FILED
JUN 03 2009
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-02192

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pasco
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 13, 2009, at 3:37 p.m., in St. Petersburg, Florida. The petitioner was not present. He was represented by his mother. The respondent was represented by Stephanie Lange, registered nurse specialist. Witnesses for the respondent by telephone from Keystone Peer Review Organization (KePRO) were Rakesh Mittal, M.D., physician reviewer, and Melanie Clyatt, registered nurse review supervisor.

ISSUE

The petitioner is appealing the notices of March 12 and 25, 2009 for the respondent's action to deny 2,160 hours of private duty nursing for the period of March 5, 2009 through August 31, 2009. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is 20 months old. He was premature sextuplet. Due to health problems at birth, he was receiving private duty nursing private duty nursing of twelve hours a day. The petitioner's health has improved. He is receiving speech therapy and requires prescription creams for a rash. He has no other impairments or medication. The petitioner resides with his mother, father and six siblings. Five siblings are 20 months old and one sibling is five years old. The father is self-employed and works seven days a week: Monday, Tuesday, Thursday, Friday and Saturday from 3:30 a.m. to either noon or 2:00 p.m. and Wednesday and Sunday from 7:00 a.m. to 10:00 a.m. The mother works in the home doing the bookkeeping for the family business five to six hours a day.

2. The nursing agency requested 2,160 hours of private duty nursing for the petitioner for the period of March 5, 2009 through August 31, 2009. This request would be twelve hours a day of private duty nursing.

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

4. The initial nurse reviewer screened the petitioner's request for private duty nursing using the Internal Focus Finding. The Internal Focus Finding provides information to KePRO of case identifiers and additional information regarding the petitioner. This information is generated to the computer for review by KePRO from the information entered by the petitioner's home health agency

via computer. The request was then referred to the board certified physician consultant.

5. The initial physician consultant determined was based on the information received from the nursing agency. The initial physician consultant determined that the petitioner did not have any medical impairment which required skilled nursing care by a private duty nurse. A PDN/PC Recipient Denial Letter was sent to the petitioner on March 12, 2009. The notice informed the petitioner that for the requested 2,160 hours of private duty nursing for the period of March 5, 2009 through August 31, 2009, all hours were denied.

6. The nursing agency requested a reconsideration. The reconsideration was reviewed by a second physician consultant. The reconsideration was denied for the 2,160 hours of private duty nursing that was requested. The respondent sent a PDN/PC Recipient Reconsideration - Denial Upheld notice on March 25, 2009.

CONCLUSIONS OF LAW

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

Florida Administrative Code 59.G-1.010, "Definitions", states for medical necessity:

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

The Home Health Services Coverage and Limitation Handbook under Private Duty Nursing, on page 2-15 "Parental Responsibility", states:

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

The Home Health Services Coverage and Limitation Handbook under Private Duty Nursing, on page 2-14 and 2-15 define skilled nursing:

> The following are examples of services that require the direct care skills of a licensed nurse:
> Administration of intravenous medication;

Administration of intramuscular injections, hypodermoclysis, and subcutaneous injections only when not able to be self administered appropriately.
Insertion, replacement and sterile irrigation of catheters;
Colostomy and ileostomy care; excluding care performed by recipients;
Treatment of decubitus ulcers when:
- deep or wide without necrotic center;
- deep or wide with layers of necrotic tissue; or
- infected and draining;
Treatment of widespread infected or draining skin disorders;
Administration of prescribed heat treatment that requires observation by licensed nursing personnel to adequately evaluate the individual's progress;
Restorative nursing procedures, including related teaching and adaptive aspects of nursing, which are a part of active treatment and require the presence of licensed nurses at the time of performance;
Nasopharyngeal, tracheotomy aspiration, ventilator care;
Levin tube and gastrostomy feedings, excluding feedings performed by the recipient, family or caregiver; and
Complex wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

The respondent's termination of private duty nursing was based on the respondent's determination that petitioner's impairments no longer required skilled care performed by a private duty nurse. The petitioner's health has improved. He is receiving speech therapy and requires prescription creams for a rash. He has no other impairments or medication. The evidence does not demonstrate that the petitioner requires skilled care services performed by a private duty nurse. The respondent has met their burden that medical necessity has not been demonstrated for the petitioner to received 2,160 hours of private duty nursing. Based on the above cited authorities, the respondent's action to deny 2,160 hours of private duty nursing for the period of March 5, 2009 through August 31, 2009 was within the rules of the Program.

DECISION

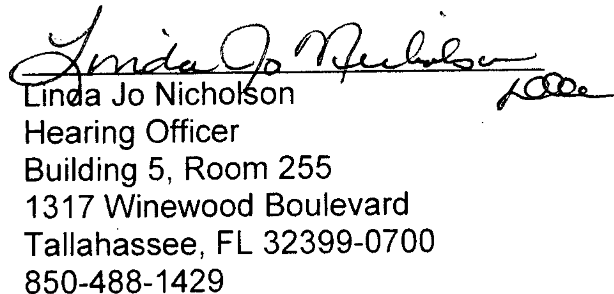
This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 3rd day of June, 2009,

in Tallahassee, Florida.



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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-02191

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pasco
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 13, 2009, at 2:12 p.m., in St. Petersburg, Florida. The petitioner was not present. He was represented by his mother. The respondent was represented by Stephanie Lange, registered nurse specialist. Witnesses for the respondent by telephone from Keystone Peer Review Organization (KePRO) were Rakesh Mittal, M.D., physician reviewer, and Melanie Clyatt, registered nurse review supervisor

ISSUE

The petitioner is appealing the notices of March 12 and 25, 2009 for the respondent's action to deny 2,160 hours of private duty nursing for the period of March 5, 2009 through August 31, 2009. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is 20 months old. He was premature sextuplet. Due to health problems at birth, he was receiving private duty nursing private duty nursing of twelve hours a day. The petitioner's health has improved. However, he is unable to walk or fully crawl. The petitioner is ambulating by what was referred to by his mother as a "commando crawl" pulling himself with his forearms. The petitioner requires monitoring as there is a danger of the petitioner aspirating when he eats. He cannot communicate. The petitioner's impairments are cerebral palsy and motor tics. His doctor indicated by prescription note that the petitioner may have possible seizures. The petitioner resides with his mother, father and six siblings. Five siblings are 20 months old and one sibling is five years old. The father self-employed and works seven days a week: Monday, Tuesday, Thursday, Friday and Saturday from 3:30 a.m. to either noon or 2:00 p.m. and Wednesday and Sunday from 7:00 a.m. to 10:00 a.m. The mother works in the home doing the bookkeeping for the family business five to six hours a day.

2. The nursing agency requested 2,160 hours of private duty nursing for the petitioner for the period of March 5, 2009 through August 31, 2009. This request would be twelve hours a day of private duty nursing. The nursing agency completed the on-line queries for the request of services. The nursing agency provided information including the petitioner was able to walk, communicate, play with his siblings and the mother did not work. The petitioner's mother noted

inconsistencies in the information the nursing agency gave KePRO. The petitioner cannot walk, communicate or play with his siblings and she works.

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

4. The initial nurse reviewer screened the petitioner's request for private duty nursing using the Internal Focus Finding. The Internal Focus Finding provides information to KePRO of case identifiers and additional information regarding the petitioner. This information is generated to the computer for review by KePRO from the information entered by the petitioner's home health agency via computer. The request was then referred to the board certified physician consultant.

5. The initial physician consultant determined was based on the information received from the nursing agency. The initial physician consultant determined that the petitioner did not have any medical impairment which required skilled nursing care by a private duty nurse. A PDN/PC Recipient Denial Letter was sent to the petitioner on March 12, 2009. The notice informed the petitioner that for the requested 2,160 hours of private duty nursing for the period of March 5, 2009 through August 31, 2009, all hours were denied.

6. The nursing agency requested a reconsideration. The reconsideration was reviewed by a second physician consultant. The reconsideration was denied for the 2,160 hours of private duty nursing that was requested. The

respondent sent a PDN/PC Recipient Reconsideration - Denial Upheld notice on March 25, 2009.

7. The petitioner's mother submitted a prescription from the petitioner's treating physician, ., M.D. The physician stated for regarding the petitioner: "...is a Ex 29 week premie with multiple medical problems requiring 24 (hour) nursing including CP, motor tics, difficulty moving + ambulating + difficult with feeds, possible seizures."

8. The physician consultant reviewed the prescription and the petitioner's testimony. He opined that monitoring is not a skilled service and the services requested in the doctor's prescription are not services that are required to be performed by a private duty nurse.

CONCLUSIONS OF LAW

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

Florida Administrative Code 59.G-1.010, "Definitions", states for medical necessity:

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

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

The Home Health Services Coverage and Limitation Handbook under Private Duty Nursing, on page 2-15 "Parental Responsibility", states:

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

The Home Health Services Coverage and Limitation Handbook under Private Duty Nursing, on page 2-14 and 2-15 define skilled nursing:

> The following are examples of services that require the direct care skills of a licensed nurse:
>
> Administration of intravenous medication;
>
> Administration of intramuscular injections, hypodermoclysis, and subcutaneous injections only when not able to be self administered appropriately.
>
> Insertion, replacement and sterile irrigation of catheters;

Colostomy and ileostomy care; excluding care performed by recipients;
Treatment of decubitus ulcers when:
- deep or wide without necrotic center;
- deep or wide with layers of necrotic tissue; or
- infected and draining;
Treatment of widespread infected or draining skin disorders;
Administration of prescribed heat treatment that requires observation by licensed nursing personnel to adequately evaluate the individual's progress;
Restorative nursing procedures, including related teaching and adaptive aspects of nursing, which are a part of active treatment and require the presence of licensed nurses at the time of performance;
Nasopharyngeal, tracheotomy aspiration, ventilator care;
Levin tube and gastrostomy feedings, excluding feedings performed by the recipient, family or caregiver; and
Complex wound care requiring packing, irrigation, and application of an agent prescribed by the physician.

The respondent's termination of private duty nursing was based on the respondent's determination that the petitioner's impairments no longer required skilled care performed by a private duty nurse. The hearing officer considered that there were inconsistencies in the information provided by the nursing agency. As such, the hearing officer relied on the testimony of the mother and evidence presented by the mother as to petitioner's situation. The petitioner's health has improved. However, the petitioner requires monitoring as there is a danger of the petitioner aspirating when he eats, cannot communicate and has impairments of cerebral palsy and motor tics. The physician reviewer opined that monitoring is not a skilled service and the services requested in the doctor's prescription are not services that are required to be performed by a private duty nurse.. As set forth in rule, services cannot be authorized that are in excess of the patient's needs. The physician reviewer and the respondent did concur that

the petitioner may need other services to assist in monitoring his aspiration. The petitioner's treating physician indicated by prescription note that the petitioner may have possible seizures. Seizure activity had not been confirmed at the time of the hearing. There was no documentation as to the type of seizure, the effect of the seizure on the petitioner, medication or the effects of the medication.

The hearing officer reviewed the physician's prescription. If a provider prescribed, recommended, or approved medical or allied care, goods, or services, it does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. The physician prescription for services did not indicate the level of skilled care the petitioner requires. The evidence that was submitted demonstrates the petitioner's impairments do not require the direct care skills of a licensed nurse. There may be indications of other services that might better suit the petitioner. The petitioner should contact the nursing agency to define these potential services. The respondent has met their burden that medical necessity has not been demonstrated for the petitioner to received 2,160 hours of private duty nursing. Based on the above cited authorities, the respondent's action to deny 2,160 hours of private duty nursing for the period of March 5, 2009 through August 31, 2009 was within the rules of the Program.

DECISION

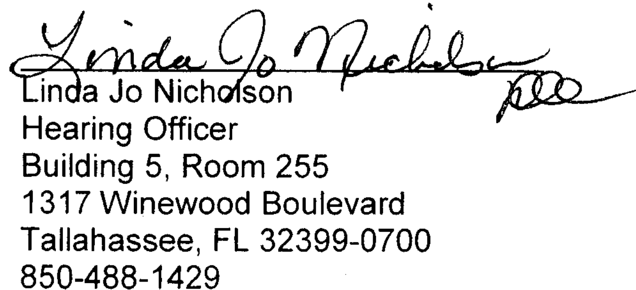
This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.



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JUN 12 2009
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-02247

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 14 Jackson
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer, by telephone, on May 8, 2009, at 10:15 a.m., in Marianna, Florida. The petitioner was present and represented himself. Testifying on behalf of the petitioner was his mother, . The Respondent was represented by Loretta Miller, Program Administrator, Agency for Health Care Administration (AHCA). Testifying on behalf of the Respondent was Juanita French, R.N. specialist, AHCA. All parties participated by telephone.

ISSUE

At issue is the Agency's action of March 25, 2009 to deny the petitioner's and his provider's request to pay for a power operated wheelchair by the Agency based on: "This service is not medically necessary based on the information provided." The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient in Marianna, Florida. He is over 21 years of age. He receives services through State Plan Medicaid. The petitioner ambulates in a standard wheelchair that has been provided to him by Medicaid. The petitioner's latest wheelchair was provided to the petitioner by Medicaid on October 12, 2007. It is a manually operated wheelchair.

2. The petitioner suffered a spinal cord injury and is paralyzed from his mid-chest down. He is confined to a wheelchair for ambulation. He is able to complete his Activities of Daily living (ADL's) independently. He is able to transfer himself and is able to propel himself manually or use a standard joystick.

3. The petitioner borrowed a power operated vehicle (POV) or motorized wheelchair. He was pleased with the POV and decided to request a POV for himself. The petitioner wants the power chair to negotiate uneven terrain. He lives in a rural area surrounded by gravel and loose dirt. His current wheelchair makes it difficult for him to maneuver outdoors. He gets stuck in the sand and requires assistance pulling him out. Because the petitioner is a young man, it is his desire to obtain a POV so that he can get out in his yard, do some gardening and participate in neighborhood activities.

4. A prior authorization request was filed on behalf of the petitioner for a GO-GO Elite Traveler 4 wheel PTO Model power operated wheelchair to AHCA. AHCA denied this request and notified the petitioner in March 2009. The denial was based on the

contention that, "This Service is not Medically Necessary based on the Information provided." (Respondent Exhibit 1)

5. The Agency also submitted a copy of the Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook. The Agency noted that several reasons for the denial of the request could have been cited other than the denial reason noted above.

6. The Agency provided a manufacturer's description of the Travel Scooter (POV) requested by the petitioner. The manufacturer's recommendation is as follows: "Your Travel Scooter is designed to provide optimum stability under normal driving conditions-dry, level surfaces composed of concrete, blacktop, or asphalt. However, Pride recognizes that there will be times when you will encounter other surface types. For this reason, your Travel Scooter is designed to perform admirably on packed soil, grass, and gravel. ...

- Reduce your ...speed when driving on uneven terrain and/or soft surfaces.
- Avoid tall grass that can become tangled in the running gear.
- Avoid loosely packed gravel and sand."

It is the Agency's further position that the requested POV is inappropriate to meet the petitioner's needs based on his statement and photographs entered as Petitioner's Exhibit 1, showing his yard is composed of loosely packed sand which is contraindicated by the manufacturer. The Agency considered this information as not relevant to the petitioner's current situation. In addition, the petitioner's request did not

rise to the level of medical necessity under Medicaid rules and his request for a POV exceeded Service limitations.

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.

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

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

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

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

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

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

(2) All durable medical equipment and supply providers enrolled in the Medicaid program must comply with the Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, July 2008, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, HCFA 1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent...

Durable Medical Equipment/ Medical Supply Services Coverage And Limitations Handbook, July 2008, sets forth the description of a wheelchair (page 2-90) and documentation requirements for a customized wheelchair (page 2-93):

Wheelchairs
Description
A wheelchair is a chair mounted on wheels used to transport a non-ambulatory individual or an individual with severely limited mobility.
Service Requirements
Medicaid will reimburse for a wheelchair when the recipient is non-ambulatory or has severely limited mobility and it is medically documented that a wheelchair is medically necessary to accommodate the recipient's physical characteristics.
Medicaid will reimburse and provide maintenance for only one wheelchair (regardless of type) or power operated vehicle (POV) procedure code per recipient, per maximum limit period, as stated in the DME and Medical Supply Services Provider Fee Schedule.

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

- customized manual wheelchairs,
- customized power wheelchairs,
- non-custom power wheelchairs,
- motorized scooters (POV), and
- power conversion kits.

Categories of Wheelchairs
Medicaid reimburses the following categories of wheelchairs:
...
- Motorized wheelchair required when medical needs cannot be met by a less costly alternative;
- Other modes(s) if the features and accessories are medically necessary...

Documentation Required for Motorized or Power Wheelchair and Power-Operated Vehicle (POV)
Medicaid will not approve a power wheelchair (custom or non-custom), power-operated vehicle (POV), or wheelchair power upgrade, without documentation from an independent licensed physical therapist or occupational therapist of physiatrist, which documents the recipient's inability to perform activities of daily living in the home and the medical consequences that will occur without the equipment requested...
The recipient must meet all of the following conditions:

- Has documented, severe abnormal upper extremity dysfunction or weakness; and
- Has demonstrated that he possesses sufficient eye and hand perceptual capabilities and the cognitive skills necessary to safely operate and guide the chair or POV independently, and is capable of evacuating a residence or building with minimal or no verbal prompting in case of an emergency; and
- Currently resides in or will primarily use the equipment in an environment conducive to the use of a motorized wheelchair of the type and size wheelchair requested....

Service Limitations Power Operated Vehicles (POVs)

...Since Medicaid may fund and maintain only one mobility device within the maximum limit period, the recipient is not eligible for more than one power-operated vehicle (POV) or wheelchair (standard or customized) within the same five-year maximum limit period.

Service Requirements

The following criteria must be met for a POV.

- Recipient's medical necessity requires the use of a POV to independently move around his residence; and
- Recipient is physically unable to operate a manual wheelchair, and...
- The recipient does not have a wheelchair that was purchased by Medicaid within the past five years.

The evidence demonstrates that the petitioner would benefit from a wheelchair and that there is medical necessity for the petitioner to have equipment to assist him in ambulation about his home. What is at issue is whether or not the requested equipment of a power wheelchair meets all of the Medicaid definitions for medical necessity, State Plan limitations and the limitations as set forth in the handbook for durable medical equipment.

The respondent has provided an effective, less costly alternative in the form of a standard wheelchair by Medicaid. The petitioner's therapist indicated the petitioner is able to complete his ADL's and is able to ambulate using the current wheelchair type. Therefore, the hearing officer concludes that the power wheelchair is not the least costly alternative. The requested equipment does not meet all criteria for medical necessity as defined in the above cited Medicaid rule.

The respondent provided a manual wheelchair to the petitioner in 2007. The State Plan allows for a new wheelchair every five years. Therefore, the request for a power wheelchair exceeds the State Plan maximum.

The petitioner's request for a power wheelchair was not consistent with the Medicaid rule for medical necessity, is in excess of the State Plan limitations and did not meet the limitations as set forth in the handbook for durable medical equipment. Based

upon the above cited authorities, the respondent's action to deny the power-operated wheelchair was within the rules of the Program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 12th day of June, 2009,

in Tallahassee, Florida.

Linda Garton
Hearing Officer
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FILED
JUN 23 2009
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09N-00051

PETITIONER,

Vs.

RESPONDENT.

_____________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on June 4, 2009, at 2:00 p.m.

The petitioner was present, but she was represented by her husband,

Ombudsman, Department of Elder Affairs, offered testimony on the petitioner's behalf. nursing home administrator, represented the respondent. social worker, and business officer manager, offered testimony for the respondent.

ISSUE

At issue is whether or not the nursing facility's March 23, 2009 proposed action to transfer and discharge the petitioner is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to transfer and discharge the petitioner because her "bill for services at the facility has not been paid

after reasonable and appropriate notice to pay". The nursing facility has the burden of proof to establish that the transfer and discharge action is consistent with the federal regulations.

FINDINGS OF FACT

1. The petitioner is a resident of a skilled nursing facility. She entered the facility in December 2007 under payment by Medicare. A Medicaid application was approved in August 2008 and a patient responsibility was assigned back to April 2008 when payment by Medicare was exhausted. After Medicare benefits were exhausted, the petitioner was considered private pay until Medicaid was approved. Medicaid was approved retroactive to January 2008 and the bill was adjusted.

2. On March 23, 2009, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner with an effective transfer date of April 24, 2009. The Notice indicated the reason for transfer as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". It also indicated that the "resident representative has failed to pay any patient liability. Facility has asked for payment verbally and through statements" (Respondent's Exhibit 1).

3. At the time of the issuance of the discharge Notice, the petitioner's unpaid bill was $2,155.60. By the June statement date, the petitioner will have incurred an outstanding bill of $2,853.10 (Respondent's Exhibit 2). The June statement reflects two additional months of patient responsibility of $232.50 per month. Currently, there is no payment plan in place and there have been no payments made on the account. The account accrues the patient responsibility amount each month.

4. The respondent asserts that bills were mailed by regular mail to the petitioner's husband each month. Several collection letters requesting payment were also mailed. Contact was made in person and several conversations took place with the petitioner's husband about the outstanding balance according to the Collection Notes Report. The respondent refers to the amount owed each month on the bill as the Medicaid Surplus (Respondent's Exhibit 3).

5. The petitioner's husband explains that he cannot pay the amount of money he is expected to pay each month and still live in the community. He has bills he needs to pay and he knew all along he could not make payments to the nursing facility. He stipulated that he has not made any payments on the outstanding bill because he did not know exactly what he was supposed to pay because the bills he receives from the facility are confusing for him. He explains that he has received bills in excess of $6000 from the respondent and he knows he could never pay that amount. He also receives bills for medication for his wife.

6. The respondent explained that when the petitioner's husband received a bill in excess of $6000, it was received before Medicaid had been approved. Once Medicaid had been approved, and every time the respondent received a Notice of Case Action showing a different amount of patient responsibility from the Department of Children and Families, the account was adjusted accordingly. The patient responsibility for April through June 2008 was $213.63 each month, although the original notice stated it would be $514.88. For July 2008, it was $175.63. In August 2008, it changed to $200. It stayed at $200 until February 2009, when it was reduced to $156.50. In March 2009, it was determined to be $232.50, until July 2009 when it decreases to $97.30

(Respondent's Exhibit 4). The respondent's representative explained that the outstanding bill owed is for patient responsibility only; it does not include transportation costs or medications. The respondent offered to call the pharmacy to help get the bill settled, but she believed that the large medication bills are from 2008 before Medicaid was approved and the petitioner was considered private pay.

7. The location to which the petitioner is to be discharged was listed on the above notice as the petitioner's residence. The Ombudsman is of the opinion that the home is not safe, and that she should not be moved. She believes that the petitioner has begun to make progress here. The petitioner's husband believes that the nursing facility she is in is a safe environment and his wife should stay here. He has no plans to move her. The facility attempted discharge planning. Six facilities were contacted but the petitioner's husband did not cooperate with touring any other facility. The nursing home administrator asserts that the petitioner will not be discharged to an unsafe location.

CONCLUSIONS OF LAW

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

Federal Regulations at 42 C.F.R. § 483.12(a) states in relevant part:

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

Pursuant to federal guidelines, the nursing facility issued a Nursing Home Transfer and Discharge Notice to the petitioner on March 23, 2009. The nursing home administrator signed the notice.

The Notice, as required, indicated the reason for transfer or discharge, as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The effective date of the transfer or discharge was given as April 24, 2009.

The Findings of Fact show that the petitioner has an outstanding balance owed to the facility for the cost of her care. The facility has notified the petitioner and her husband of the balance due for the cost of her care. No payment arrangements have been made and no payments have been made on the balance. The petitioner's husband argues that it takes all of the money he has to pay his bills in the community and he cannot afford to pay the nursing facility, too. He indicated that he did not know exactly what he was supposed to pay because he received so many bills with different amounts on them.

According to the above authorities, the facility may not discharge except for certain reasons, one of which is when the resident has failed after reasonable and appropriate notice to pay for their stay at a facility. The hearing officer concludes that the nursing facility has met its burden to prove that the resident has failed after reasonable and appropriate notice to pay for her stay at the facility. Therefore, the hearing officer concludes that the discharge action is in accordance with the federal regulations.

Once discharge planning has been completed to include a safe and appropriate location, the respondent may proceed with its discharge in accordance with the guidelines established by the Agency for Health Care Administration.

DECISION

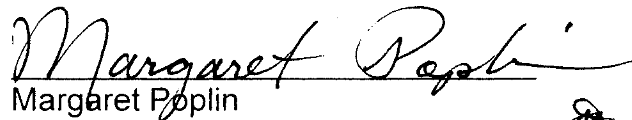
The appeal is denied. The respondent met its burden of proof to show the discharge reason meets the reasons stated in the federal regulation. The facility may proceed with the discharge in accordance with applicable Agency for Health Care Administration requirements when appropriate placement is found.

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 23rd day of June, 2009,

in Tallahassee, Florida.



Margaret Poplin
Hearing Officer
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FILED
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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-02767

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 09 Orange
UNIT: AHCA

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on May 28, 2009, at 9:55 a.m., in Orlando, Florida. The petitioner, a minor child who did not testify, appeared. , petitioner's mother and authorized representative, appeared and represented the petitioner. Lisette Knott, human services program specialist with the Agency for Health Care Administration (AHCA), appeared and represented the respondent-Agency. Dr. Rakesh Mittal, board certified pediatrician with KePro, and Melanie Clyatt, registered nurse operations supervisor with KePro, appeared as witnesses for the respondent via telephone.

ISSUE

At issue is the respondent's action of April 7, 2009, reducing the petitioner's number of private duty nursing care hours from twelve (12) hours per day, seven (7) days per week, to eight (8) hours per day, seven (7) days per

week, due to a reduced level of medical necessity. The respondent bears the burden of proof in this appeal.

FINDINGS OF FACT

1. The petitioner is a three-year old child who has several medical conditions including seizure disorder, congenital diaphragmatic hernia, bilateral hydronephrosis (dilation of the kidneys), cholostomy, vesticostomy, chromosomal balance and imbalance, cerebral palsy, legal blindness, gastrostomy, pulmonary heart disease and other diseases of the trachea and bronchus. He is non-ambulatory and non-verbal.
2. Because of these conditions the petitioner's level of care requires various treatments including that from a heart and lung machine and receipt of nutrients through G-tube feedings. He receives private duty nursing services due to his conditions.
3. In March 2009, the respondent forwarded the petitioner's case file for ongoing certification of services to its contract provider, KePro, the entity designated to review all requests which require prior service authorization. Private duty nursing is such a service. The petitioner requested to continue receiving twelve (12) hours of private duty nursing per day for seven (7) days a week. The review was conducted by one of KePro's board certified pediatricians for a determination of medical necessity.
4. Upon review, the pediatrician considered several factors which included both the mother's capability and availability to provide care. The reviewing physician found that the mother was providing excellent care of her son

and was capable of continuing to do so. He also found that the child was attending daycare (pediatric extended care) from 9:00 a.m. to 3:00 p.m. Also, the mother was no longer enrolled in and attending school which allowed her more time to be available to provide care. As a result, he found that continuing twelve (12) hours of private duty nursing per day for seven (7) days a week was no longer medically necessary. He found that a reduction in services was appropriate and approved nursing services in the amount of eight (8) hours per day for seven (7) days a week.

5. The respondent issued a notice informing of the reduction on March 27, 2009. The petitioner received this notice and requested a reconsideration.
6. A different KePro physician reviewer, also board certified in pediatrics, conducted the reconsideration. This physician found that the mother was available to provide more care and upheld the original denial. The respondent issued another notice, dated April 7, 2009, informing of this decision.
7. The petitioner appeals. At the hearing, the mother stated that the child has a new heart condition, including a heart murmur. She provided no medical evidence of the condition as further testing had yet to be conducted. She did not disagree with the reduction in regarding her own availability to provide care but stated that the home health agency is not sending enough nurses to cover the approved hours and she needs the greater number of hours to "flex" the time to get as many shifts covered as

possible. The petitioner believes that there is a nursing shortage that results in difficulty in receiving all of the requested hours of service.

8. The respondent's KePro physician reviewer stated that with the household's living situation at the time of both reviews as well as at the hearing, the hours from 11:00 p.m. to 7:00 a.m. seven days per week, are sufficient based on the current level of medical necessity. Because the mother is not attending school, does not work outside the home, and the child attends pediatric day care from 9:00 a.m. to 3:00 p.m., the mother is available to provide care from 3:00 p.m. to 11:00 p.m.

CONCLUSIONS OF LAW

Medical Services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Fla. Admin. Code 59G-1.010(166)(a)(c), as follows:

> (a) “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must 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, a covered service.

The evidence shows that while the petitioner received twelve (12) hours per day, seven (7) days per week of private duty nursing, his mother, his only caregiver, was enrolled in school. The petitioner's mother argued that the home health agency does not provide her with a nurse for each shift for which she receives approved nursing hours. She is fortunate to get a nurse out to the home three to five days a week. The reason she wants the number of hours to remain at twelve is so that she can "flex" the shifts that need to be covered so that the home health agency will send her a nurse at the needed times. In other words, she feels the more hours her son is approved to receive; the more likely it is that the home health agency will continue to cover the shifts at the same rate. She fears that a reduction to eight hours per day will result in the home health agency not covering but just a few shifts instead of most. The respondent argued that medical necessity is not met for twelve hours a day at this time. However, should the mother's living situation change, she can, at any time, request an increase in the number of hours.

In reviewing the evidence presented, the hearing officer concludes that the respondent's action in this case reducing the number of hours was correct. The mother is not working and is not enrolled in school. The child attends daycare for almost the entire day. The mother is an excellent caregiver and is available to cover the four extra hours per day needed for her son. It is unfortunate that the

petitioner is experiencing difficulty getting the home health agency to send nurses for care, but the respondent nor the hearing officer have jurisdiction over this issue. Should the family's situation change, the mother is encouraged to request an increase in nursing hours. Until then, medical necessity for twelve hours per day is not met and the respondent's action must be upheld.

DECISION

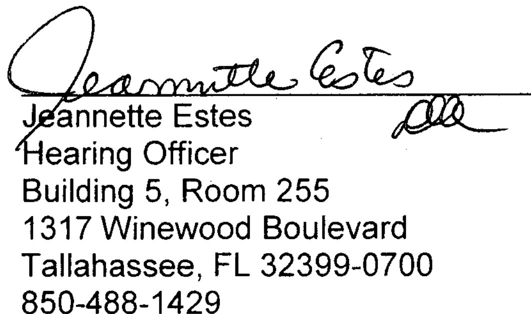
The appeal is denied. The respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30th day of June, 2009,

in Tallahassee, Florida.



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FILED
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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-01861

PETITIONER,

Vs.
AGENCY FOR HEALTH
CARE ADMINISTRATION
CIRCUIT: 19 St. Lucie
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on May 6, 2009, at 9:05 a.m., in Fort Pierce, Florida. The petitioner was present. He was represented by his mother . Her fiancé, , was also present. Margery Lacey, private duty nurse, LPN, was present and gave testimony. Dave King, management analyst, Area 9 Medicaid, Agency for Health Care Administration, represented the respondent. Dr. Robert Buzzeo, medical director and physician reviewer, KePRO; Edna Clifton, operations manager, KePRO; and Melanie Clyatt, operations supervisor, KePRO, appeared as witnesses for the respondent.

Continuances were granted to the petitioner and to the respondent for prior scheduled hearings.

ISSUE

At issue is the reduction of 200 hours of Private Duty Nursing services and approving 2480 hours of the requested 2680 hours. The certification period is January 5, 2009 through July 3, 2009. The respondent has the burden of proof in this matter.

FINDINGS OF FACT

1. The petitioner is six years old (at the time of the review) and a Medicaid beneficiary. His primary medical conditions as reported to the agency are "chronic lung disease, seizures, trach, GT, hypoglycemia, retinopathy of prematurity, and periventricular leukomala". The petitioner has been receiving Private Duty Nursing (PDN) services at the level of 16 hours per day Monday through Friday, and 12 hours per day on the weekends.

2. On January 28, 2009, the PDN provider, Maxim Healthcare Services Inc. requested 2680 hours of skilled nursing for the petitioner for the period of January 5, 2009 through July 3, 2009.

3. The agency has contracted with Keystone Peer Review Organization (KePRO) to perform medical necessity reviews for PDN and Personal Care for Medicaid beneficiaries. This prior authorization review determines medical necessity for the hours requested under the terms of the Florida Medicaid Program. The request for service is submitted by the provider of the PDN, along with all information and documentation required in order for KePRO to make a determination on medical necessity for the level of service being requested.

4. On January 29, 2009, an initial screening of the request was completed by a registered nurse reviewer. At this level of review, the amount of PDN hours being requested could not be approved by the nurse reviewer. The request was referred to a board certified pediatric physician consultant for review.

5. On February 6, 2009, the physician consultant (PC1) reviewed the information submitted, approved 2480 hours, and denied 200 hours. The petitioner's mother works Monday through Friday from 5:00 p.m. to 1:00 a.m. She does not work on the weekends. PDN was approved Monday through Friday from 4:00 p.m. - 8:00 a.m., and from 11:00 p.m. – 7:00 a.m. Four hours on the weekends were denied, 8:00 p.m.-11:00 p.m. and 7:00a.m.-8:00 a.m. (Respondent's Exhibit 2).

6. On February 9, 2009, a PDN/PC Recipient Denial Letter was issued to the petitioner denying 200 and approving 2480 hours of PDN.

7. On February 12, 2009, the provider submitted a reconsideration request for the reduction of weekend hours citing recent changes in the petitioner's conditions. The petitioner was admitted to the hospital on January 29, 2009 "with increased lethargy, irritability and seizure activity. He was diagnosed with Pneumonia. MRI conducted with mild changes found. On February 8, 2009 child with ER visit for increased irritability and involuntary movement. Diagnosed with uncontrolled seizures. Child to see Neurologist for medication adjustment with seizure safety precautions strictly followed at all times". A different board certified physician reviewer looked at the entire case, including the additional information provider by Maxim and upheld the initial denial citing, "There was no additional information submitted for reconsideration that addresses the denied hours on Sat and Sunday".

8. The physician reviewers considered all social and medical information of the petitioner and the household members, including work schedules. The petitioner has no siblings. He and his mother live with her parents, but they do not provide care for him and their presence in the home was not considered when rendering a decision of PDN hours. They are usually not home on the weekends. The petitioner attends school Monday through Friday from 7:00 a.m. - 12:00 p.m. The school provides a nurse for one-on-one care for him.

9. On February 23, 2009, a PDN/PC recipient Reconsideration –Denial Upheld letter was issued to inform the petitioner that the requested 200 hours of PDN was denied.

10. The petitioner's mother is asking for the weekend hours to be reinstated mainly because she is tired. On Saturday, she has to get up at 7:45 a.m. to relieve the nurse after getting off work at 2:00 a.m. from her Friday night shift. She is then responsible for his care until 11:00 p.m. Saturday night. The petitioner requires constant monitoring as he pulls out his trach and gtubes. He is restless and his heart rate needs to be monitored.

11. The nurse who cares for the petitioner is of the opinion that the petitioner's mother cannot safely provide for his care when she is tired. She believes it is detrimental to the petitioner's health for his mother to provide his care after only getting four and a half hours of sleep (2:30 a.m. to 7:45 a.m) once she gets home from work on Saturday mornings. He is very active and some of his care requires two people. His mother hurt her shoulder lifting him now that he weighs 50 pounds, and is receiving physical therapy.

CONCLUSIONS OF LAW

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

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

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.
>
> (4)(b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services...The utilization management program shall also include a process for periodically reviewing the ongoing use of private duty nursing services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents...

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

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

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

(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 III, 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, July 2008, 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 (July 2008), pages 2-17 and 2-19 states in part:

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

Parental Responsibility

> Private duty nursing services are authorized to *supplement* care provided by parents and caregivers. Parents and caregivers *must* participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.
>
> Flex Hours or Banking of Hours
>
> Medicaid does not allow "banking of hours" or "flex hours". Only the number of hours that are medically necessary may be approved. Home health service providers must request only the number hours that are expected to be used and must indicate the times of day and days per week that the hours are needed. If a recipient requires additional hours due to unforeseen circumstances or change in medical or social circumstances, the home health service providers should submit a modification request to the PRO for the additional hours needed.
>
> Authorization Process
>
> Private duty nursing services are authorized by the Medicaid peer review organization if the services are determined to be medically necessary. Private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child's condition improves.

The focus of this appeal is the denial of four hours of PDN services on Saturday and four hours on Sunday. The petitioner's mother is the sole provider of his care. She works from 6:00 p.m. to 2:00 a.m. Monday through Friday. He was approved to receive 16 hours of PDN Monday through Friday. He goes to school Monday through Friday from 7:00 a.m. until noon.

According to the above cited rule, PDN services are to decrease over time as the parent is taught skills to care for the child safely. The petitioner is able to provide care for her son. However, the nurse who cares for the petitioner is of the opinion that the petitioner's mother cannot safely provide for his care when she is tired. She believes it is detrimental to the petitioner's health for his mother to provide his care after only

getting four and a half hours of sleep once she gets home from work Saturday morning. The respondent's position is that over time, the goal is to reduce hours of PDN, and that a reduction of four hours when the petitioner's mother is not working is reasonable.

The hearing officer considered the evidence, testimony and controlling authorities. Based on the mother's current work schedule as well as the testimony of the nurse who provides the petitioner's care, it is concluded that the petitioner's mother cannot safely provide care to the petitioner for 16 hours on Saturday with less than five hours of sleep. Therefore, the fours hours of PDN on Saturday is considered medically necessary and that portion of the denial is hereby reversed. However, the denial of four hours of PDN on Sundays is affirmed as there was no rebuttal evidence to show that the petitioner's mother cannot safely provide care for those additional hours or that those hours are medically necessary, as defined in the above rule.

DECISION

The appeal is partially granted. The denial of four hours of PDN on Saturdays is hereby reversed for the reasons stated above. The denial of four hours of PDN on Sundays 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 5th day of June, 2009,

in Tallahassee, Florida.

Margaret Poplin
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To

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

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
AREA: 04 Duval

RESPONDENT.
_______________________/

APPEAL NO.08F-08628

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 20, 2009, at 10:25 a.m., in Jacksonville, Florida. The petitioner was present and represented himself. The petitioner's mother was present as a witness. The respondent was represented by Michelle Manor, program administrator, Selwyn Gosset, Medical Health Analyst and Jill Hrcz, senior 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 7 days to allow the respondent's w[illegible] additional evidence which was received and entered as Respondent'[illegible] Exhibit 2.

FILED
MAY 13 2009
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs.

APPEAL NO.08F-08628

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 March 20, 2009, at 10:25 a.m., in Jacksonville, Florida. The petitioner was present and represented himself. The petitioner's mother was present as a witness. The respondent was represented by Michelle Manor, program administrator, Selwyn Gosset, Medical Health Analyst and Jill Hrcz, senior 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 7 days to allow the respondent's witness to provide additional evidence which was received and entered as Respondent's Composite Exhibit 2.

ISSUE

At issue is the respondent's December 2008 action reducing the petitioner's attendant care and companion care hours received under the Brain and Spinal Cord Injury Medicaid Waiver Program (BSCIP). The respondent held the burden of proof.

FINDINGS OF FACT

1. The petitioner is a 27 year male with a spinal cord injury. The petitioner is quadriplegic; he has no use of his arms or legs and requires assistance with all the activities of daily living. The petitioner lives with his mother.

2. The petitioner has been receiving attendant care (skilled nursing care) and companion care through the BSCIP since at least September 2008. This 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.

3. Prior to the action under appeal, the petitioner was receiving 8 hours per week attendant care and 4 hours per day companion care. In December 2008, the respondent notified the petitioner that due to program budget cuts, his services were being reduced to 1 hour per week attendant care and 3 hours per day companion care.

4. The respondent explained that in early December 2008 all BSCIP staff was informed that the program was planning to reduce services due to funding limitations. The program support coordinators were instructed to consult with each recipient's home health care agency and to reduce services without adversely affecting the recipients' health or safety. Although noticed about the date and time of the hearing, the petitioner's support coordinator did not appear at the hearing; nor did the home health

care agency appear. The BSCIP program administrator asserted that the reduction in services was based on the aforementioned consultation between the support coordinator and the home health care agency; however, she did not have access to any of the assessments, evaluations or case notes which were used to make the determination in the instant case. She explained that the program has a shared online record storage system on to which the coordinators save all their supporting documentation; the documentation for the petitioner's case had not been saved to the online system at the time of the hearing. The petitioner asked that the support coordinator be called to testify at the hearing, however, the support coordinator could not be located. Additionally, the petitioner tried, without success, to contact the home health care agency to testify at the hearing. Both parties agreed to leave the record open for 7 days to allow the respondent to provide the documentation that the support coordinator used in making his decision in this case. Some documentation was received and entered as Respondent's Composite Exhibit 2.

5. On March 26, 2009, six days after the hearing, the undersigned hearing officer received a letter from the BSCIP administrator which explained that after additional research, she concluded that the petitioner's service reductions were not determined by the support coordinator and the home health care agency as she asserted during the hearing. In this instant case, the service reductions were based exclusively on the support coordinator talking with the petitioner. However, a letter from the support coordinator, also included in the documentation received from BSCIP administrator on March 26, 2009. contradicts this assertion. The letter from the support coordinator states in part "Lamont Walker did not and is not asking for his services to be reduced."

The petitioner's testimony during the hearing also contradicts the assertion that he agreed to service reductions.

6. The petitioner argued that he needs 8 hours of attendant care weekly for bowel and bladder care. This service is performed every other day and takes approximately 2 hours to complete. The complexity of this service requires it be performed by a skilled nurse; it can not be performed by an unskilled companion or the petitioner's mother. The BSCIP administrator reconsidered the reduction in the petitioner's attendant care hours and in the letter received March 26, 2009, determined that the hours would remain at the previous level of 8 hours weekly. The letter states in part; "It is our experience that most quadriplegics require assistance with bowel and bladder care which is covered under our service for attendant care. This definition requires the service be provided by a registered nurse or licensed practical nurse...Therefore, I am offering to re-instate his attendant (nursing) care at the previous level of 2 hours every other day as this meets the definition of medically necessary."

7. The petitioner argued that he needs 4 hours per day companion care to assist him two hours in the morning and evening with the bathing, grooming, dressing/undressing, and getting out and back into bed. The BSCIP administrator explained that the decision to reduce the companion care hours from 4 daily to 3 daily was based in part on the fact that the petitioner's mother lives in the home and can assist with his care. The petitioner's mother explained that she is not able to assist with the petitioner's care due to a leg injury she suffered getting off a city bus; she has been diagnosed with neuropathy. She experiences excruciating pain and finds walking very difficult. In addition, she suffers from carpal tunnel syndrome in both wrists.

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 Centers for Medicare and Medicaid 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. A general description of each service cluster is provided. Individuals eligible for the respective HCB services waiver programs may need and receive the following services:

(a) Adaptive and Assistive Equipment, and Adaptive Equipment, include selected self-help items that are necessary for recipient safety and that assist recipients to increase their functional ability to perform activities of daily living.

(b) Adult Day Health Care and Day Health Care are services provided in an ambulatory care setting. They are directed toward meeting the supervisory, social, and health restoration and maintenance needs of adult recipients who, due to their functional impairments, are not capable of living independently.

(c) Caregiver Training and Support are services that encourage the provision of care for the recipient in the home or home-like settings from caregivers such as relatives, friends, and neighbors. Activities include workshops or in-home training conducted by professionals to increase the caregivers' knowledge of care giving skills and understanding of the aging or disease process and to provide emotional support through caregivers' support groups.

(d) Case Aide services are adjunctive to case management and provided by paraprofessionals under the direction of case managers. These services include: assistance with implementing plans of care, assistance with obtaining access to appointments for care plan and other services, supervision of provider activities, and assisting with linkages of providers with recipients via additional telephone contacts and visits. They will not develop care plans or conduct assessments or reassessments.

(e) Case Management, Waiver Case Management, and Support Coordination are services that assist Medicaid eligible individuals in gaining access to needed medical, social, educational and other services, regardless of funding source.

(f) Chore Services and Housekeeping/Chore Services are provided to maintain the home in a clean, sanitary and safe environment. Chore services will be provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision.

(g) Companion Services include those activities necessary to assist the recipient in performing household or personal tasks and providing social stimulation to relieve the negative effects of loneliness and isolation.

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.

The Florida Medicaid Summary of Services Handbook Traumatic Brain and Spinal Cord Injury Waiver Services, 2008 – 2009 states in part:

Brain and Spinal Cord Injury Program Medicaid Waiver Program

The Traumatic Brain Injury/Spinal Cord Injury Waiver Program allows individuals with a traumatic brain injury or spinal cord injury to live in their homes or in community based settings rather than living in a nursing facility...Waiver services include: adaptive health and wellness, assistive technologies, attendant care, behavioral programming, companion services, community support coordination, consumable medical supplies, environmental accessibility adaptations, life skills training, personal adjustment counseling, personal care and rehabilitation engineering evaluation.

To be eligible for waiver services an individual must meet the following criteria:

Must have one of the following conditions:

Traumatic Brain Injury (TBI)...
Spinal Cord Injury (SCI)...
Must be considered medically stable...

The legal authorities cited above set forth the policies and procedures which govern the Brain and Spinal Cord Injury Program.

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

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

The respondent reduced the petitioner's attendant and companion care hours. The legal authority cited above makes it clear that the respondent holds the burden of proof.

Fla. Admin. Code 65-2.056 Basis of Hearings states in part:

The Hearing shall include consideration of:
(1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or

> Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance...
>
> (2)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 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 cut where possible without impacting the health and safety of the recipient. The decision to reduce the petitioner's attendant care and companion hours were based in part on the resondent's belief that the petitioner's mother could assist with providing for the petitioner's care. At the hearing, evidence was introduced which proves the petitioner's mother is not able to help with his care. As the respondent's determination was not based on the petitioner's actual situation, it can only be given limited weight. Based on the above cited rule concerning de novo hearings, relevant new evidence can be considered.

The respondent has agreed to re-instate the attendant (nursing) care hours to 8 weekly. This issue is now moot.

The remaining issue was the reduction of companion care hours from 4 per day to 3 per day. The petitioner provided evidence which proves it takes approximately 2 hours in the morning and 2 hours in the evening to feed, bath and dress/undress him. There is no one in the home physically able to assist the petitioner. After carefully reviewing the testimony, evidence and controlling legal authorities, the hearing officer

finds that the respondent has not met its burden of proof and that the respondent's action to reduce companion care hours is not supported by the record. The hearing officer cannot affirm the respondent's action in this matter.

DECISION

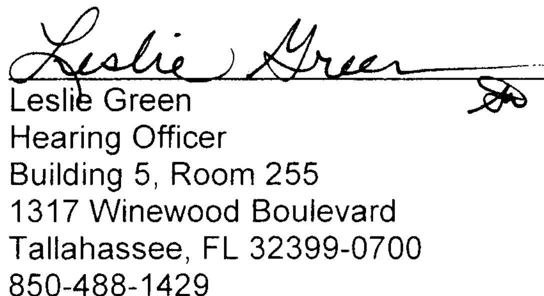
The appeal is granted. The respondent's action reducing companion care hours from 4 hours daily to 3 hours daily is hereby reversed.

The respondent's decision to reinstate attendant care hours to 8 weekly made rendering a decision on this issue moot.

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 13th day of May, 2009, in Tallahassee, Florida.



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JUN 23 2009

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs.

APPEAL NO. 09F-00888

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 05 Sumter
UNIT: ICP

CASE NO. 1291204792

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 18, 2009, at 2:35 p.m., in Wildwood, Florida. The hearing officer appeared by telephone. The petitioner was not present. Present representing the petitioner was , office manager, The Department was represented by Sandra Maxwell, ACCESS supervisor. Present as a witness for the Department was Edward Broom, senior economic self sufficiency specialist.

The record was held open for seven days to allow the Department the opportunity to submit additional evidence. However, no additional evidence was received from the Department.

ISSUE

The petitioner is appealing the Department's action to deny Institutional Care Program (ICP) benefits for August 2008.

FINDINGS OF FACT

1. On August 8, 2008, a representative of the facility acting as the petitioner's authorized representative submitted an application for ICP benefits on behalf of the petitioner. At the time of the application, the petitioner was residing at a skilled nursing facility.

2. On October 9, 2008, by Notice of Case Action, the Department notified the facility that the petitioner's application was denied because verification of the petitioner's assets or unearned income was not provided. The above notice was mailed to the facility at which was the facility's address. The above notice was not returned to the Department as undeliverable.

3. On December 30, 2008, a representative of the facility, acting as the petitioner's authorized representative, submitted another application for ICP benefits on behalf of the petitioner. This application was approved and the petitioner received ICP benefits effective December 2008. The Department also approved ICP benefits for the three retroactive months of September 2008, October 2008 and November 2008. ICP was not approved for the month of August 2008 as it was not considered a retroactive month.

4. believes that the facility did not receive the Notice of Case Action of October 9, 2008. believes that if the notice had been received, another application would have been submitted prior to December 30, 2008.

5. The hearing officer must rely on the premise that a letter mailed which followed proper business mailing procedure and not returned, has been received. Therefore, the hearing officer finds that the petitioner received the notice of October 9, 2008. There was no evidence to the contrary.

6. On February 4, 2009, [illegible] requested a hearing on behalf of the petitioner because she believed that ICP benefits should have been approved for the month of August 2008.

CONCLUSIONS OF LAW

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

(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period)...
(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services.

The Department's Policy Manual 165-22, Section 0640.0509 in part states:

Retroactive Medicaid (MSSI)
This policy does not apply to QMB.
Medicaid is available for any one or more of the three calendar months preceding the application month, provided:
1. at least one member of the SFU has received Medicaid reimbursable services during the retroactive period, and
2. the individual meets all factors of eligibility during the month(s) he requests retroactive Medicaid.
The applicant may request retroactive Medicaid at any time, as long as the coverage period is for any one of three months prior to any Medicaid or SSI application.

This retroactive coverage is not affected by:
1. the application's disposition (approval or denial);
2. whether or not the individual was alive at the time of the application; or
3. when the request for assistance or request to add was made.

The petitioner submitted an application for ICP benefits on December 30, 2008. The application was approved effective December 2008 and ongoing. ICP benefits were approved for the three retroactive months prior to the month of application.

Based on the above authorities, the month of August 2008 was not considered a retroactive month because it is not within the three months preceding the month of application. Therefore, it is determined that the Department was correct to not process the ICP eligibility request for August 2008 from this application.

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

Time Limits in Which to Request a Hearing.
(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
(a) The date on the written notification of the decision on an application.
(b) The date on the written notification of reduction or termination of program benefits.
(c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.
(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

The above rule states that an individual must request a hearing within 90 days of the date of the written notification of the decision to deny an application. In this case, written notification of the denial of the petitioner's application for ICP benefits was

mailed to the petitioner on October 9, 2008. The notice was mailed to the facility and was not returned as undeliverable by the United States Postal Service. Therefore, the hearing officer must rely on the premise that a letter properly mailed and not returned has been received. On February 4, 2009, a hearing was requested as ICP benefits were not approved for the month of August 2008. The hearing request was not filed within 90 days of the written notification as required by the above rule. Therefore, the correctness of the Department's action to deny the petitioner's application of August 8, 2008 cannot be addressed and is non-jurisdictional.

There is a provision in the Florida Administrative Code that the petitioner may wish to pursue for the reevaluation of Medicaid Adverse Actions when the individual did not request a hearing within the time prescribed in the above Florida Administrative Code. Florida Administrative Code 65A.1.702, Special Provisions, states in relevant part:

> (7) Re-evaluating Medicaid Adverse Actions. The department shall re-evaluate any adverse Medicaid determination upon a showing of good cause by the individual that the previous determination was incorrect and that the individual did not request a hearing within the time prescribed in Chapter 65-2, Part IV, F.A.C. This provision applies only when benefits were terminated or denied erroneously or a share of cost or patient responsibility was determined erroneously.
>
> (a) Good cause exists if evidence is presented which shows any of the following:
>
> 1. Mathematical Error – The department made a mechanical, computer or human error in its mathematical computations of resources, income, or spend down requirements for Medicaid eligibility.
>
> 2. Error on the Face of the Record – The department made an error in a Medicaid determination which caused an incorrect decision. For example, there is evidence showing that the individual's resources satisfied Florida's standard of eligibility but the application was denied on the basis of excess resources.
>
> 3. New and Material Evidence – The department's determination was correct when made but new and material evidence that the

department did not previously consider establishes that a different decision should be made.

(b) Failure of the individual to obtain information required by the department to accurately determine eligibility for Medicaid where the failure was beyond the individual's control constitutes good cause for re-evaluation. However, if the individual fails to cooperate with the department in establishing eligibility good cause for re-evaluation does not exist.

(c) A re-evaluation must be requested before the expiration of 12 months from the effective date of the notice of adverse action.

(d) The public assistance specialist (PAS) is responsible for the initial determination of good cause. All initial decisions must be reviewed by the PAS's supervisor. If both the PAS and the supervisor determine that good cause does not exist the operational program administrator must review the good cause determination in consultation with the District Program Office. The operational program administrator's decision is final. If a final determination is made that good cause does not exist, the individual will be notified of the decision and of the right to request a hearing.

(e) If a case is re-opened and the department discovers that an error was made in the eligibility determination, benefits must be provided retroactively as follows:

1. If an application was denied, benefits will be awarded back to the date of eligibility provided all other eligibility requirements are satisfied.

2. If an ongoing case was terminated, benefits will be awarded back to the effective date of the termination provided the individual or family is eligible according to all other eligibility requirements.

(f) If re-evaluation of the previous decision results in adverse action, the individual has 90 days from the date of notice of disposition of the re-opened case to request a hearing. If at the end of 90 days a hearing is not requested the adverse action will be final and binding upon the individual. The decision on the re-opened case is final and may not be re-opened.

DECISION

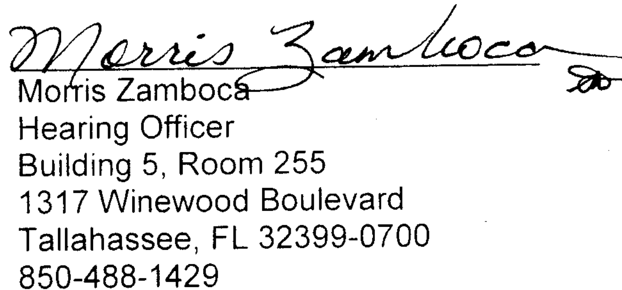
The appeal is denied. The Department's action is affirmed.

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 23rd day of June, 2009,

in Tallahassee, Florida.



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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09N-00061

PETITIONER,

Vs.

CASE NO.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on June 4, 2009, at 3:57 p.m., in Lakeland, Florida. The petitioner did not appear. , petitioner's daughter and authorized representative holding power of attorney, appeared via telephone to represent the petitioner. petitioner's other daughters, appeared as witnesses for the petitioner. , ombudsman, and district ombudsman manager, appeared for the petitioner but did not testify and only observed the proceeding. facility's Medicaid specialist, appeared and represented the respondent-facility. , facility administrator, and regional director of reimbursement, appeared as witnesses for the respondent. business office consultant, appeared for the respondent but did not testify and only observed the proceeding.

ISSUE

At issue is the respondent's action of March 30, 2009, issuing a notice intending to discharge and transfer the petitioner due to non-payment for services rendered. The respondent bears the burden of proof in this appeal.

FINDINGS OF FACT

1. The respondent admitted the petitioner to its facility on September 24, 2008. At the time of admission, the petitioner intended to remain in the facility for rehabilitative purposes only and eventually return to her home (apartment) once her Medicare and other health insurance was exhausted. The facility was informed of this and as a result, did not conduct a full financial status review (income and available assets) to see whether or not the petitioner should apply for Medicaid or other services.
2. The respondent billed Medicare and the petitioner's Health Maintenance Organization (HMO) (Wellcare) for her stay beginning September 24, 2008. The respondent received a denial from the HMO. Medicare paid 100% of the petitioner's stay for the first twenty (20) days. After that, Medicare paid a partial portion of the expense.
3. Once the petitioner exhausted her Medicare benefits, she intended to return home but instead remained in the facility with interim stays at the hospital. The facility billed the petitioner at the private pay rate for services rendered.
4. In the interim, instead of paying the facility each month for services rendered to the petitioner, her daughters used her Social Security check to

continue to pay the rent and upkeep of her apartment in keeping with the original plan for her to return home.

5. In January 2009, the facility's Medicaid specialist reviewed the petitioner's account and found that an application for Medicaid should be submitted. An application for Medicaid was submitted to the Department of Children and Families (DCF) on the petitioner's behalf to pursue this medical coverage to pay for the nursing home care received.
6. The petitioner's balance with the facility continued to grow and because no payments were made except one (February 2009), the facility issued a notice of intent to discharge on March 30, 2009. The effect date of the notice was April 29, 2009. The petitioner received this notice which listed the reason for discharge and a discharge location as well as the total amount due as of that date ($12,917.78).
7. The petitioner made the following payments to the facility based on an estimated patient responsibility amount yet to be officially determined by DCF should Medicaid be approved: February 4, 2009, - $1,183.00, April 30, 2009, - $1,073.00, May 12, 2009, - $1,223.00, and May 19, 2009, - $1,148.00.
8. As of the date of the hearing, the petitioner made no other payments to the facility and the total balance owed was $24,845.48.
9. The respondent stated at the hearing that it anticipated the petitioner's Medicaid application being approved. However, even with Medicaid payments applied toward the balance, some months would not be covered

due to retroactive Medicaid paying back only three months prior to the date of application which in this case was January 2009. There would be a remaining arrearage owed to the facility in the amount of approximately $4400.00.

10. The petitioner's representative stated at the hearing that the petitioner has no income or assets to use toward settling the approximate arrearage balance in full.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

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

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

(6) *Contents of the notice*. The written notice specified in paragraph (a)(4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged...

The federal regulation cited above requires the facility to comply with notice requirements for discharge and transfer. In reviewing the notice, the hearing officer finds that the requirements of the law regarding the notice itself have been met.

The evidence shows that the facility remains unpaid on the balance beginning September 2008 through the date of the hearing. The petitioner

argued at the hearing that the facility should have followed its own admission policy by "screening" the petitioner for Medicaid or other resources at the time of admission as indicated in its admission agreement. The facility argued that it did not conduct the usual screening because the petitioner informed that she would leave the facility once her Medicare and/or HMO benefits were exhausted. The facility applied for Medicaid as soon as it came to the realization that private payment was difficult, if not impossible for the petitioner, and that she had no other means by which to pay. Also, the ultimate responsibility for payment and application for Medicaid lies with the petitioner.

While it is unfortunate that an underlying Medicaid eligibility issue may exist, the fact of the matter remains that the facility must receive payment for services rendered to its residents. The hearing officer finds that the facility intends to discharge and transfer the patient based on one of the reasons cited in the regulation above which is failure to pay. The discharge and transfer must therefore be upheld.

DECISION

The appeal is denied. The respondent's action is affirmed. The respondent may proceed with the discharge and transfer.

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 22nd day of June, 2009,

in Tallahassee, Florida.

Jeannette Estes
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09N-00040

PETITIONER,

Vs.

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 27, 2009, at 9:45 a.m., in Ft. Walton Beach, Florida. The petitioner was not present but was represented by his wife, who testified telephonically. The Respondent was represented by Administrator, Testifying on behalf of the Respondent was social worker and , business office manager,

ISSUE

At issue is whether or not the facility's action of February 26, 2009 to discharge the petitioner, was correct on the basis of nonpayment for care and services provided. The nursing facility bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a resident of a nursing home in ! , Florida. He has been a resident of the facility since at least May 10, 2002 under Medicare and subsequently Medicaid. The petitioner's coverage for nursing home care under Medicaid ended July 2008 due to a missed redetermination for eligibility.

2. On September 25, 2008, an application for Institutional Care Program (ICP) Medicaid assistance on behalf of the petitioner was submitted to the Department of Children and Families (Respondent's Exhibit 3). The petitioner was to provide information to the Department to complete the eligibility determination (Respondent's Exhibit 6). The petitioner's wife indicated she would submit the information to the Department of Children and Families (DCF) on October 10, 2008. The application was denied on December 3, 2008 based on the contention that the petitioner did not verify unearned income and information needed to process the application was not provided.

3. The petitioner's wife has been making patient responsibility payments to the nursing facility. The nursing facility has not received any payments from Medicaid since July 2008.

4. The petitioner's wife believes she reapplied for Institutional Care Program benefits with DCF on April 2, 2009. As of the date of the hearing, the application was still pending.

5. As of the date of the hearing, the petitioner's outstanding bill was $23,776.02. The petitioner's representative argued that she was unable to take care of her spouse

and that she has provided all requested information to the DCF. She believes more time is needed to complete the application process. The petitioner's patient responsibility has been paid to the facility toward the unpaid balance.

6. The nursing facility sent statements to the petitioner's wife showing Medicaid pending rate through April 30, 2009 as $23,776.02

7. On February 26, 2009, the facility, by Nursing Home Transfer and Discharge Notice, notified the petitioner of its intent to discharge him because the bill for services at the facility had not been paid, after reasonable and appropriate notice to pay.

8. The location to which the petitioner was to be discharged was listed on the above notice as "tbd" (to be determined). The nursing facility has stipulated that it will make arrangements through its social services office to insure the safe and orderly transfer of the petitioner to another appropriate living arrangement. The petitioner's wife does not object to a transfer to another facility. She is concerned that she cannot provide for his care in her home and wants the petitioner to be allowed to remain in a nursing facility.

CONCLUSIONS OF LAW

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

Federal Regulations at 42 C.F.R. § 483.12(a) states in relevant part:

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

The Findings of Fact show that the petitioner has an outstanding balance, owed to the facility, for the cost of his care and that the facility has notified the petitioner's wife of the balance due for the cost of care. The petitioner's wife argued that more time is needed to complete the application for Medicaid coverage. However, the controlling federal regulations do not address any excusable situations which lead to a balance owed to the facility and therefore are not considered in the ruling.

According to the above authorities, the facility may not discharge except for certain reasons, of which one is when the resident has failed, after reasonable and appropriate notice to pay for the stay at the facility. Therefore, the Hearing Officer concludes that the nursing facility has met its burden to prove that the petitioner has not appropriately paid for his stay at the facility, and that reasonable and appropriate notice to pay for such stay has been made. Therefore, the hearing officer concludes that the discharge action is in accordance with the federal regulations.

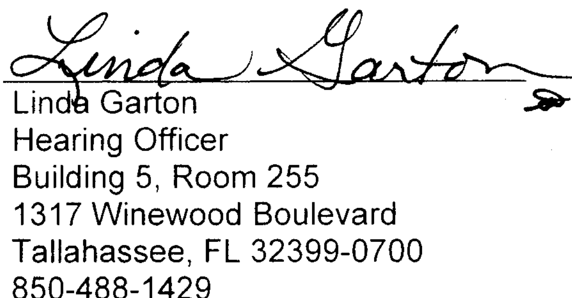
DECISION

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

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 3rd day of June, 2009, in Tallahassee, Florida.



Linda Garton
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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DEPT OF CHILDREN & FAMIL

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

APPEAL NO. 09N-00067

PETITIONER,

Vs.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 4, 2009, at 8:39 a.m., in Boca Raton, Florida. The petitioner was not present. Representing the petitioner was his wife, Appearing as witnesses were. sister-in-la :, daughter; and , Ombudsman. Representing the respondent was director of nursing. Appearing as a witness was MDS coordinator who completes the care plan. Present as an observer was administrator.

ISSUE

At issue is whether or not the nursing home's action to transfer and 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 transfer

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

FINDINGS OF FACT

1. The petitioner is presently a resident of the Nursing and Rehab Center. He has been a resident since April 2006.
2. On April 16, 2009, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner with an effective transfer date of May 16, 2009. The Notice indicated the reason for transfer as "your needs cannot be met in this facility".
3. The petitioner suffers from multiple sclerosis with an associated cognitive disorder; particularly his memory is affected in the short range. When not in his bed he is confined to his motorized wheelchair.
4. The respondent explains that because the petitioner has cognitive deficits, he will go through the facility's front door in his chair. For approximately one year there have been different approaches in attempting to keep the petitioner safe within the facility.
5. Presently, the facility has a staff member providing one on one care, eight hours per day, to maintain his safety. This has been effective since February 2009 and it is costly to the facility. It started in February 2009 because the petitioner was found in the parking lot alone.

6. The respondent is concerned that because the petitioner is "exit seeking", they explain that his needs can no longer be met.
7. It is noted that the facility's medical director, , MD, signed the discharge Notice. By doing so it is presumed he agrees with the facility's determination that the petitioner's needs cannot be met.
8. The family explains that they are with the petitioner approximately six of the eight hours that he is awake. In fact they will take the petitioner out of the facility at least once a week.
9. Further, they explain that the petitioner has a monitor both on his person and his wheelchair that will set an alarm if he should attempt to go through a set of doors prior to the doors that lead to the outside.
10. The family also explains that in the last approximate two years, the petitioner left the facility, on his own, once and possibly twice.
11. The petitioner and his family are happy with the facility and staff.
12. Lastly, the petitioner's family doctor, , MD, in a letter to the facility February 13, 2009 (prior to the discharge Notice), explains the reason why the petitioner may have left the facility in February. This was due to lot construction that may have confused him. He concludes by stating "Please allow him to remain at your facility...."

CONCLUSIONS OF LAW

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

> (a) Transfer and discharge--
>
> (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical 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....

In this instant case, the petitioner is either confined to his bed or motorized wheelchair due to his medical condition. His movements are monitored electronically and have been since February by a staff member, one on one, approximately eight hours per day. The facility is incurring an extra expense due to the individual attention.

The family indicates that there is a household member with the petitioner approximately six of the eight hours the petitioner is awake. Thus, the facility could reduce the individual attention by the approximate six hours daily.

Further, in the past approximate two years, the petitioner has only been outside the facility, on his own, at least one definite time and possibly one other time. The facility is concerned for the petitioner's safety as they should be with all their residents.

However, to this hearing officer, seeking to discharge or transfer a resident in anticipation of their leaving the facility on their own and not having documented multiple instances does not comply with the intent of the discharge Notice. The petitioner's personal physician has indicated that in the best interest of the petitioner he should remain at the facility.

The respondent should keep records as to when and if the petitioner actually leaves the facility. This is the proper indication that his needs can no longer be met.

DECISION

The appeal is granted. No discharge is allowed at this time. The respondent should continue to monitor the petitioner and log the times when he actually leaves the premises on his own.

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 11th day of June, 2009,

in Tallahassee, Florida.

Melvyn Littman
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09N-00049

PETITIONER,

Vs.

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 29, 2009, at 11:08 a.m., at the respondent facility in Bunnell, Florida. The petitioner was present and represented herself. Testifying on behalf of the petitioner was assistant director of nursing for the respondent facility and , registered nurse (RN) for the respondent facility. The respondent was represented by , director of nursing (DON). Testifying on behalf of the respondent was risk manager/abuse coordinator, , social worker and business office manager.

ISSUE

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

FINDINGS OF FACT

1. The petitioner was a resident of the respondent facility from July 25, 2008 through April 9, 2009. The petitioner is 52 years old and is diagnosed with Acquired Immune Deficiency Syndrome (AIDS), below elbow amputation of left arm, neuropathy, bulging disks in back, anxiety, depression and post traumatic stress disorder (PTSD).

2. The respondent asserted that beginning the month of admission (July 2008), the petitioner repeatedly engaged in behavior which endangered the health and safety of other residents as well as the petitioner's own health and safety. The respondent entered into evidence business records which contemporaneously documented incidents of the petitioner's providing unauthorized nursing care to other residents, incidents of noncompliance with facility smoking policies, incidents of noncompliance with infection control guidelines and incidents of verbally abusive behavior towards facility staff. Some of the incidents occurred on the following dates: July 31, 2008 - petitioner "observed with burn holes in clothes while smoking...declined smoking apron", August 4, 2008 - petitioner "observed slumped over... sleeping on smoking patio...", September 6, 2008 - petitioner "observed using another resident's bathroom...", September 20, 2008 - petitioner "observed yelling and cursing at staff member...", September 23, 2008 - "resident counseled about taking other resident to the bathroom...", October 19, 2008 - "resident stated to CNA and nurse that her roommate has sore on the crack of her butt, nurse ask how do you know this, stated she was moaning and told her to come and see...", October 26, 2008 -

"resident…yelling…called CNA smartass…", November 18 2008 - facility staff "walked into another resident's room, ˉ ı was over the bed trying to reach for something. Spoke to resident to find out what she was doing…stated that she was helping after she heard call for help. Instructed resident not to go into other resident's room, instead come to the nurse station", November 19, 2008 - "nurse noted resident sleeping in sink, head under water…", December 13, 2008 - "resident upset another resident by yelling that she almost died last night…", December 22, 2008 - "resident refused to go to scheduled DR appt…stated she didn't sleep well and she will reschedule", January 21, 2009 - "CNA observed resident in hallway…reviewing other residents' records…", January 29, 2009 - "resident observed in another resident's room @ 1 AM, when asked by nurse what she was doing…resident stated 'it's a nice night, she needs to go outside to calm down,' nurse advised resident that it was late …allow other resident to rest.", January 30, 2009 - "resident was observed angry and yelling, pushing another resident's wheelchair away from hallway west side of the bldg. Spoke to resident she stated that the resident she pushed was insulting her and she decided to get her away from her…", February 5, 2009 - "upon entering resident's room, observed lighter lying in the open on ledge by sink…resident out of room", February 9, 2009 - "resident noncompliant when asked to stay in bed while IV ABT being administered…resident took IV pole along w/ ABT to another resident's room because she heard the other resident yelling", March 5, 2009 - facility staff "walked by resident's room…resident's clothing in piles around the bed…asked if I could put items out of the

way as this was an infection control and safety issue. She refused to allow me to move any of her personal items...", April 6, 2009 - "nurse came around the corner noted resident going through papers @ nursing station, picking up papers that are turn down, reading private information...". The respondent also presented testimony of first hand observations of the petitioner repeatedly falling because she declined to use her wheelchair or cane when drowsy (due to her medication) and the engaging in behavior potentially dangerous to the safety and well being of the other residents.

3. The evidence shows facility staff tried to redirect the petitioner when her behavior was inappropriate. These actions were not successful, the noncompliant behavior continued. The petitioner received psychotherapy and psychotropic medication also without success. A magnetic resonance imaging (MRI) was conducted to determine if the petitioner suffered from a brain abnormality. The results showed no documentable brain abnormalities.

4. On March 10, 2009, the respondent, by Nursing Home Transfer and Discharge Notice, notified the petitioner that it was their intent to discharge her, effective April 9, 2009, because the health and safety of other individuals in the facility was endangered. On March 23, 2009, the petitioner requested a hearing. On April 9, 2009, the petitioner was transferred to another skilled nursing facility.

5. The petitioner did not dispute the aforementioned incidents of providing unauthorized nursing care for other residents. The petitioner explained that prior to receiving a diagnosis of AIDS in 1986, she was a certified nursing assistant (CNA) and

knows how to provide care to other residents. The petitioner asserted that she only provided care to other residents when facility staff did not respond to the residents' needs. The petitioner did not dispute that she has fallen repeatedly. The petitioner believes that she knows how to "fall properly", without injuring herself, and uses her wheelchair or cane only when she feels it is necessary. The petitioner did not dispute refusing medication and medical treatment that she felt was inappropriate. The petitioner denied that her smoking practices were not safe. She admitted that prior to receiving education from staff (and signing the facility's smoking agreement on February 9, 2009), she would light cigarettes for other patients without knowing their medical history or if they were allowed to smoke, but she denies that she ever shared cigarettes. The petitioner explained that the burn holes observed on her clothes and blanket occurred prior to her admission into the facility, when she was home and bed ridden. The petitioner admits that an unattended lighter was found in her room. The petitioner asserted that the lighter was out of fluid and she had thrown it in the trash a week earlier. She does not know when or how the lighter was returned to her room. She suspects staff did it to "set her up." The petitioner admitted cursing facility staff; she explained that these incidences only occurred because facility staff were not appropriately addressing her medical needs.

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.

Federal regulations at 42 C.F.R. §483.12 states in part:

(a) Transfer and discharge--

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

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

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

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

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

(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice may be made as soon as practicable before transfer or discharge when--
(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or
(E) A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement that the resident has the right to appeal the action to the State;
(v) The name, address and telephone number of the State long term
care ombudsman;
(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals
established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

The Findings of Fact show that the petitioner's behavior included providing unauthorized nursing care to other residents, noncompliance with prescribed medical treatment, noncompliance with facility smoking rules and verbal abuse. The Findings of Fact also show that the petitioner received redirection counseling in addition to psychotherapy and medication to modify her behavior. In spite of the facility's efforts, there was no substantial or sustained change in the petitioner's conduct or behavior.

After carefully reviewing all the testimony, evidence and controlling legal authorities, it is determined that the petitioner's behavior endangered the health and safety of other residents in the facility. Therefore, the respondent's discharge of the petitioner from the facility was 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 was in accordance the reasons stated in the Federal Regulation.

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 22nd day of June, 2009,

in Tallahassee, Florida.

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

APPEAL NO. 09N-00053

PETITIONER,

Vs.

'N

RESPONDENT.

_______________________________/

FINAL ORDER

Per notice, a hearing was held in the above-styled matter on May 8, 2009, at 2:24 p.m., in Brandon, Florida. The petitioner was not present. He was represented by his wife and power of attorney, . The petitioner's daughter, , appeared as a witness. The facility was represented by , administrator, who also testified. Present as witnesses from the Ombudsman Office were: attorney and legal advocate, and , ombudsman manager for

ISSUE

At issue is the respondent action of March 11, 2009 to temporarily discharge the petitioner to lospital for a psychiatric evaluation under the Baker Act. The petitioner was later placed in another area nursing facility after the respondent facility refused to readmit the petitioner. The

petitioner seeks to return to the respondent facility. It is necessary to determine whether or not the matter is jurisdictional to this hearing authority.

FINDINGS OF FACT

1. The petitioner was admitted to the respondent facility on May 22, 2008.
2. On March 11, 2009, the petitioner was sent to (TGH) for a psychiatric evaluation under the Baker Act after a choking incident at the facility. On March 11, 2009, the respondent physician signed a Nursing Home Transfer and Discharge Notice for the temporary transfer to TGH. As of March 13, 2009, TGH had completed the evaluation and determined the petitioner ready to be discharged back to the respondent facility.
3. The petitioner sought return to the respondent facility, but the facility refused to readmit the petitioner. The listed reasons for discharge on the notice were: unable to meet needs, and the health and safety of other individuals is endangered. On April 1, 2009, the petitioner was admitted to another skilled nursing facility. He remains in that facility as of the date of the hearing. However, he wants to return to the former respondent facility, because it is nearer to his wife's residence, and the former familiar facility provided good care.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by extension of the federal regulations appearing at 42C.F.R.§431.200. The fair hearing process is set forth in 42C.F.R.§431.220:

42 CFR § 431.220 When a hearing is required.
(3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged...

42 CFR § 431.241 Matters to be considered at the hearing.
The hearing must cover—

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

A defined discharge or transfer action that is jurisdictional to this authority is set forth at 42 C.F.R.§ 483.12 Admission, transfer and discharge rights:

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

This law provides that an individual may be transferred or discharged from a facility for one of the above listed reasons. The authority is conveyed to this venue to review a decision by a skilled nursing facility only in the defined "transfer or discharge" of a resident as in paragraph a) above. Paragraph b) of the above regulation addresses bed-hold policy and readmission:

b) Notice of bed-hold policy and readmission--(1) Notice before

transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies--

(i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility; and

(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.

(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.

(3) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident--

(i) Requires the services provided by the facility; and

(ii) Is eligible for Medicaid nursing facility services.

This hearing authority's jurisdiction only applies to the defined transfer and discharge of a resident described in paragraph a) of the above regulation. This authority does not have jurisdiction over the bed-hold or readmission policy set forth in paragraph b). Issues regarding "bed-hold" and readmission are under the jurisdiction of the Agency for Health Care Administration. Since the petitioner's issue is the refusal of the respondent nursing home to readmit the petitioner following hospitalization as in paragraph b) above, appeal matters are outside of the jurisdiction of this venue. Therefore, the appeal is denied or dismissed as non-jurisdictional to this hearing authority.

DECISION

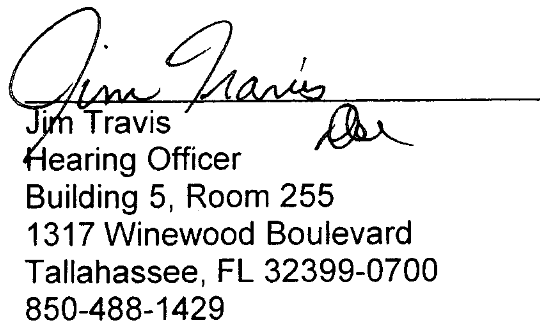
This appeal is denied or dismissed as non-jurisdictional to this hearing authority. The petitioner is referred to the Agency For Health Care Administration for matters related to the readmission of the petitioner to the respondent facility.

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 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 22nd day of June, 2009,

in Tallahassee, Florida.



Jim Travis
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DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09N-00065

PETITIONER,

Vs.

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 26, 2009, at 9:07 a.m., at the , Florida. The petitioner was present and represented himself at the hearing. Also present on behalf of the petitioner was , ombudsman and , ombudsman. Also present on behalf of the petitioner was the petitioner's friend, . The respondent was represented at the hearing by administrator, . Also present as witnesses for the facility were; director of nursing and director of social services, both from . A continuance was granted on behalf of the petitioner for a hearing previously scheduled on May 11, 2009.

ISSUE

The respondent notified the petitioner that he was to be discharged for the following reasons: "Your health has improved sufficiently so that you no longer need the services provided by this facility..." The respondent will have the burden of proof to establish by clear and convincing evidence that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and FS 400.0255.

FINDINGS OF FACT

1. The facility notified the petitioner on or about April 8, 2009 that he was to be discharged by May 8, 2009. The discharge location was given: . This location is an ALF. Currently, the petitioner resides at the

The Discharge Notice was not signed by the treating physician, but physician's orders agreeing with the discharge were attached to the Discharge Notice that was submitted as part of Respondent Exhibit 1.

2. When the petitioner was admitted to the facility; he was in need of nursing care. The petitioner received therapy and other care and his health improved. The respondent also submitted into evidence as part of Respondent Exhibit 1, copies of Social Service notes and basic assessment tracking forms. The facility currently does not provide the petitioner any skilled nursing care. The petitioner is considered fully independent. The petitioner has independently made doctor appointments and had medication prescriptions filled separate from what the facility provides. The petitioner does not require any (nursing) help in getting out of bed; taking baths; taking medication or any of his activities of daily living. The petitioner ambulates in a wheelchair, but he is able to walk.

3. The petitioner submitted into evidence, Petitioner Exhibit 1, which contains copies of medical information concerning the petitioner and statements from two doctors about the petitioner's condition(s) and about his need of nursing home care. One of the doctors is a heart specialist and the other doctor is a pain specialist.

CONCLUSIONS OF LAW

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

> (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;...
>
> (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; ...

As shown in the Findings of Fact, the facility notified the petitioner on or about April 8, 2009 that he was to be discharged by May 8, 2009 to an ALF. The facility has indicated that the petitioner's health has improved and that he no longer needs skilled nursing care. Additionally, the petitioner's physician at the facility has signed an order agreeing the petitioner should be discharged to an ALF.

The petitioner argued that he still needs therapy. He argued that his condition may get worse and he would need nursing care. He argued that he has fallen several times

based on his balance and walking problems. He agreed however, that he did not report theses "falls" to the nursing staff at the facility.

The facility argued that the petitioner had arranged, on his own, for transportation see the "other" doctors, which also proves the petitioner is quite independent of the facility's nursing staff. The respondent also argued that the petitioner would be able to access therapy from an ALF. The respondent argued that as of the current time; the petitioner is not in need of specialized nursing care as provided by this facility. They argued that an ALF would be more suited for the petitioner.

The petitioner's representative argued that the physician who wrote the letters noted in the Findings of Fact, have been treating the petitioner for some time.

The respondent argued that the physician who ordered the petitioner to be discharged from the facility is the petitioner's treating physician with knowledge of the petitioner's conditions and care that was provided by the facility.

It should be noted that the hearing officer has taken into consideration all of the petitioner's physicians letters and statements, but gives more weight to the physician's opinion who ordered the discharge, as he has served the petitioner at the nursing home.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the facility's action to discharge the petitioner is appropriate as the petitioner's health has improved sufficiently for him to be transferred to an ALF. The facility has met its burden of proof as the evidence indicates the resident does not need the services provided by the facility.

DECISION

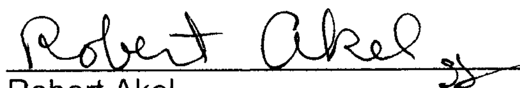
This appeal is denied and the facility's action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th day of June, 2009,

in Tallahassee, Florida.



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