petitioner at risk for personal injury such as being hit by a vehicle because she is unable to hear car horns or other sounds associated with oncoming traffic.

3. The petitioner's teacher and speech pathologist believes that the petitioner is drastically behind her peers in educational development due to her impairment; the petitioner exhibits profound delays in listening, speech and both receptive and expressive oral language. Documentation of the petitioner's auditory and speech assessments, completed in November 2007, were entered as part of Respondent's

Composite Exhibit 1. The petitioner's representatives believe bilateral implantation is the only remedy to the petitioner's hearing loss.

4. The petitioner also suffers from cerebral palsy. This impairment impacts the petitioner's facial muscles; she has little control over her mouth and tongue. It is difficult for her to speak, to chew food and swallow. The petitioner's representatives believe this additional impairment compounded with the petitioner's hearing loss significantly contributes to the petitioner's limited language skills and may lead to her being held back in school and could result in the petitioner being unable to live an independent life. The representatives believe that with bilateral implantation, the petitioner will be able to overcome many of the impairments, will be able to develop at the same rate as her peers and eventually live as an independent adult.

5. A second cochlear implantation was requested for the petitioner in March 2008. The request was denied in April 2008. The AHCA representative stipulated that the requested procedure does meet the definition of medical necessity. The request for a second cochlear implantation was denied due to service limitations. The Medicaid handbook defines service limitations; the handbook shows cochlear implantation services are limited to unilateral implantation only. Therefore, the petitioner's request for a second or bilateral implantation was denied. The agency asserted that the petitioner's provider service network (PSN) Access Health Solutions does not cover bilateral implantation, but other health maintenance organizations or service providers may cover bilateral implantation. The agency referred the petitioner to Choice Counseling; a service which helps Medicaid recipients choose service providers based on the specific needs of the Medicaid recipient. There is a lock-in period within

which a recipient cannot change service providers, however, the agency agreed that the petitioner may meet a good cause exception to the lock-in period and may be allowed to change providers. The agency agreed to speak with the petitioner's representatives after the hearing to further explore this option. None of the evidence or testimony provided during the hearing changes the denial decision submitted in response to the petitioner's request for bilateral implantation. If Choice Counseling locates for the petitioner a service provider that covers bilateral implantation, another prior authorization request for bilateral implantation can be submitted for the petitioner at that time, but would not change previous denial decision.

6. The petitioner's insurance advocate argued that a redacted letter from AHCA dated April 10, 2007 shows that Medicaid has made exceptions to the unilateral cochlear implantation service limitation and approved bilateral implantation. A copy of the redacted letter was provided during the hearing. The agency argued that the letter was not relevant because it was too vague in nature; the letter provided no specifics regarding the petitioner's demographics, condition, third party coverage or service provider. The letter references a proposed order only from the Insurance Commission. The letter does not document any final orders and implementation of proposed orders. The undersigned hearing officer could not make a finding of fact that an exception was made to the Medicaid limitations set forth in the Medicaid handbook based only on that evidence. The petitioner's insurance advocate had no other evidence.

## 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.

The Florida Medicaid Coverage and Limitations Handbook, Cochlear Implant Services (January 2007) states as follows:

> The physician who performs the cochlear implant procedure must obtain prior authorization from Medicaid before providing the implantation...
>
> Medicaid reimburses for one cochlear implant in either ear. Medicaid does not reimburse for bilateral cochlear implantation.
>
> Medicaid reimburses for only one wearable speech processor at the time the cochlear implant is purchased.

Both parties stipulate the requested bilateral cochlear implantation meets the definition of medically necessary for the petitioner's impairment. The petitioner was denied because of service limitations. The above authorities document that Medicaid covers only unilateral cochlear implantation.

Based on all evidence and testimony presented, the hearing officer concludes that the agency's action at issue was correct.

## 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 4th day of June, 2008,

in Tallahassee, Florida.

Leslie Green

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

Copies Furnished To: [redacted] Petitioner
Lisa Broward, Area 4 AHCA

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

[redacted]

PETITIONER,

Vs.

APPEAL NO.08F-01441

AGENCY FOR HEALTH
CARE ADMINISTRATION
AREA: 04 Duval

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 2, 2008, at 10:45 a.m., in Jacksonville, Florida. The petitioner was present and represented herself. The respondent was represented by Michelle Manor, program administrator and Rebecca Amidon, human services program specialist. Present as a witness for the respondent was Kristen Russell, Department of Health Brain and Spinal Cord Injury program administrator.

The record was held open for 10 days to allow the respondent's witness to provide additional evidence which was received and entered as Respondent's Composite Exhibit 1.

## ISSUE

At issue is the respondent's action of February 20, 2008 to place the petitioner on the Brain and Spinal Cord Injury Medicaid Waiver Program (BSCIP) waiting list. The petitioner had the burden of proof.

## FINDINGS OF FACT

1. The petitioner is a 54 year old female with a spinal cord injury. The petitioner has limited use of her arms and legs. She lives on her own without any assistance. The petitioner applied for the BSCIP Waiver Program February 2006 and was placed on the waiting list that same month.

2. The Waiver Program provides home and community based services to allow individuals who would otherwise require nursing home care or other institutional care to receive services in their own homes or in home-like settings. Under the provisions of the Medicaid Act, states may include as medical assistance the cost of home and community based services, which if not provided, would require care to be provided in a nursing home, hospital or other institutional setting. The BSCIP specifically provides personal and companion care services. Due to budgetary constraints there is a wait list for program services.

3. In February 2006, the petitioner requested that the Waiver Program provide her with assistance obtaining public housing placement. The program does not directly assist with this type of service. The program services are limited to personal and companion care. The program referred the petitioner to local public housing programs. The petitioner was denied housing assistance because of past criminal convictions.

4. In June 2006, the Waiver Program sent the petitioner a letter to update her waiting list information. The letter returned undeliverable and the contact number for the petitioner was no longer in service. In September 2006, the petitioner contacted the Waiver Program, reported that she had moved to Orlando, FL from Jacksonville and needed assistance finding public housing. The program referred the petitioner to the

city's public housing programs. In October 2006, the petitioner reported she had moved back to Jacksonville and needed assistance locating housing. The Waiver program referred the petitioner to a housing assistance program. In January 2007 the Waiver Program attempted to contact the petitioner to update her waiver list information. The letter returned marked address unknown. The petitioner's phone number was no longer in service. The petitioner was removed from the Waiver Program waiting list. The petitioner contacted the program later that same month, reported she had moved to Ft. Myers, FL. The petitioner was placed back on the program waiting list.

5. In July 2007, the petitioner contacted the Waiver Program again seeking housing assistance. The petitioner reported she was living in a homeless shelter. The Waiver Program again referred the petitioner to local public housing programs and again made the petitioner aware that the program services were limited to personal and companion care. In August 2007, the program attempted to update the petitioner's waiting list information. The petitioner's phone number was no longer in service. The petitioner was removed from the program waiting list. In January 2008, the petitioner contacted the Waiver Program and provided her new address in Jacksonville. The petitioner was placed back on the program waiting list back to the February 2006 month of application. The petitioner remains on the program waiting list.

6. The petitioner stipulated that she did move repeatedly. The petitioner asserted that she called the Waiver Program as soon as possible to report her change of address. The petitioner stipulated that she did request housing assistance in Jacksonville, Orlando and Ft. Myers. The petitioner asserted that she requested the program provide her with help around the house as her spinal injury makes it difficult to

do chores. The petitioner believes the Waiver Program has not provided her with any assistance. The Waiver Program notes for the petitioner's case (Respondent's Composite Exhibit 1) show repeated requests for housing assistance and assistance expunging criminal convictions. The record does not show any other requests from the petitioner. The records are updated after each contact with the petitioner. There is limited program funding and a long waiting list. There are only 300 openings available in the entire state of Florida. No additional people will be placed on the program until July 2008. The petitioner will be considered to fill one of the openings following the prioritization screening (Respondent's Composite Exhibit 1).

## CONCLUSIONS OF LAW

Fla. Statutes Title XXIX Chap. 408.301 in part states:

> 408.301 Legislative findings.--The Legislature has found that access to quality, affordable, health care for all Floridians is an important goal for the state. The Legislature recognizes that there are Floridians with special health care and social needs which require particular attention. The people served by the Department of Children and Family Services, the Agency for Persons with Disabilities, the Department of Health, and the Department of Elderly Affairs are examples of citizens with special needs. The Legislature further recognizes that the Medicaid program is an intricate part of the service delivery system for the special needs citizens. However, the Agency for Health Care Administration is not a service provider and does not develop or direct programs for the special needs citizens. Therefore, it is the intent of the Legislature that the Agency for Health Care Administration work closely with the Department of Children and Family Services, the Agency for Persons with Disabilities, the Department of Health, and the Department of Elderly Affairs in developing plans for assuring access to all Floridians in order to assure that the needs of special citizens are met.

Fla. Statutes Title XXIX Chap. 408.302 states in part:

(1) The Agency for Health Care Administration shall enter into an interagency agreement with the Department of Children and Family Services, the Agency for Persons with Disabilities, the Department of Health, and the Department of Elderly Affairs to assure coordination and cooperation in serving special needs citizens. The agreement shall include the requirement that the secretaries or directors of the Department of Children and Family Services, the Agency for Persons with Disabilities, the Department of Health, and the Department of Elderly Affairs approve, prior to adoption, any rule developed by the Agency for Health Care Administration where such rule has a direct impact on the mission of the respective state agencies, their programs, or their budgets.

Fla. Admin. Code 59G-13.080 entitled "Home and Community-Based Services Waivers" establishes:

(1) Purpose. Under authority of Section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness.
(2) Definitions. General Medicaid definitions applicable to this program are located in Rule 59G-1.010, F.A.C. Additional descriptions of services available under this program are provided in subsection (3) of this rule. The following definitions apply:
(a) "Agency" means the Agency for Health Care Administration, the Florida state agency responsible for the administration of Medicaid waivers for home and community-based (HCB) services.
(b) "Department" means the Florida Department of Elderly Affairs (DOEA).
(3) Home and Community-Based (HCB) Waiver Services are those Medicaid services approved by the Health Care Financing Administration under the authority of Section 1915(c) of the Social Security Act. The definitions of the following services are provided in the respective HCB services waiver, as are specific provider

qualifications. Since several similar services with different names may be provided in more than one waiver, this section lists them as a cluster...The availability of these services to waiver program participants is subject to approval by the Medicaid office and is subject to the availability of the services under the specific waiver program for which a recipient has been determined eligible.
(5) Service Limitations -- General. The following general limitations and restrictions apply to all home and community-based services waiver programs:
(a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.
(b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient.
(c) Additional service limitations applicable to specific waiver programs are specified in subsections (10) through (14) of this rule.
(6) Program Requirements -- General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003, which is incorporated by reference and available from the Medicaid fiscal agent. The following requirements are applicable to all HCB services waiver programs:
(a) The Medicaid program will deny an applicant's enrollment request if the proposed enrollment could cause the program to exceed the maximum enrollment level authorized by the Health Care Financing Administration in the applicable HCB services waiver.
**(b) A person can not receive Medicaid waiver services until he is determined eligible, waiver funding is available, and is enrolled in the appropriate waiver program** [emphasis added]. **...**

Florida Administrative Code 59G-13.130 Traumatic Brain and Spinal Cord Injury Waiver Services, states:

(1) This rule applies to all traumatic brain and spinal cord injury waiver services providers enrolled in the Medicaid program.
(2) All traumatic brain and spinal cord injury waiver services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook, April 2006, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook,

Non-Institutional 081, which is incorporated by reference in Rule 59G-13.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

(3) The following forms that are included in the Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook are incorporated by reference: Appendix C contains the Home and Community-Based Waiver Referral Agreement, April 2006, seven pages; Appendix D contains the Brain and Spinal Cord Injury Program Request for Level of Care, April 2006, two pages; Appendix E contains the Notification of Level of Care, which is incorporated by reference in Rule 59G-13.030, F.A.C.; Appendix F contains the Brain and Spinal Cord Injury Program Waiting List Policy for the Traumatic Brain/ Spinal Cord Injury Medicaid Waiver Program, April 2006, five pages, and Home and Community-Based Medicaid Waiver Prioritization Screening Instrument, April 2006, four pages; Appendix G contains the Notice of Decision, April 2006, two pages; and Appendix H contains the Brain and Spinal Cord Injury Program Medicaid Home and Community-Based Waiver Service Plan, April 2006, one page.

The Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook, June 2006, Appendix F,

Brain And Spinal Cord Injury Program Waiting List Policy For The Traumatic Brain/Spinal Cord Injury Medicaid Waiver Program And Home And Community-Based Medicaid Waiver Prioritization Screening Instrument, states:

Brain and Spinal Cord Injury Program Waiting List Policy for the Traumatic Brain/Spinal Cord Injury Medicaid Waiver Program

I. Introduction
The purpose of the Brain and Spinal Cord Injury Program (BSCIP) waiting list policy for the Traumatic Brain /Spinal Cord Injury Medicaid Waiver (TBI/SCI Medicaid Waiver) Program is three-fold:
1. to provide for statewide consistency for developing and managing the TBI/SCI Medicaid Waiver waiting list;
2. to provide a valid process for ranking individuals requesting services when budgetary restraints necessitate that they be placed on the waiting list log rather than referred for application and eligibility determination; and
3. to provide a reliable process for referring individuals for face-to-face

> assessment, application, and eligibility determination from the waiting list log in priority order into the TBI/SCI Medicaid Waiver program when funding is available. ...
> IV. Funding Available to the TBI/SCI Waiver Program
> A. Allocation Methodology
> Funds will be allocated to the BSCIP Regional Offices for the TBI/SCI Medicaid Waiver program at the beginning of each fiscal year. The allocation of funds to the program will be based on the total annualized authorized Care Plan costs of active clients in the TBI/SCI Medicaid Waiver program in each Region. The balance of the funds will be maintained in a control account to be used for amending existing care plans or adding new individuals to the TBI/SCI Medicaid Waiver program.
> B. Funding Unmet Need
> 1. It is the intent of federal policy that the TBI/SCI Medicaid Waiver program will meet identified and medically necessary Care Plan needs which are within the range of services offered by the TBI/SCI Medicaid Waiver for individuals enrolled in the program. Any unmet needs of recipients enrolled in the Medicaid Waiver program will be funded prior to moving the highest-ranking individuals off the TBI/SCI Medicaid Waiver waiting list into the program.
> 2. The TBI/SCI waiting list policy is written in order to discourage the moving of individuals from the TBI/SCI Medicaid waiver list while recipients enrolled in the waiver program have unmet needs. In order to accomplish this, case managers must:
> a.) Keep accurate records of Care Plan costs associated with each current Medicaid Waiver recipient; and,
> b.) Annualize, and update as necessary, the cost of each TBI/SCI Medicaid Waiver Care Plan. ...

The respondent agrees that the petitioner meets the basic eligibility requirements for the program, however the respondent argues that because of a lack of funding services must currently be denied and the petitioner must be placed on a waiting list until sufficient funds are available.

The state is allowed to limit participation to waivers based on available funding. Both the Florida Constitution and Florida Statutes prohibit agencies from contracting or agreeing to spend any moneys in excess of the amount appropriated to them unless authorized by law. *See* Art. VII, Sec. 1(c), Fla. Const.; § 216.311(1), Fla. Stat. (2002).

Applicants are entitled to receive services only within available resources, and the respondent has discretion to prioritize how it will distribute funds. § 393.13(3)(c)-(d), Fla. Stat. (2002); *see also* Dep't of Health & Rehab. Servs. v. Brooke, 573 So.2d 363 (Fla. 1st DCA 1991) (holding budgetary decision-making was within agency head's executive discretion).

In Bridget Ellingham v. Dept. of Children and Family Services, 896 So.2d 926 (Fla. 1st DCA 2005) the court concluded that lack of funding is an affirmative defense to a claim for developmental disabilities services, analogous to the defense of impossibility of performance in a contract action. The party seeking to assert the affirmative defense has the burden of proof as to that defense.

As this case involves the petitioner's assertion of eligibility for waiver services and the respondent is asserting that the petitioner must be placed on a waiting list because of a lack of funding, the respondent has the burden to show that there is insufficient funding for the petitioner to receive benefits.

The hearing officer concludes that there is limited funding which results in the petitioner being evaluated under the waiting criteria. As the respondent has met its burden of showing the lack of funding, the petitioner now has the burden to establish his eligibility for benefits under the waiver.

The petitioner is on the waiting list effective February 2006, the month she applied for services. The program will next fill openings in July 2008. The petitioner will be considered to fill one of the openings based on the prioritization screening set forth in the above handbook.

Based on all the evidence and testimony presented, the hearing officer concludes that the respondent's action concerning the petitioner's case was correct. There was no evidence presented to show that the petitioner is eligible for immediate services. The budgetary constraints faced by the respondent mandate service provision limitations and the petitioner remains on the wait list.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 02 day of June, 2008, in Tallahassee, Florida.

Leslie Green

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

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

[redacted]

APPEAL NO. 08F-2317

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 21, 2008, at 8:20 a.m., in Miami, Florida. The petitioner, [redacted] was present and represented himself. Present, as a witness for the petitioner was his mother [redacted] The respondent was represented by Mara Perez, program specialist with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the respondent was, Laura Rumph, administrator Medicaid Compliance Unit; and Cathy Wilson, RN consultant for AHCA. Also appearing telephonically as witnesses for the respondent was, Dr. Gabriel Novoba; medical director; Nancy Garcia, grievance coordinator; Janet Carter, director of government benefits; and Preferred; and Gladys Fernandez, provider relations all with Preferred Medical Plan.

## ISSUE

At issue is the March 17, 2008 action by the respondent in denying the petitioner's request to change plans, outside of open enrollment. As a request, the petitioner has the burden of proof.

## FINDINGS OF FACT

1. The petitioner is a Medicaid beneficiary in the state of Florida. The petitioner has been enrolled with Preferred Medical Plan since August 2007.
2. The petitioner made a request to change his Plan and the request was denied stating, "Your request does not meet a state-approved good cause reason to leave your present health plan. You will be able to change plans beginning 5/19/08 if you want." A notice dated March 17, 2008 was provided to the petitioner.
3. The notice informed the petitioner that as of May 19, 2008 he would be able to change plans, as it was the open enrollment period. The respondent confirmed this information.
4. The hearing was requested on March 27, 2008.

## CONCLUSIONS OF LAW

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

The petitioner stated that there were difficulties in finding out whether his physician was a provider for the Plan and he requested the change. He stated that he may stay

with his current plan, if his doctor is still a provider. The respondent offered to assist the petitioner in any additional information needed on the provider.

The hearing officer finds that there is no further need for a decision by the hearing officer. The petitioner may choose any plan within the open enrollment period that began on May 19th. Therefore, the issue is now moot.

## DECISION

The appeal is dismissed as moot.

## 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, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Rhea Grey, Acting Prog. Adm., Medicaid Area 11
Health Systems Development Administrator

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

[redacted]

APPEAL NO. 08F-02806

PETITIONER,

Vs.

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

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 20, 2008, at 2:30 p.m., in St. Petersburg, Florida. The petitioner was not present. She was represented by her parents [redacted]. The respondent was represented by Aaron Lounsberry, program specialist. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Robert Buzzeo, M.D. consulting physician, and Gary Erickson, register nurse hearing specialist.

## ISSUE

The petitioner is appealing the notices of April 4 and 14, 2008 for the respondent's action to decrease private duty nursing for the period of March 25, 2008 through September 20, 2008. The respondent has the burden of proof.

## FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Denial Letter on April 4, 2008. The notice informed the petitioner that for the requested 4,270 hours of private duty nursing for the period of March 25, 2008 through September 20, 2008, 2,672 hours were approved and 1,598 hours were denied. The petitioner received a PDN/PC Recipient Reconsideration notice. The notice informed the petitioner that for the requested 4,270 hours of private duty nursing for the period of March 25, 2008 through September 20, 2008, 3,387 hours were approved and 883 hours were denied. At the beginning of the hearing, the parents requested 24 hours a day, seven days a week.

1. Both sides presented evidence. Due to new and material evidence, the consulting physician rescinded the denial as set forth in the reconsideration. The consulting physician recommended that the private duty nursing would be denied for the hours on Saturday from 3:00 p.m. to 11 p.m. and on Sunday from 7:00 a.m. to 12:00 p.m. for the period of March 25, 2008 through September 20, 2008. The parents agreed to that recommendation. The respondent agreed to authorize 24 hours of private duty nursing Mondays through Fridays, 16 hours of private duty nursing on Saturdays and 19 hours on Sundays for the period of March 25, 2008 through September 20, 2008.

## CONCLUSIONS OF LAW

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

As all parties have entered into an agreement, no further issue is indicated for appeal. Therefore, the appeal is granted in accordance to the agreement reached at the hearing.

## DECISION

This appeal is granted.

## NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the 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 26th day of June, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Noreen Hemmen, Area 5 Medicaid Adm.

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

[redacted]

APPEAL NO. 08F-02172

PETITIONER,

Vs.

CASE NO. 1035499495

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 08 Collier
UNIT: 88287

RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 22, 2008, at 11:55 a.m., in Immokalee, Florida. The petitioner was not present. She was represented telephonically by [redacted] her sister and power of attorney. The respondent was represented by Jim Clay, senior worker. Present as a witness for the respondent was Anna Toledo, economic self-sufficiency eligibility specialist.

The respondent was allowed 10 days to return further evidence. Evidence was received from the petitioner on April 22, 2008. It was accepted as Petitioner's Exhibit 3.

## ISSUE

At issue is the November 29, 2007 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program for failure to return requested information.

## FINDINGS OF FACT

The respondent objected to the hearing of this appeal stating that the petitioner failed to request the hearing within the required time period. The notice at issue was mailed on November 29, 2007. The request for a hearing was received on March 3, 2007. 90 days from the date of the notice was March 2, 2008 which was a Sunday.

The respondent argued that the hearing request was filed beyond the 90 days from the date of the notice. Therefore, the appeal should not proceed through the fair hearing process. The petitioner argued that the 90th day fell on a Sunday, therefore, the appeal was filed in a timely manner on the next business day. The hearing officer overrules the respondent's objection and finds that the appeal was filed within the required 90 days.

1. On August 21, 2007, the respondent filed a Request for Assistance to apply for benefits through the Institutional Care Program. She resided in a nursing facility. On September 7, 2007, the respondent interviewed the petitioner's brother (her representative) on the telephone.
2. On September 14, 2007, the respondent issued a pending notice requesting that the petitioner provide copies of bank statements and proof of the value of any life insurance policies. The deadline to return the information was September 24, 2007. The representative telephoned the worker several times requesting extensions to provide the information.
3. On October 16, 2007, the worker spoke with the representative again when he reported that the petitioner was moved to a different nursing

facility. She reminded the representative that the petitioner was pending for the return of bank statements and the value of a life insurance policy. The respondent did not have any further contact with the representative. On November 29, 2007, the respondent issued a notice to the petitioner denying the application for benefits due to her failure to provide requested information.

4. The petitioner was in and out of either the hospital of nursing homes since July 30, 2007. She resided in three different nursing homes between August 2007 and November 2007. Finally, the family moved her to New York in November 2007. She has resided in a nursing home there since her move.
5. Her representative knew that the information was needed. However, they experienced problems obtaining the information since the sister moved in and out of different residences. Therefore, her address changed and mail was delayed. The first representative does not dispute that he lost contact with the eligibility worker when a telephone number changed.
6. On March 3, 2008, the petitioner returned copies of bank statements for the months of August 2007 through November 2007 and a statement as to the value of her life insurance policy. The verification was received with the request for a fair hearing.

## CONCLUSIONS OF LAW

The Fla. Admin. Code at 65A-1.204 discusses Rights and Responsibilities and states in relevant part:

> (1) Any person has the right to apply for assistance, have his/her eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing all necessary facts and documentation to establish eligibility, advise the Department of any changes in his/her circumstances which might affect eligibility and/or the amount of the public assistance benefit, and to provide the department with any channel of information concerning his/her affairs that may be determined necessary. If the information or documentation is difficult for the person to obtain, the department must provide assistance in obtaining the information or documentation when requested or when it appears necessary.

Florida Administrative Code at 65A-1.205(1)(d) states regarding requests for verification in the processing of an application:

> (d) If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, or that an assistance group member is required to register for employment services, the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated). Medical information for temporary cash assistance related cases is due within 30 calendar days of the request. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day...

The respondent's Integrated Online Policy Manual HRSM165-22 section 0610.0401 states:

> If the department needs **additional information** or verification from the applicant, provide:
>
> 1. A written list of items required to complete the application process,
> 2. The date the items are due in order to process the application timely, and
> 3. The consequences for not returning additional information by the due date.

> The verification/information due date is 10 calendar days from the request date. If the due date falls on a holiday or weekend, the deadline for the requested information is the next working day. At the individual's request, extend the due date.
>
> If the individual does not return the requested verification(s) or additional information necessary to process the case during the specified time frames, take the following action:
>
> 1. Deny application the day after the pending period ends, or no later than 30 days from the date of application. If the SFU provides the missing verification within the initial 30-day period, reopen the AG if eligible. Provide food stamps from the date of application.
> 2. Use the same application form for the denied case if reapplication is after the 30th day, but before the 60th day. The new date of application is the date the client requests a new appointment. The AG loses benefits for the initial 30 days; prorate benefits from the new date of application if eligible.

The evidence establishes that the respondent applied for benefits through the Institutional Care Program. The respondent issued a pending notice requesting verification of the petitioner's bank balances and life insurance value. The petitioner asked for extensions to provide the information that were granted. The last contact that the petitioner had with the respondent was the middle of October 2008. The respondent allowed the application to remain pending for another month with no further contact from the petitioner.

The above-cited policy and laws make it clear that the applicant has the responsibility to provide requested information. The respondent allowed additional time for the petitioner to provide the information but denied the application when the communication with the representative stopped. Therefore,

the respondent correctly denied the application for failure to return requested information.

## 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 4th day of June, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Roseann Liriano, Suncoast Region

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

[redacted]

APPEAL NO. 08F-2398

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 7, 2008, at 8:22 a.m., in Miami, Florida. The petitioner, [redacted], was represented at the hearing by his mother, [redacted] The respondent was represented by Monica Otoriola and Carlos Rodriguez, both program specialists with the Agency for Health Care Administration (AHCA). Present as witnesses for the respondent via the telephone, was Dr. Rakesh Mittal, physician reviewer and Gary Erickson, registered nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South.

## ISSUE

At issue is the respondent's action of March 13, 2008 and March 27, 2008 (reconsideration), to approve 528 hours and deny 80 hours of private duty nursing (PDN) services, from the total of 608 hours requested. The 80 hours denied represent Saturday and Sunday hours, from 6 pm to 11 pm. The respondent has the burden of proof.

## FINDINGS OF FACT

1. The petitioner is ten years old and a Medicaid beneficiary in the state of Florida. The petitioner is medically complex with diagnosis as reported to the respondent, "Infantile cerebral palsy, unspecified; Esophageal reflux; Other diseases of lung, not elsewhere classified; Chronic airway obstruction, not elsewhere classified." Services have been continued at their prior level throughout the hearing process.

2. March 7, 2008, the provider (ARC Professional Services) requested 608 hours of skilled nursing services for the petitioner for the certification period of February 11, 2008 through April 10, 2008. The request was for services for Monday through Friday, 10pm-6am; Saturdays and Sundays, 12noon-3pm and 6pm-7am. The petitioner attends specialized medical daycare (PPEC) from 8am-2pm, Monday through Friday.

3. The respondent has contracted KēPRO South to perform medical reviews of 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 only submitted by the provider, along with all information required in order for KēPRO to make a determination on medical necessity for the level of service being requested.

4. On March 13, 2008, an initial screening of the request was completed by the registered nurse reviewer. The nurse reviewer was unable to approve at this level of review, the amount of hours that were being requested. The nurse reviewer referred the case to a board-certified pediatric physician, for review of the level of care being requested.

5. On February 5, 2008, the physician consultant reviewed the social and medical information submitted and denied 80 hours and approved 528 hours of the request for PDN services documenting, "Not clear [reason] more hrs are requested on weekend evenings as mom's work hrs are the same for all 7 days. I would deny 6p-11p on Sat./Sun. and would approve the rest."

6. On March 13, 2008, a PDN/PC Recipient Denial Letter was issued to the petitioner denying 80 (Sat/Sun 6pm-11pm) hours and approving 528 hours of PDN.

7. On March 21, 2008, the provider submitted a reconsideration request along with additional medical information on the petitioner's needs and care required. No specific information submitted on mother's work schedule as previously had provided work hours as "varies, usually from 1am to 4am, Monday through Friday and weekends depending on the availability of hours."

8. On March 26, 2008, a different board certified physician reviewer upheld the original denial of 80 hours. The physician reviewer documents, "...I agree with physician consultants denial proposal of five (5) hours (6pm-11pm). Provider does not submit clinical or social information which would suggest that PCG cannot provide independent care during this time period on Saturday and Sunday. Suggest to UPHOLD the DENIAL of five (5) hours, 6pm to 11pm on Saturdays and Sundays only and continue the PDN services coverage for the other hours requested."

9. On March 27, 2008, a PDN/PC Recipient Reconsideration-Denial Upheld notice was issued to the petitioner and provider informing them of the approval and denial of hours. The petitioner appealed the decision on March 31, 2008.

## CONCLUSIONS OF LAW

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

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

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided *only* when medically necessary...
>
> (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. Stat. ch. 409.9132(d) states in part:

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

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

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

(a) Meet the following conditions:

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

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

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

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

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

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

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

Fla. Admin. Code 65-2.056, Basis for Hearing states in part:

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

The petitioner's mother states that the work schedule that was used by the respondent was not correct. She states that her hours have also changed twice since then. The petitioner presented a letter dated March 26, 2008 to the hearing officer, where it provides information that is not clear, on her schedules for "training," her "home job," and her "other job" On Saturday's schedule she explains that she works from 6pm through 7am and Sundays, 12noon to 3pm and again 6pm through 6am.

In the letter, the mother states that one of her four children has cerebral palsy which "requires total care." There is no information whether there is outside assistance for this child.

The respondent explained to the petitioner's mother that flexible hours cannot be approved, but approved hours can be adjusted, through a modification request submitted to them. A request for hours on the mother's new work/training schedules had not been

submitted to the respondent. The respondent stated that for the current certification period, she needs to submit the new schedules and specific hours of work.

The hearing officer finds that according to testimony from the petitioner's mother, wrong information on her work schedule was provided to Kepro. The petitioner provided current schedule information and hours for the previous certification period. The respondent's determination was based on incorrect information that was provided to them and because of that, their denial of PDN hours from 6 pm through 11 pm for the weekend was not correct. As a de novo hearing is conducted by this hearing officer, new or additional evidence not previously considered by the respondent in making its decision is now considered. The respondent's decision is reversed for the certification period of February 11, 2008 through April 10, 2008.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 12 day of June, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
Rhea Grey, Acting Prog. Adm., Medicaid Area 11
Sharon Lang
Mary Wheeler
Karen Kinser, Nursing Consultant

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 08F-01967

CASE NO. 1261539940

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 3:05 p.m. on April 8, 2008 in Orlando, Florida. [redacted] did not attend the hearing, but she was duly represented at hearing by her husband, [redacted] and her son, [redacted] The respondent was represented by Reginald Schofield, ACCESS supervisor.

## ISSUE

At issue was whether or not denial of Institutional Care Program (ICP) benefits was correct on the basis of excess assets for months before July 2007. Burden of proof was on the petitioner, as an applicant.

## FINDINGS OF FACT

1. On April 26, 2007, an ICP application was filed. Benefits were authorized beginning July 2007, but denied with a determination of excess assets for months

between February and June 2007. Denial notice is Respondent Exhibit 1, as under challenge.

2. At application, the petitioner resided in a nursing facility and she resided there between February and June 2007. Presently, both the petitioner and her husband live in the facility and both receive ICP, but with different levels of care. Recent residential history, which may not be truly relevant, but helps clarify the circumstances, follows: The husband was in the nursing facility for about a year, and he and his family presumed that he would be discharged to his home. Efforts were made to retain bank account funds so that money would be available upon his discharge. The petitioner was at their home, but her mental challenges increased and she then entered the same facility. Just when his discharge was anticipated, the husband slipped and fell, with serious injury. He was unable to return home, and then received Medicare for an additional time.

3. Due to their differing levels of income, the ICP asset eligibility options are different for the couple. For the husband with a higher level of income, resource level was listed as $2000, and for the petitioner, who has lower income, it was $5000 in the ICP category related to MEDS-AD. Income is not in dispute.

4. During recent past the petitioner's son performed maintenance and improvements to their home. In more distant past, October 1, 1998, husband and son signed a handwritten document (Petitioner's Exhibit 2) saying in part, "I...am loaning my father...$15,000 to help him with his bills, and to pay off his morgage *{sic}*. To be paid back whenever..." with a happy face drawn in. No details or repayment plan appeared. Repayment was not occurring and had not occurred.

5. Between all times from February and June 2007, the "Interest Checking" joint bank account of the petitioner and her husband had values from $22,000 - $25,350 (Respondent's Exhibit 2). Checks written during June totaled just under $2,200 (Petitioner's Exhibit 1).

6. With assets significantly depleted, ICP eligibility was authorized effective July 2007. Eligibility for July and ongoing is not in dispute. Department review of the "loan" situation and bank account balances did not result in eligibility prior to July 2007.

7. The Department reviewed the situation using loan evaluation policy, along with financial eligibility standards, as shown in Respondent's Exhibit 3. The respondent did not consider the loan or the agreement a "bona fide and negotiable" loan. The respondent considered the bank account as accessible to the petitioner and excessive for eligibility purposes for months between February and June 2007. The respondent's representative noted that even if $2500 burial fund set-aside were considered, assets would still be excessive.

## CONCLUSIONS OF LAW

Relevant to the case at hand, 20 C.F.R. § 416.1201 (a) defines resources:

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

Florida Administrative Code 65A-1.712 addresses **SSI-Related Medicaid Resource Eligibility Criteria**:

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

Fla. Admin. Code 65A-1.303, also addresses **Assets**, as follows:

(1) Specific policies concerning assets vary by program and are found in program specific rule sections and codes of federal statutes and regulations and Florida Statutes.
(2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.
(3) Once the individuals' ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless legal restrictions were caused or requested by the individual or another acting on their request or on their behalf.

In accord with state and federal regulations, the Department's guidelines at

**Florida Integrated Public Policy Manual 165-22,** inform as follows:

**1640.0205 Asset Limits** ...
Total countable assets for an individual or a couple must not exceed $2,000 or $3,000 respectively.
Exceptions to these asset limits include the following:
1. for MEDS-AD, assets cannot exceed $5,000 for an individual and $6,000 for a couple.

**1640.0408 Determining Asset Value (MSSI, SFP)**
The countable value of an asset is the equity an individual or couple has in the asset. In some cases, the asset value counted toward the applicable asset limit is first reduced by an allowable excluded amount.
Equity value is the amount that an asset can expect to sell for on the open market in the particular geographic area involved (that is the fair market value of the asset), less any legal debt on the asset.
Debts are any form of legal indebtedness against the asset in question, such as:
1. mortgages,
2. liens,
3. loans,
4. purchase contracts, or

5. security interests.
...
Outstanding checks that have not cleared the bank yet are considered a form of legal indebtedness against the asset.

**1640.0514 Burial Exclusion Policy...**
...may set aside funds of up to $2,500 each...

**1840.1303 Loans**
...When an individual is the borrower:
Proceeds of a bona fide loan received by the borrower are not income in the month of receipt. If the loan is determined not to be bona fide, the proceeds are considered income in the month received. The amount remaining from the loan in the month following receipt is considered as an asset to the borrower.

Within state and federal guidelines, $5,000 is the asset standard for an individual whose income is below $743 per month for February and March 2007, or below $749 effective April 2007. These standards appear in Fla. Integrated Pub. Policy Manual 165-22, Appendix A-9 and Florida Administrative Code 65A-1.716, as referred to in 65A-1.712, cited previously. Income was not a matter under dispute, however, and only has relevance to this case because for any potential eligibility, the highest asset standard was $5,000. At all times, the assets exceeded such, unless assets were determined as reduced by the amount described in the son's statement.

After careful consideration, and in the absence of any repayment plan or ongoing repayment, it is concluded that the $15,000 described in the October 1998 document does not constitute a bona fide loan for asset reduction purposes. The bank account balances documented by the bank between February and June 2007 were factually available to the petitioner without legal restrictions or ramifications if she had used them. The assets would not be reduced by the $15,000 figure.

Therefore, based upon regulations, policies, and findings, it is concluded that assets exceeded standards between February and June 2007. The respondent's action to deny benefits was justified.

## DECISION

The appeal is denied and the Department'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 9th day of June, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
District 7 ACCESS Cassandra Johnson

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

[redacted]

APPEAL NO. 08F-02798

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 22, 2008, at 9:23 a.m., in Plant City, Florida. The minor petitioner was present, but is not able to testify. [redacted] a registered nurse with [redacted] accompanied and assisted the petitioner, and also testified. The petitioner was represented by her mother, [redacted] who also testified. Maria Diaz, registered nurse specialist with AHCA, represented the respondent and testified. [redacted], registered nurse and director of nursing with [redacted] appeared as a potential witness for the petitioner. [redacted] registered nurse supervisor also with [redacted] observed.

Two individuals from Kepro were present by telephone. Dr. Rakesh Mittal, physician and pediatrician, and Gary Erickson, registered nurse and hearing specialist, both appeared as witnesses by phone.

## ISSUE

At issue is the respondent's reconsideration decision of April 9, 2008 to reduce private duty nursing (PDN) services paid by Medicaid by four hours on Tuesdays and Wednesdays, from 22 hours daily to 18 hours daily on these weekdays. The respondent retains the same number of prior approved PDN services on other days of the week. The respondent has the burden of proof.

## FINDINGS OF FACT

1. The petitioner is ten years old with a birth date of [redacted]. The petitioner lives with and receives primary care from his mother, [redacted].
2. The petitioner has diagnoses to include anoxic brain damage, congenital anomalies of larynx, trachea, and bronchus. The petitioner has a history of convulsions, has a tracheostomy, and has a diagnosis of encephalopathy. Medical services requested to be performed by a private duty nurse include medication administration, tube feedings, seizure precautions, and tracheostomy care. The petitioner requires suctioning and oxygen when needed. The respondent continues to approve PDN services of 22 hours daily on Monday, 21 hours daily on Thursdays and Fridays, and 12 hours daily on Saturdays and Sundays. In dispute is the respondent's action to reduce approved PDN hours by four hours on Tuesdays and Wednesdays, from 22 hours daily to 18 hours daily.

3. Dr. Rakesh Mittal is a pediatrician who provides a physician review for requested medical services for the contracted Kepro organization. Dr. Mittal relies on social and clinical information provided by the home agency via the internet to determine the need for requested PDN hours. Dr. Mittal believed the petitioner to have no siblings living in the home based on this internet information. However, the petitioner has three other generally healthy siblings living in the home, ages 11, 7, and 4.
4. The petitioner's mother is a licensed practical nurse and the petitioner's primary caretaker. The petitioner's mother is able to provide needed care to the petitioner when her time permits. The petitioner's mother attends school full-time with the goal to become a registered nurse. Further, the petitioner's mother works 56 to 66 hours weekly as a licensed practical nurse. The petitioner's grand-mother does not live in the home, but has helped with the petitioner's care when PDN services were not available. The petitioner grand-mother helps with baths and other needs, but does not have complete training on the petitioner's medical needs.
5. The petitioner attends RN school from 3:00 p.m. to 9:00 p.m. on Tuesdays and from 3:00 p.m. to 11:00 p.m. on Wednesdays. Dr. Mittal opines that the petitioner's mother should be able to provide care to the petitioner from 7:00 a.m. to 11:00 a.m. on Tuesdays and Wednesdays. The petitioner's mother has used this time to meet

with the other siblings' teachers about hyperactivity and other behavioral problems. The petitioner's siblings will be out of school for the summer.

## CONCLUSIONS OF LAW

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

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

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the contracted Kepro reviewing pediatrician

recommends the reduction of PDN services from 22 hours on Tuesdays and Wednesdays to 18 hours daily on these two days.

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

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

The Findings of Fact show that the petitioner's mother, as caregiver, is able to safely provide all needed aspects of the petitioner's care, when her time permits. Findings show that the petitioner's mother has a heavy schedule of full-time work and school, along with responsibility for three other young children. This schedule leaves little time to provide care for the petitioner. However, findings show that the petitioner's mother is not in school or at work on the Tuesday and Wednesday mornings when the respondent proposes to reduce PDN hours. Since the petitioner's other siblings are no longer in school for the summer, the petitioner's mother will not need to use this time for school conferences, as during the school year. Since the language of the above handbook requires the caretaker to provide care to the "fullest extent possible," the respondent's action to reduce PDN hours on Tuesdays and Wednesdays is upheld. If the petitioner's mother finds that this reduction in PDN hours is not feasible in the future, then the petitioner's mother can then request an increase in PDN hours.

## DECISION

This appeal is denied. The respondent has met its burden to prove that PDN services can be safely reduced to the amount at issue, 18 hours on Tuesdays and Wednesdays.

## NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 12 day of June, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Sue McPhee, Area 6 Medicaid Field Manager
[redacted]

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 08F-02416

CASE NO. 1276945299

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 5, 2008, at 2:15 p.m., in Pensacola, Florida. The petitioner was not present but was represented by her aunt and designated representative, [redacted]. Testifying on behalf of the petitioner was [redacted], office manager, [redacted]. The Department was represented by Franzaro Dudley, supervisor, ACCESS Florida. Testifying on behalf of the Department was Jennifer Brunson, economic self sufficiency specialist I.

## ISSUE

The petitioner is appealing the Department's action of March 17, 2008 to deny Institutional Care Program (ICP) and Medicaid benefits for the month of application and the retroactive months of October through December 2007 based on the contention that the value of her assets was too high for the program.

## FINDINGS OF FACT

1. The petitioner is a 72 year-old woman who was admitted to the nursing home in September 2007. The petitioner's representative thought the nursing home would be paid by Blue Cross/Blue Shield. When it was discovered that Blue Cross/Blue Shield would not cover the nursing home stay, a web-based application requesting ICP and Medicaid coverage was submitted on January 2, 2008. The web application also requested retroactive ICP and Medicaid coverage for the months of October through December 2007.

2. The petitioner's representative reported assets consisting of life insurance with Liberty National Life Insurance Company with a face value of $15,000 and a checking account. The petitioner was pended for proof of life insurance cash value and copies of bank account statements. The Department received copies of the life insurance policy and bank statements on January 2, 2008 and January 18, 2008.

3. The Department determined that the petitioner's ICP asset limit based on her income was $2,000. Her countable assets for October 2007 through January 2008 were determined as follows. The petitioner's bank balance was $6,125.64 for October 2007; $6,705.63 for November 2007; $5,529.92 (after subtracting direct deposited income totaling $1474.53) for December 2007 and $1,949.52 for January 2008. The life insurance policy had a face value of $15,000 and a cash surrender value of $6,347.10. After applying the $2,500 burial exclusion amount, the cash surrender value was $3,847.10. As the bank balance and cash surrender value

exceeded the $2,000 asset limit, the Department advised the representative to spend down some of the resources. The representative paid $6,000 from the checking account on December 31, 2007 toward the nursing home bill. This cleared the bank on January 4, 2008 thereby reducing the bank balance in January 2008 to $1,949.52. In addition, she surrendered the life insurance policy and received proceeds totaling $6,347.10. This was received on February 19, 2008 and deposited to the resident trust account. On February 26, 2008, a check for $6,343 was written from the resident trust account and used to pay for an irrevocable pre-need burial contract. The petitioner's countable assets were reduced below $2,000 effective February 2008.

4. The petitioner's representative was concerned that the Department advised her to reduce the assets by purchasing an irrevocable preneed burial contract rather than paying the proceeds toward the nursing home bill. The Department responded that it explains its policy to the petitioner or the representative but does not mandate that spend down of resources must be used for any particular purpose. The petitioner was free to use the proceeds from her life insurance toward her obligation at the facility or toward the purchase of an irrevocable pre-need burial contract.

The Department responded that the delay in applying for ICP was responsible in part for the petitioner's accumulated bill at the facility. The nursing home was aware as early as November 2007 that Blue Cross/Blue Shield would not pay for the petitioner's stay. The representative was ill during that month and an application was not submitted until January 2008.

## CONCLUSIONS OF LAW

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

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

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

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

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

Eligibility Criteria, states in relevant part:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C. ...
(2)(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is $2,500 or less. (d) The individual, and their spouse, may designate up to $2,500 each of their resources for burial funds for any month, including the three months prior

> to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

20 C.F.R.§416.1205 sets forth the maximum asset limitation in the Institutional Care Program at $2,000 for an individual.

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

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

The Findings of Fact show that the petitioner had a checking account and life insurance policy. The life insurance policy had a face value of $15,000 and total countable cash surrender value, after application of the burial exclusion policy, of $3,847.10. The above authorities indicate the applicable asset limit is $2000. The countable cash value of the policy alone created ineligibility. The combined balances in the bank account, after deducting the direct deposited income, and the countable cash value of the life insurance policy from October through December 2007 and January 2008 exceeded the asset limit of $2,000 for the ICP Program. Even after deducting the payment to the facility when it was made, in December 2007, the remaining assets still exceeded the $2000 limit. All applicable exclusions were allowed before determining the countable asset values.

The resources exceeded the applicable limit for the months at issue, therefore, the Hearing Officer concludes that the petitioner was not eligible and the Department correctly denied her ICP benefits from October through December 2007 and January 2008.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18th day of June, 2008, in Tallahassee, Florida.

Linda Garton

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

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

[redacted]
PETITIONER,

APPEAL NO. 08F-02240

Vs.
AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
DISTRICT: 12 Volusia
RESPONDENT.
_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 2:50 p.m. on April 28, 2008 in Daytona Beach, Florida. The petitioner was present with his brother [redacted] and was represented by his mother, [redacted] LPN with [redacted], assisted them and she also testified on behalf of the petitioner. The respondent was represented by Sheila Broderick, RN specialist, with telephone testimony presented by Theresa Ashey, RN reviewer with KePro; Rakesh Mittal, MD, pediatric and pediatric emergency physician with KePro; and Gary Erickson, RN review operation supervisor with KePro.

## ISSUE

At issue was whether or not reduction of 70 hours private duty nursing (PDN) was correct based upon medical need. Burden of proof was on the respondent.

## FINDINGS OF FACT

1. At time of review, the petitioner was almost 5 years old and lived at home with his family. He undisputedly requires much personal and professional care due to

severe health impairments. Under AHCA provisions, PDN had been authorized at 24 hours daily. Due to limitations of the Maxim health care provider (not AHCA) he had not actually been receiving full time PDN, however.

2. During February 2008 KePro began certification review under AHCA for continuing services. Information was exchanged between the health care provider (Maxim) and KePro. Reconsideration occurred with further review and the March 15, 2008 KePro final determination, denied a total of seventy hours for certification period February 13 – April 12, 2008. This is approximately eight hours per week reduction in certification.

3. The KePro authorization at reduced hours did not represent factual reduction in services because the petitioner had not been receiving the full 24 hour PDN for which he was previously authorized.

4. A hearing was requested, in part, because the family did not want PDN services reduced even more. Additionally, the family wanted KePro staff to be better aware of their situation. The mother recently completed education as a phlebotomist and she anticipated employment. The father manages a restaurant and opens new ones, and his schedule is very unpredictable. Generally, he works five days and then is off two days in a week.

5. While both parents are able to and do perform full care for the petitioner, the care/work scheduling situation poses practical problems with the nursing provider. The provider appears to have staffing problems.

6. The final AHCA-KePro determination would result in this: On two days during the week, when a parent is home, a parent would be expected to provide four hours of

care. (This actually would be fewer hours of care than the family now provides.) This could be, as an example but not set firmly, from noon to 4:00 p.m. two days on a weekend when both parents are home.

7. The petitioner's mother was concerned that the weekly eight hours without PDN assistance would be consistent with the family schedule and the father's employment.

8. Respondent's Exhibit 2 showed review details including the notice under challenge and Respondent's Exhibit 1 reflected AHCA procedural guidelines.

## 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** 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 AHCA must review continued need for private duty nursing (PDN) service and that accurate information about family circumstances would be relevant for review purposes.

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) describing "medical necessity or medically necessary" standards. 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-4.130 stating:

> **Home Health Services**.
> ...
> (3) When terminating, reducing, or denying private duty nursing or personal care services, Medicaid will provide written notification to the recipient or the recipient's legal guardian. The notice will provide information and instructions regarding the recipient's right to request a hearing.

The Home Health Services Coverage and Limitations Handbook (page 2-2) defines **Medically Necessary** standards saying, "Medicaid reimburses services that are medically necessary for the treatment of a specific documented medical disorder, disease or impairment, do not duplicate another provider's service..." The Handbook continues with information appearing in Florida Administrative Code previously noted.

Facts, governing standards, and arguments have been carefully considered. This situation is most unusual in that the AHCA-KePro determination would not factually result in PDN reduction. Since the petitioner has not actually been receiving a full 24 hour PDN service and testimony was that the family already provided at least eight hours of care weekly, the AHCA determination does not factually represent a reduction. Additionally, the family care-provision situation has demonstrated that the ACHA-KePro determination is medically feasible. However, the family concern is also completely reasonable. The family does not want to lose even more PDN coverage. Also, it is appropriate for KePro to know actual circumstances and difficulties. It is reasonable for the family to be concerned about practicality as to availability of services. However, the matter of service or provider availability is not within purview of an administrative hearing officer.

It is concluded that the KePro plan to reduce authorization by eight hours of PDN per week is appropriate. This was set forth on the March 15, 2008 notice of action. Medical necessity for PDN at 24 hours daily has not been demonstrated and the March 15, 2008 notice 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 16th day of June, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
Lisa Broward, Area 4 Medicaid Adm.
[redacted]

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

[redacted]

APPEAL NO. 08F-2401

PETITIONER,

Vs.

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

RESPONDENT.

_____/

## FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 20, 2008, at 9:05 a.m., in Miami, Florida. The petitioner, [redacted], was represented at the hearing by her father, [redacted] Present as an observer for the petitioner was her aunt, [redacted] The respondent was represented by Jeffrey Douglas, program administrator and Monica Otoriola, program specialist, both with the Agency for Health Care Administration (AHCA). Present as witnesses for the respondent via the telephone, was Dr. Rakesh Mittal, physician reviewer and Mary Wheeler, review manager, both with Keystone Peer Review Organization (KēPRO) South.

## ISSUE

At issue is the respondent's action of March 14, 2008 and March 19, 2008 (reconsideration), to approve 2,064 hours and deny 208 hours of private duty nursing (PDN) services, from the total of 2,272 hours requested. The hours requested were for

certification period of March 7, 2008 through September 2, 2008. The respondent has the burden of proof.

## FINDINGS OF FACT

1. The petitioner is seven years old and a Medicaid beneficiary in the state of Florida. The petitioner is medically complex with diagnosis as reported to the respondent, "Cerebral edema, Chronic obstructive asthma, with acute exacerbation, Other generalized ischemic cerebrovascular disease, Vesicoureteral reflux unspecified or without reflux nephropathy, Urinary tract infection, site not specified."

2. On March 11, 2008, the provider (Nationwide Healthcare Services) requested 2,272 hours of skilled nursing services for the certification period of March 7, 2008 through September 2, 2008. The request was for services for Monday through Friday, 11pm-7am; and 24 hour daily nursing on Saturdays and Sundays.

3. The petitioner lives in the home with her mother, father and another adult, that have no medical problems. The petitioner attends specialized medical daycare (PPEC) from 8am-3pm, Monday through Friday. The mother works from Wednesday to Sunday (until 7pm) and the father works weekdays to 3pm and on the weekend has been working until 6pm.

4. The respondent has contracted KēPRO South to perform medical reviews of 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 only submitted by the provider, along with all information required in order for KēPRO to make a determination on medical necessity for the level of service being requested.

5. On March 13, 2008, an initial screening of the request was completed by the registered nurse reviewer. The nurse reviewer was unable to approve at this level of review, the amount of hours that were being requested. The nurse reviewer referred the case to a board-certified pediatric physician, for review of the level of care being requested.

6. On March 13, 2008, the physician consultant reviewed the social and medical information submitted and denied (7pm-11pm) 4 of the 24 hours requested for the weekend, approving (11pm-7am) 20 hours each day of PDN services documenting, "On weekends parents are home by 7pm so could provide some care. I would deny 7p-11p Sat/Sun. Approve the rest."

7. On March 14, 2008, a PDN/PC Recipient Denial Letter was issued to the petitioner denying 208 (Sat/Sun 7pm-11pm) hours and approving 2,064 hours of PDN.

8. On March 14, 2008, the provider submitted a reconsideration request along with the following information: "This father already cut his hours of work on weekdays in order to care for his daughter at 3p after PPEC. ı takes care of his daughter everyday Monday to Friday after school until 11p when the nurse arrive. The only day that this couple have some time to spend together after work is in the weekend. Please give the weekends hour back 24hrs/day Sat/Sun."

9. On March 18, 2008, a different board certified physician reviewer upheld the original denial of 208 hours. The physician reviewer documents, "...The decision made by the physician consultant is a reasonable request and is within the statute requirements of this program, (see the PDN Home Health Handbook). I agree with the physician

consultant and the decision to deny four (4) hours, 7pm to 11pm each Saturday and Sunday, Denial should be upheld."

10. On March 19, 2008, a PDN/PC Recipient Reconsideration-Denial Upheld notice was issued to the petitioner and provider informing them of the approval and denial of hours. The petitioner appealed the decision on March 31, 2008.

## CONCLUSIONS OF LAW

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

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

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided *only* when medically necessary...
>
> (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. Stat. ch. 409.9132(d) states in part:

> Medical necessity or medically necessary means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or

infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

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

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

(a) Meet the following conditions:

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

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

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

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

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

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

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

The petitioner's father states that they have their own business. He has adjusted his work schedule on the weekdays and on the weekends in order to care for his daughter and the petitioner's mother works at the business as well.

The father presented two letters (Petitioner's Exhibit 1) from treating physicians which included medical information. One of the letters states, "Due to her extremely complex medical conditions, it is necessary for [redacted] to have home health nursing 12 hours per day during the day and 24 hours a day on the weekends."

The physician consultant argues that the letters (January 2008) provide no new information that would warrant the approval of the 4 hours (7pm-11pm), as the information was previously considered. He states that the petitioner has not had any complications and believes that the reason the treating physician recommends 12 hours of care for weekdays and 24 hours of care for weekends, is because the parents work the weekends. The hearing officer agrees.

The hearing officer finds that according to the above-mentioned rules and authorities, the respondent correctly denied the 4 hours of PDN from 7pm through 11pm as at least one parent is available to care for the petitioner and continues to care for her. The respondent's decision is affirmed for the certification period of March 7, 2008 through September 2, 2008.

## DECISION

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

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25th day of June, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Rhea Grey, Acting Prog. Adm., Medicaid Area 11
Mary Wheeler
Sharon Lang
Karen Kinser, Nursing Consultant