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

APPEAL NO. 07F-00431

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 7, 2007, at 9:05 a.m., at the Sony Service Center, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's sister, . The agency was represented by Nicole Griffin, program administrator, Agency For Health Care Administration (AHCA). Present as witness for the agency, via the telephone, was Dr. Marcelino Oliva, physician reviewer, from KePRO South. Also present, via the telephone, as witnesses for the agency was Susan Ziebell, review operation manger, from KePRO. KePRO is located in Tampa, Florida.

ISSUE

At issue is the agency's action of December 1, 2006, to deny the petitioner's request for acute rehabilitation admission and stay services for the period of November 30, 2006 through December 7, 2006. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about thirty nine years of age, has severe and numerous medical problems that requires medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "agency". The petitioner is currently residing in a nursing home in the Florida panhandle.

KePRO has been authorized to make Prior (service) Authorization Process decisions for the agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on December 1, 2006, that the petitioner's request for acute rehabilitation admission and stay for the period of November 30, 2006 through December 7, 2006 would be denied. The agency's witness indicated that after review of the information provided to KePRO, from the petitioner's service provider(s), the information did not indicate a need for acute rehabilitation service for the petitioner.

The Internal Focus Review Findings from KePRO states in part; "...Pt. with full rehab prior with multiple contracture and appears to be low level with no significant progress noted. No medical issues that require inpatient rehab. Issues can be addressed in alternative setting."

The petitioner's (medical) providers had requested a reconsideration of the above agency decision. Additional information was provided to KePRO by the petitioner's providers. A different reviewer from KePRO reviewed this reconsideration, but still agreed with the agency's first decision for this case.

The petitioner submitted into evidence, Petitioner Composite Exhibit 1, which contains copies of a letter from the petitioner's neurologist; other medical information concerning treatment and a copy of a therapy report completed by a therapist. These reports and letters are dated in January and February 2007. The respondent did not object to their submission, but emphasized that the respondent's decision was based on information provided (by the petitioner's providers) at the time of the request for services. The respondent suggested the petitioner's representative could request the petitioner's providers to submit a new request for the rehabilitation service.

The above referenced petitioner's physician's (Dr. , dated January 30, 2007) letter states in part: "It is my strong belief that due to her age and cognitive function she should advance greatly given the appropriate rehabilitative environment. She needs aggressive physical and occupational therapy."

CONCLUSIONS OF LAW

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

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

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...
Fla. Admin. Code 59G-4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.

(e) Rehabilitative services. Individualized services prescribed by a health care professional that are designed to restore a recipient to self-sufficiency or to the highest attainable functional level in the shortest possible time following an illness or injury.

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.

(4) Skilled Rehabilitative Services. To be classified as skilled rehabilitative services, the services must meet all of the following conditions:

(a) Ordered by and remain under the supervision of a physician;

(b) Reasonable and necessary to the treatment of a recent or presently existing illness or injury;

(c) Performed by a physical therapist, occupational therapist, certified respiratory care practitioner/therapist;

(d) Required at least 5 days a week; and

(e) Reviewed and reevaluated at least every 30 days by the physician and the physical, occupational therapist or respiratory care practitioner/therapist.

(5) Examples of services that qualify as skilled rehabilitation services:

(a) Daily services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(b) Ongoing assessment of rehabilitation potential and needs in accordance with 59G-4.320, F.A.C.

1. Such services must be provided as an integral part of the management of the care plan; and

2. Must include results of tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, physical capacities, perceptual deficits, speech and language or hearing disorders.

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary.

The agency, through KePRO, took action on December 1, 2007 to deny the petitioner's request for acute rehabilitation admission and stay for the period of November 30, 2006 through December 7, 2006. This decision was based on the information as provided by the petitioner's medical providers and the petitioner's medical necessity need of the request for the service at that time.

The petitioner's representative argued that the petitioner's providers, physicians; nurses and therapist strongly recommended that the petitioner receive the rehabilitation

service. Additionally, she argued that as her sister is very young; with the rehabilitation service she can again become independent. She also argued that her sister has gained a considerable amount of weight since she does not receive the service. She argued that she herself can only do so much, for her sister, as she lives in Broward County and her sister is in the panhandle. The respondent's witness suggested the petitioner's providers may request a new request for the rehabilitation services and supply any new information on the petitioner. The petitioner's representative argued that she may have difficulties with the above agency "suggestion" based on the petitioner not having the same "provider" as she had back in November 2006.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action of December 1, 2006, to deny the petitioner's request for acute rehabilitation admission and stay services for the period of November 30, 2006 through December 7, 2006.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 1st day of March, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-08169

PETITIONER,

Vs.

CASE NO. 1249906024

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Nassau
UNIT: 88368

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 28, 2007, at 3:10 p.m., in Jacksonville, Florida. The petitioner was not present. However, she was represented by her son and Power of Attorney, The Department was represented by Teresa Harris, economic services self-sufficiency specialist.

ISSUE

At issue is the Department's action of November 6, 2006 to deny Institutional Care Program (ICP) Medicaid benefits for September 2006, due to excess income. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner was placed in a nursing home in September 2006. The petitioner's representative submitted an on-line application for ICP Medicaid on August 21, 2006 at the Department of Children and Families Office in Green Cove Springs. The maximum income limit to receive ICP Medicaid was $1809. The petitioner's income consisted of $1290 in Social Security and a pension of $853.13 for a total gross monthly income of $2143.13. The petitioner's income was not disputed. Since the petitioner's income exceeded the maximum income limit, an income trust had to be set up and properly funded before the petitioner could be approved for ICP Medicaid benefits.

The petitioner's representative set up an income trust and funded it with $300 on September 6, 2006. On September 26, 2006, the petitioner's representative made contact with Rycha Redden to inquire about the status of his case. Ms. Redden reviewed the case and called the petitioner's representative back on September 29, 2006 to inform him that he needed to submit another application, which he did on September 29, 2006. The August application had been denied because the petitioner's living address was listed as . The petitioner's representative had mistakenly listed his address as the petitioner's address and a non resident of Florida cannot receive ICP Medicaid in Florida.

The Department did not provide the petitioner with written notification of the denial of the August application. A telephone interview was conducted on October 2, 2006 wherein the funding procedures for the income trust were explained. The income

trust was properly funded in October and on November 6, 2006 ICP Medicaid was approved effective October 2006 and ongoing.

Based on the petitioner's income the income trust would have had to be funded with at least $343.13 to achieve ICP Medicaid eligibility. The Department's records showed that for September 2006, only $300 of the petitioner's income was deposited into the trust. All parties acknowledged at the hearing that during the month of September 2006, the income trust had not been properly funded and as a result, the petitioner's income was over the ICP Medicaid income limit of $1809.

The petitioner's representative believed that if he had been interviewed or contacted within 10 to 15 days of the August 21, 2006 application as stated on the application confirmation page then he would have known how much to put in the income trust and he would have been able to achieve eligibility for the month of September 2006.

CONCLUSIONS OF LAW

The argument of the petitioner's representative was that the petitioner should not be adversely affected due to miscommunications or inadequate information which resulted in the deficient funding of the income trust. The argument of agency staff was that all policy criteria must be fulfilled before ICP Medicaid benefits can be authorized and there are no provisions in the agency policy to make exception to meeting such criteria.

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

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

(b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36-month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual. Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.

(c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income."

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

"(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:...(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in Rule 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in Rule 65A-1.702(13)(a), F.A.C."
(To be eligible for ICP Medicaid, under Title XVI policy, the maximum income standard is $1,809.)

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

"Income Trusts (MSSI)
The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and

> Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
> To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:
>
> It is established on or after 10/01/93 for the benefit of the individual;
> It is irrevocable;
> It is composed only of the individual's income (social security, pensions, or other income sources); and
> The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.
>
> The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.
> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested**." (emphasis added)f

The above authorities provide for the establishment of an income trust by an Institutional Care Program applicant in order to reduce monthly income below the state income limitations. The Findings of Fact show that an income trust was established in September 2006 and funded with $300. Based on the petitioner's income the amount that was funded did not reduce the petitioner's income to at or below the maximum income limit for ICP Medicaid of $1809.

Since the petitioner's income for September 2006 exceeded the maximum limit, the Department denied ICP Medicaid benefits for that month. The Department's action

is consistent with the above cited authorities and there were no grounds presented to make an exception to this policy.

The petitioner's argument that he was not given all of the necessary information needed to properly fund the trust until after the month had passed is insufficient to justify the approval for ICP Medicaid benefits. Therefore, the Department correctly denied Institutional Care Program benefits for the month of September 2006.

The Department is hereby ordered to send the petitioner a notice denying the August 21, 2006 application since the record reflects that this was not done.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-07059

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 26, 2007, at 11:32 a.m., in Bradenton, Florida. The petitioner was not present, but was represented by his mother, [redacted], who also testified. The respondent agency was represented by Sandra Barile, registered nurse specialist with the Agency for Health Care Administration (AHCA), who also testified. Dena Gay, also a registered nurse specialist with AHCA, was also present as a Department witness. Jodi Winter, licensed physical therapy consultant with the Bureau of Medicaid Services, appeared as a witness for the agency via telephone.

ISSUE

At issue is the Department's decision of September 20, 2006 to deny funding under the regular "State Plan" Medicaid Program for a requested standing device, specifically a Rifton Dynamic Standing Device.

FINDINGS OF FACT

The respondent agency generated notice to the petitioner on September 20, 2006 that a standing device without large wheels could be approved. This specific notice was not submitted as evidence.

The petitioner is one year old and was born on May 18, 2005. The petitioner is approved to receive eligible services under the Florida Medicaid Program. The petitioner lives with his mother. The petitioner diagnoses include cerebral palsy, microencephaly, with vision and hearing impairments. The petitioner receives physical therapy and ambulates with the assistance of a standing device.

On July 20, 2006, the petitioner's treating physical therapist sent clinical documentation to the agency for the requested stander, a Rifton Dynamic Standing device, as shown in Respondent Exhibit 3 and the Petitioner Exhibit 1. This specific standing device contains large wheels which facilitates increased speed of mobility. However, the ability to move a standing device does not impact the medical benefits of weight-bearing. The agency stipulated that the less costly standing device without large wheels could be approved, but asserts that the more costly standing device with large wheels does not meet defined medical necessity criteria.

CONCLUSIONS OF LAW

The Florida Administrative Code Rule 59G-1.010(166) addresses relevant definitions within the Medicaid Program, which are also applicable to this specific Medicaid decision regarding the request for the standing device with large wheels, at issue. Subsection (166) of the Florida Administrative Code Rule defines what constitutes "medically necessary" care, goods or services, as follows:

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

Paragraph 2. of the above-cited Administrative Code Rule indicates that goods or services must be individualized, specific, consistent and must not be "in excess of the individual's needs." The Findings of Fact show that the requested stander with large wheels does not impact the medical benefits of weight-bearing. Therefore, the requested stander with large wheels is in excess of the petitioner's medical needs.

Paragraph 4. of the above F.A.C. Rule shows that needed goods or service must be provided in an effective, but least costly manner. Findings show that there is another standing device without the large wheels that would address the medical benefits of weight-bearing, which is less costly alternative to the device with larger wheels. This suggested alternative is a viable and less costly alternative to the standing device with large wheels.

Paragraph 5. of the above F.A.C. Rule shows that the requested goods or services must be "furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." The Findings of Fact show that the provision of the requested stander with large wheels would primarily be provided for the convenience of the petitioner with greater speed of mobility.

Since the request for the standing device with large wheels does not meet the defined medical necessity criteria in paragraphs two, four, and five of F.A.C. Rule 59G-1.010(166), the respondent agency is correct to deny the requested stander with large wheels.

DECISION

This appeal is denied and the agency decision 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 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 5th day of March, 2007,

in Tallahassee, Florida.

Jim Travis

Jim Travis
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 06F-07705

PETITIONER,

Vs.

CASE NO. 1171054360

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES (DCF)
DISTRICT: 12 Volusia
UNIT: 88216

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, and rescheduling request of the parties, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 11:40 a.m. on February 7, 2007. The petitioner was not present but was duly represented by , with testimony presented by , nursing home administrator and , business office manager. The respondent was represented by Ernestine Bethune, economic self-sufficiency supervisor, with testimony available from Susan Mauro, senior economic self-sufficiency specialist.

ISSUE

At issue was whether or not Institutional Care Program (ICP) Medicaid denial was correct due to insufficient follow through in the application process. As an applicant the petitioner had the burden of proof.

FINDINGS OF FACT

The petitioner does not have a legal guardian and has not been adjudicated incompetent. She is not in a coma. However, she is not fully capable and she is a resident in a long term care nursing facility due to medical need. Such is undisputed.

Due to a belief that possible exploitation may have occurred, a referral to the Adult Protective Investigative function within DCF was made by nursing facility staff regarding a family member. The situation also may have been referred for law enforcement action. The Economic Self-sufficiency function of DCF (the respondent's representative) was aware of the Adult Protective Investigation referral. No results were known from either referral source.

While residing at the nursing facility, costs are being incurred. To help meet those costs, and in the absence of full payment for such expenses, the nursing facility filed an application for ICP Medicaid coverage at the end of September 2006. However, facility staff were unaware (and are unaware) of the full financial circumstance of the petitioner. Thus the September 2006 application (and another one before it) faced obvious difficulty.

Some income of the petitioner is from the state's Florida Retirement System (FRS), but the exact amount is unknown and all efforts to verify allegedly have been unsuccessful, although full details and nature of such efforts were not in evidence. Substantive evidence did not establish how diligently, when, or by whom, verification was attempted. However, testimony of both the respondent's representative and the petitioner's representative was that efforts had repeatedly occurred, and all efforts were unsuccessful.

The FRS amount is believed to exceed $1000 monthly and total income of the petitioner is believed by both the petitioner's representative and the respondent's representative to exceed state income limits. Additional income is Social Security Administration (SSA) retirement in the amount of $839. Additionally, there may be property or asset ownership. On behalf of the petitioner, the nursing facility staff successfully obtained some financial information and the SSA pension was being directed to the facility at the time of the September-October 2006 ICP application process.

As the income was thought to exceed state ICP income limit of $1809, and was unverified, the application was pended on October 16, 2006 for further verification of income as shown in Respondent's Exhibit 2, with income trust information also given to the petitioner's nursing home/ICP representative. Deadline to submit information was October 26, 2006. Verification of all income was not received by DCF at any time, a trust was not established, and the application was denied on November 13, 2006 (Respondent's Exhibit 1), with a determination that the representative did "not follow through in establishing eligibility."

Between the first scheduled date of hearing (January 3, 2007) and the new date of hearing, efforts at issue resolution continued, without success. As of date of hearing, no party had verification of the FRS income and a trust had not been established, approved or funded.

CONCLUSIONS OF LAW

From the outset, the unique predicament and misfortune of this situation is noted. Nevertheless, appropriate eligibility requirements must be applied, they cannot be

ignored, and eligibility must only be authorized when and if all eligibility factors are met.

Accordingly, Fla. Admin. Code 65A-1.204 addresses **Rights and Responsibilities** in part as follows:

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

Additional guidelines appear at Fla. Admin. Code 65A-1.205, addressing the **Eligibility Determination Process.** The pertinent excerpt appears at subsection (1), as follows:

> (d) If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, or that an assistance group member is required to register for employment services, the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated) or 30 days from the date of application whichever is later. In cases where medical information is requested the return due date is 30 calendar days following the request or 30 days from the date of application whichever is later. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day. If the verification or information is difficult for the person to obtain, the eligibility specialist must provide assistance in obtaining the verification or information when requested or when it appears necessary. If the required verifications and information are not provided by the deadline date, the application is denied, unless a request for extension is made by the applicant or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension based on extenuating circumstances beyond the control of the individual, such as sickness, lack of transportation, etc.

When all required information is obtained, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

Argument on behalf of the petitioner was, in part, that the petitioner should not be so severely impacted by miscommunications or difficulties which have created the deficient verification and/or trust establishment. Argument of agency staff was that all criteria of policy needed to be fulfilled and no ability to authorize benefits existed until all criteria were completely fulfilled.

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

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

(b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36-month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual. Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.

(c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income.

Fla. Admin. Code 65A-1.713 in part states:

SSI-Related Medicaid Income Eligibility Criteria.

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:...

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(15), F.A.C.

Consistent with these regulatory standards, Fla. Integrated Pub. Policy Manual 165-22 Appendix A-9 sets ICP income limit for an individual at $1,809 during the end of 2006 and at $1869 for the first part of 2007. Without income verification, it simply cannot be determined whether standards were met. Additionally, as related to trust situations when income exceeds standards, Fla. Integrated Pub. Policy Manual, 165-22, Section 1840.0110 further states:

Income Trusts (MSSI)
The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

It is established on or after 10/01/93 for the benefit of the individual;
It is irrevocable;
It is composed only of the individual's income (Social Security, pensions, or other income sources); and
The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The Economic Self-Sufficiency Specialist must forward all income trusts to their District Program Office for review and submission to the District Legal

> Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases. The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.** (emphasis included in policy)

The preceding rules and policies provide for establishment of an income trust by an ICP applicant in order to reduce monthly income below the state income limitations. This opportunity was created at federal level by the 1993 Omnibus Reconciliation Act.

In the case at hand, the critical problem was that all standards necessary for approval were not fulfilled at any time prior to the denial or before date of hearing, and the application simply could not be approved with such deficiencies. Thus, despite the unique circumstances, it must be concluded that agency denial was justified.

DECISION

The appeal is denied and the agency action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30th day of March, 2007, in Tallahassee, Florida.

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

Copies Furnished

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

PETITIONER,

Vs.

APPEAL NO. 06F-08125

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 03 Levy
UNIT: 88325

CASE NO. 1248601785

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on January 12, 2007, at 8:30 a.m., in Chiefland, Florida. The petitioner was not present. Present representing the petitioner was his daughter, . Present as a witness for the petitioner was his son-in-law, . The Department was represented by Luella Teague, ACCESS supervisor.

ISSUE

The petitioner is appealing the Department's action of November 9, 2006, to deny his application for Institutional Care Program (ICP) benefits for the months of August 2006, September 2006 and October 2006 based on excess assets.

FINDINGS OF FACT

The petitioner has been a resident of Health and Rehabilitation Center, , Florida since May 2006. On October 11, 2006, the respondent received an

application for ICP benefits on behalf of the petitioner. The request was for ICP benefits from October 2006 and ongoing and also for the retroactive months of August 2006 and September 2006.

At the time of the application and also during the months of August 2006 and September 2006, the petitioner had a savings account at SunState Federal Credit Union. The monthly balance in the savings account was not less than $500.

At the time of the October 11, 2006, application and during the months of August 2006 and September 2006, the petitioner was the owner of a 2001 Gheenoe Classic 16 ½ foot boat, a 1991 Mariner 20 HP motor and trailer. On October 24, 2006, the petitioner obtained an appraisal of the boat, motor and trailer from Inboard and Auto Forte's Connection. The average retail value of the boat, motor and trailer was $2,030. There were no encumbrances on the boat, motor and trailer and the petitioner was the sole owner. In determining the petitioner's eligibility for ICP benefits, the Department included as assets the balance in his savings account and the value of his boat, motor and trailer. The total assets that were included in determining eligibility was $2,530. The Department determined that the petitioner was not eligible because his assets exceeded the asset limit for the ICP of $2,000. On November 9, 2006, the Department notified the petitioner that his application for ICP benefits was denied because of excess assets.

At the time of the application and during the months of August 2006 and September 2006, the petitioner had a pre-paid burial contract. As the petitioner had a pre-paid burial contract, the burial exclusion of $2,500 was not subtracted from his total assets in determining his eligibility for ICP benefits.

On November 14, 2006, the petitioner sold the boat, motor and trailer to his son for $2030. On November 15, 2006, the petitioner used the proceeds from the sale of the boat, motor and trailer plus funds from his savings account to pay for the cost of his care at * Health and Rehabilitation Center. The total amount of the payment was $2,436.41. The Department approved the petitioner's request for ICP benefits effective November 2006 as his assets fell below the $2,000 asset limit during November 2006 because he sold the boat , motor and trailer and used the proceeds to pay for the cost of his care. However, the Department denied the petitioner's request for ICP benefits for August 2006, September 2006 and October 2006 because his total assets exceeded the ICP asset limit of $2,000 during each of those months.

On August 30, 2006, the petitioner submitted an application for ICP benefits. At the time of this application, the petitioner stated that he had no intent to return to his home. Therefore, the Department included the value of his home as an asset. The Department denied the petitioner's application of August 30, 2006, because the value of his home exceeded the asset limit of $2,000. The denial of the petitioner's August 30, 2006, was not at issue.

CONCLUSIONS OF LAW

20 C.F.R. § 416.1201 in part states:

> Resources; general. (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance... (b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are ...life insurance policies, financial institution accounts (including

savings, checking, and time deposits, also known as certificates of deposit)...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fla. Integrated Pub. Policy Manual, passage 1640.0543.01 in part states:

Home as Principal Place of Residence (MSSI, SFP)
An individual's temporary absence from the home does not affect the exclusion of the home as an asset regardless of the length of absence, if:

1. a spouse or dependent relative continues to reside in the home, or

2. the sale of the home would cause undue hardship due to loss of primary residence to a co-owner of the property, or
3. the individual (or, on his behalf, a designated representative) states an intent to return home.

The Findings of Fact showed that the petitioner's assets from his saving account and the value of his boat, motor and trailer exceeded the $2,000 asset limit in the ICP Program during the months of August 2006, September 2006 and October 2006. Based on the amount of the assets, the petitioner was not eligible to receive ICP benefits during the above months. Therefore, the Department correctly denied ICP benefits for the months of August 2006, September 2006 and October 2006.

DECISION

The appeal is denied. The respondent's actions are 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 4th day of March, 2007,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished

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

APPEAL NO. 06F-08170

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 St. Johns
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 19, 2007 at 3:15 p.m., in St. Augustine, Florida. The petitioner was present and represented by her mother at the hearing. caregiver nurse appeared as a witness for the petitioner. The agency was represented by Gwen Mathis, registered nurse specialist. Appearing as witnesses for the agency were Teresa Ashey, Kepro and Dr. Galdinn Silva-Neto, Kepro. Ms. Ashey and Dr. Silva-Neto participated in the hearing by telephone.

ISSUE

The petitioner disagrees with the agency's action of December 14, 2006 to approve 12 hours a day of private duty nursing instead of the requested 18 hours a day

during the week day and 12 hours daily on the weekend. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner was previously approved to receive 18 hours daily of private duty nursing service during the week and 12 hours of private duty nursing service on the weekend. On November 30, 2006, a request was made from the nursing service provider that private duty nursing services continue at the previously approved level. The Kepro Unit evaluated the request to determine if medical necessity existed to approve the service at the requested level. The Kepro Unit's review states in part:

> "Initial PC Review:
> On 12/13/06 at 10:29pm, A Board Certified Pediatrician reviewed the case and made the following determination:
> Mom cares for the baby 12 hrs/day on weekends so no clear why she can't do the same on weekdays. On the appointment days perhaps a HHA can help out. I would only approve for 12 hrs/day to provide some relief to mom and also to cover the sleep hrs (hours). So approve 720 hrs and deny the rest...ADDITIONAL INFORMATION... the Provider submitted the following information: THIS IS A REQUEST FOR RECONSIDERATION: the nurse that travels to and from appointments with mom sits in the back seat with the client and suctions her frequently. The child is not able to set up in a car seat. She lies in the back seat in a harness. A HHA would not be albe (able) to suction ı nor assist with any feedings if travel time took place during a feeding. There is usually appointments schedule for Jordan at a minium (minimum) 4x/week. She has ST (Speech Therapy), OT (Occupational Therapy), Vision therapy, PT (Physical Therapy), and craniosacral therapy... The additional information along with request for Reconsideration was referred to a second Physician Consultant who is Board-Certified in Pediatrics and who had not issued the initial level denial...RECONSIDERATION PC Reviv: On 12/14/06 at 8:17 pm, a Reconsideration review was completed by a second Physician Consultant who is Board-Certified in Pediatrics and who has not issued the initial denial resulted in the following determination... Previous physician consultant determination is not compatible with this clients medical needs. I suggested to deny the four (4) hours a day7 days/week as a considered daily PDN coverage. A PDN can accompany PCG (Primary Care Giver) for appointments, but this is not every day. Since

these are appointments, schedule should be known in advance and provider may request when the need arises. Suggest to APPROVE only 12 hours/day/7 days/week For a total of 720 hours for the stated certification period."

The Kepro Unit determined that based on information provided the petitioner was eligible for 720 hours of private duty nursing or 12 hours a day. The petitioner was notified of the agency's decision on September 14, 2006. A reconsideration was performed and the original decision was upheld. The petitioner's condition is medically complex. She requires frequent suctioning and therapeutic repositioning to assist with her breathing. The petitioner has a diagnosis of encephalopathy; unspecified, chronic respiratory failure, other respiratory problems, convulsions, tracheostomy, gastrostomy tube and funoplication.

The petitioner is severely developmentally delayed, incontinent, has contractures and is speech and visually impaired. The petitioner is fed through a gastric tube and must be monitored closely for reflux and aspiration since she has no swallow reflex. The petitioner is on regular medication regimen as well. The petitioner's mother is a single parent with no other children in the household. The petitioner's mother does not work outside of the home.

The petitioner lives in St. Augustine however, the medical appointments are frequently in Jacksonville or Gainesville which can take several hours in travel time. The agency stipulated to approve up to 18 hours a day for medical appointments when notification of said appointments are provided in advance. The agency representative explained that there could not be a blanket approval of 18 hours a day because that would be in excess of what is medically necessary.

CONCLUSIONS OF LAW

Pursuant to the Florida Administrative Code at 59G-1.010 **Definitions**, which 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."

Fla. Stat. § 409-905, states in part:

> "(4) (b) The agency shall implement a comprehensive utilization management program that requires prior authorization of all private duty nursing services, an individualized treatment plan that includes information about medication and treatment orders, treatment goals, methods of care to be used, and plans for care coordination by nurses and other health professionals. 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. When implemented, the private duty nursing

utilization management program shall replace the current authorization program used by the Agency for Health Care Administration and the Children's Medical Services program of the Department of Health. The agency may competitively bid on a contract to select a qualified organization to provide utilization management of private duty nursing services. The agency is authorized to seek federal waivers to implement this initiative."

The Home Health Services Coverage and Limitations Handbook dated October 2003 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. Who **Can Receive Private Duty Nursing** Medicaid reimburse private duty nursing services for recipients under the age of 21 who:
Have a complex medical problems; and
Require more individual care than can be provided through a home health nurse visit...**Parental Responsibility** Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver. "

The record shows that the petitioner was previously approved to receive 18 hours daily of private duty nursing and 12 hours a day on the weekend of private duty nursing service. The agency referred the case to the Kepro Unit for a prior authorization evaluation. The Kepro unit evaluated the information provided and determined that the petitioner should be approved for 12 hours daily of private duty nursing services because medical necessity was not proven for the amount of the service requested.

The petitioner's mother disagreed with the agency's decision and argued that because the petitioner needs frequent suctioning she is unable to do anything else when help is not available. The petitioner's mother explained she cannot leave the

house or drive the car because of the frequent suctioning that must take place since the petitioner does not have a swallow reflex, she cannot sit-up and she is always in danger of aspirating fluids into her lungs.

The agency indicated the petitioner's mother could have up to 18 hours daily of private duty nursing services approved whenever a schedule is provided that would substantiate that the additional private duty nursing hours were needed to accommodate getting the petitioner to her medical appointments. The petitioner however explained that some appointments are not planned or scheduled. The agency's determination was based on the medical necessity criteria and the description of private duty nursing service found in the Coverage and Limitations handbook.

In carefully comparing the evidence presented to the applicable authorities, the hearing officer concludes that the agency carried its burden of proof. As such, the agency's action to approve 12 hours daily of private duty nursing service instead of the requested 18 hours on weekdays and 12 hours on weekends is a justified action that is in accordance with the above cited authorities.

DECISION

This appeal is denied.

NOTICE OF RIGHT TOAPPEAL

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

be the petitioner's responsibility.

DONE and ORDERED this 15th day of March, 2007,

in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES (DCF)
DISTRICT: 13 Lake
UNIT: 88566

RESPONDENT.
_____/

APPEAL NO. 06F-07979

CASE NO. 1238395244

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer at 2:45 p.m. on January 22, 2007, in Tavares, Florida. The petitioner was not present but was duly represented by her son and daughter-in-law, - The respondent was represented by Diana Anderson, Department of Children and Families (DCF), economic self-sufficiency supervisor, with testimony available from Pat Peppers, economic self-sufficiency specialist.

ISSUE

At issue was whether or not Institutional Care Program (ICP) denial was correct based upon excess assets. As an applicant, the petitioner had the burden of proof.

FINDINGS OF FACT

The petitioner has been receiving institutional nursing care due to medical need. Such need is not in dispute. On July 3, 2006, a (second) application for state medical assistance under the Institutional Care Program was filed. Interview occurred a few

days later. That application was approved and eligibility was authorized effective August 2006. It was not approved for months of May through July 2006 due to a DCF determination of excess assets. Notice of such was Respondent Exhibit 1, and denial provides the matter under challenge for hearing purposes.

Assets which were determined to create ineligibility were those in Payless stock (valued at least $1890 for each month) and checking account (valued at least $405.16 for each month). By July 2006, no money was available in the savings account, and that did not adversely impact for July 2006. At all times between May and July 2006, value of Payless was at least $1890 and value of the checking account was at least $405.16. During May and June 2006, checking account value was at least $11,263. Respondent's Exhibit 3 reflected bank information.

Opportunity to create a burial exclusion with existent assets did not provide remedy as that arrangement had already been achieved. DCF did not count income as both income and an asset during any of the months under challenge. Social Security income was approximately $1101 per month.

Although the petitioner's representative was concerned that an excess value was placed on land in Washington State (Petitioner's Exhibits 3-5 and 7) and had created ineligibility, there was no finding of such made. Asset value rebuttal (Respondent's Exhibit 6) submitted in July 2006 was successful, and for months of June and July 2006, the checking account value was quite significant and would have been an eligibility obstacle. Thus, it must be found that the land was not significant to the ineligibility determination.

During all months, the petitioner was incurring cost for her care at the nursing facility. During July and August 2006 the facility account showed a balance owing of more than $14,000, shown in Petitioner's Exhibit 2 and Respondent's Exhibit 3, page 6. The petitioner's representative believed that the assets should be considered depleted by the costs for such medical and nursing care. Evidence did not establish that a lien had been sought by the nursing facility against such assets. Among other ICP eligibility review concerns, the petitioner's representative believed that DCF had "refused to evaluate actual medical liabilities" as shown in Petitioner's Exhibit 1.

Evidence did not reflect that the petitioner has been adjudicated legally incompetent. The petitioner's representative had difficulty attending to her financial arrangements, including stock liquidation. The petitioner invoked her son as "financial Power of Attorney" on July 3, 2006 (Petitioner's Exhibit 6 page 1). financial institution, then gave a "security receipt" dated July 8, 2006 (Petitioner's Exhibit 6, page 2) reflecting petitioner c/o the son.

ICP eligibility was determined by DCF staff for the month of August 2006 and thereafter. The eligibility determination occurred when DCF received verification (Respondent's Exhibit 4) that the Payless stock was liquidated on August 8, 2006, and Suntrust checking account with $2245.24 was depleted by $310 with check number 1613 (Respondent's Exhibit 3). Total asset value was determined by DCF as $1935.24 for August 2006.

CONCLUSIONS OF LAW

Argument of the family was that the expenses accruing, especially medical and nursing care costs, should have been used to deplete the assets so that asset eligibility

could occur for months of May through July 2006. Additionally, the family believed that the difficulty in liquidating funds and DCF communication difficulties or misunderstandings, should remedy the problem. Argument of agency staff was that all criteria of policy needed to be fulfilled, the financial difficulties did not rise to a level of legal inaccessibility, assets were somewhat over the $2000 limit prior to August 2006, and benefits could not be authorized until all eligibility factors were met.

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

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

20 C.F.R. § 416.1205 establishes the maximum asset limitation for the ICP category as $2,000 for an individual with income at the level of the petitioner's (greater than $743 per month in accord with regulation and Fla. Integrated Pub. Policy Manual 165-22, Appendix A-9). Section 416.1207 addresses **Resources determinations**, with subsection(c) informing:

> Decrease in value of resources. If, during a month, a resource decreases in value or an individual spends a resource or replaces a resource that is not excluded with one that is excluded, the decreases in the value of the resources is counted as of the first moment of the next month.

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

> (1) Specific policies concerning assets vary by program and are found in program specific rule sections and codes of federal statutes and regulations and Florida Statutes.
> (2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.
> (3) Once the individuals' ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted

> access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless legal restrictions were caused or requested by the individual or another acting on their request or on their behalf.

Fla. Admin. Code 65A-1.712 addresses **SSI-Related Medicaid Resource Eligibility Criteria**:

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

DCF policy set forth at Fla. Integrated Pub. Policy Manual passage 1640.03221 informs that "Assets unavailable due to circumstances beyond the individual's control are not considered in the determination of eligibility." Policy further informs that the "individual must present convincing evidence to prove the asset is unavailable to him due to circumstances beyond his control..."

After careful review of all findings of fact and the relevant regulatory guidelines, it must be concluded that the stock and bank assets were slightly excessive and accessible to the petitioner for the month of July 2006, and were excessive and accessible for months of May and June 2006. Access of the petitioner to her own funds may have been delayed for a variety of reasons, and arrangements for her son to handle affairs may have been cumbersome, but there was legal availability and legal inaccessibility was not evident. The assets had not been encumbered by a lien.

Although the situation is unfortunate, remedy cannot be found within applicable regulations. Despite argument and explanations offered, the evidence does not

substantively establish that the petitioner's access was restricted such that asset unavailability existed. There is greater evidentiary and regulatory support for the position that access and availability existed, rather than the contrary position. Thus, it is concluded that DCF action of denial due to excess assets and availability of such was justified.

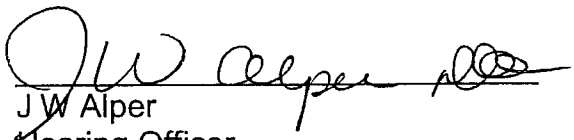
DECISION

The appeal is denied and the agency action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 5th day of March, 2007, in Tallahassee, Florida.



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

Copies Furnished To

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

APPEAL NO. 06f-06820

PETITIONER,

Vs.

CASE NO. 1246535254

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 08 Lee
UNIT: 88285

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 20, 2006, at 10:05 a.m., in Naples, Florida. The petitioner was present and represented by his power of attorney, [redacted] The Department was represented by Mary Lou Raab, economic self-sufficiency supervisor. Present as a witness for the petitioner was his other power of attorney, [redacted]. Present as witnesses for the Department from CARES were Merline Edwards, program manager, and Cheryl Armstrong CARES assessor. Also present as a witness for the Department was Millie Martinez, program manager of [redacted].

The Department was allowed 10 days to return further information. Information was received from the Department on December 22, 2006. It was accepted as Department Exhibit 4.

ISSUE

At issue is the action by authorizing Long Term Community Care Diversion benefits for the petitioner with an effective date of November 2006.

FINDINGS OF FACT

On July 27, 2006, the petitioner filed a Request for Assistance to apply for benefits through the Long Term Community Care Diversion Program and Medicaid. The Long Term Community Care Diversion Program (LTCCD) is one of the Home and Community Based Services Waiver Programs available to prevent institutionalization by providing care in a community setting. The petitioner resided in an Assisted Living Facility.

The Department interviewed the petitioner on August 11, 2006. He needed to establish an income trust. The income trust was approved by the Department on August 30, 2006. On August 18, 2006, the Department received a Notification of Level of Care from the CARES unit. The level of care was effective July 28, 2006. It established that the petitioner met the required level of care for the LTCCD waiver Program in an assisted living facility. On August 31, 2006, the Department completed a Notice of Case Action approving the petitioner for the LTCCD Program effective August 1, 2006. The Notice of Case Action was sent to the contract provider, not CARES.

CARES is the collector of the necessary authorizations. When the "packet" is complete, it goes to the contractor of services. In this case the contractor of services is . The packet includes the

level of care, Notice of Case Action from the economic services financial determination, a CARES assessment for the LTCCD Waiver, a routing form, enrollment data form, a Freedom of Choice form, 3008 from the physician, copy of the Medicare card, and an informed consent form. Once the packet is received by the contractor from CARES, enrollment can occur.

The representative telephoned the contractor, multiple times in September and October 2006. Finally, the contractor found part of the paperwork that should have gone to CARES on a desk. On October 11, 2006, the necessary forms were forwarded to CARES. Taking into consideration the delay experienced by the petitioner, CARES expedited the completion of the forms for the packet. The packet was sent to the contractor in time for the petitioner to be enrolled effective November 1, 2006.

The Department explains that LTCCD waiver does not allow for retroactive benefits. They explained that this waiver is a capitation rate program, which pays for services and medical care for the petitioner in full. The petitioner must be approved for Medicaid and enrolled in the program, before payments can be made. The contract between the Department of Elder Affairs and the provider, specifically states that enrollment in the LTCCD Waiver Program cannot occur until all forms are completed and sent by CARES to the contractor. The contractor enrolls individuals who have completed packets on the Wednesday before the second to last Saturday in the month. Eligibility would begin the first of the following month.

The delay occurred in the petitioner's case when the Notice of Case Action from the Department was not sent to CARES. It was sent to the contractor who did not forward the form. They waited for the completed packet from CARES. Despite the delay, CARES and the contractor agree that enrollment does not occur retroactively. It only occurs in the future once all required forms are complete.

CONCLUSIONS OF LAW

Fla. Admin. Code at 59G-13.080 Home and Community-Based Services Waivers states as follows:

> (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. ...
>
> (6) Program Requirements-General. All HCB services waiver providers and their billing agents must comply with the provisions of the Florida Medicaid Provider Reimbursement Handbook,... The following requirements are applicable to all HCB services waiver programs:
>
> (b) A person *can not* receive Medicaid waiver services until he is determined eligible, waiver fund is available, and is *enrolled* in the appropriate waiver program.

Fla. Stat. 409.908 (2006) Reimbursement of Medicaid providers states in part:

> Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law,

> according to methodologies set forth in the rules of the agency and in policy manual and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. ...
>
> (4) Subject to any limitations or directions provided for in the General Appropriations Act, alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed prepaid amount negotiated, or competitively bide pursuant to s. 287.057, by the agency and prospectively paid to the provider monthly for each Medicaid recipient enrolled. ...

Fla. Public Assist. Policy Manual section 1440.1302 explains who determines need for placement for long-term care and states in part:

> The agency or office responsible for determining the need for care depends on the applicant's age and what kind of facility or program is needed. After the ESS requests a determination, he must receive DOEA CARES Form 63 (Notification of Level of Care) from the responsible office to document the specific need in the case record.
>
> Note: ESS does not request level of care decisions for HCBS waivers but must receive documentation of decisions from case managers or CARES. ...

Section 2040.0815.09 lists additional criteria for individuals in the Long-Term Care Community Diversion Waiver and states as follows:

1. must be age 65 or older,
2. must meet the nursing facility level of care requirement as determined by CARES, and
3. must be enrolled in the waiver with specific managed care providers as documented by for CF-ES 2515.

Each year the Department of Elder Affairs enters into a contract with "contractor" to provide services through the LTCCD Waiver Program. That contract for the 2006-2007 year states in relevant part:

DEPARTMENT OF ELDER AFFAIRS
STANDARD CONTRACT
NURSING HOME DIVERSION

THIS CONTRACT is entered into between the State of Florida, Department of Elder Affairs, hereinafter referred to as the "department", and _____ hereinafter referred to as the "contractor".

I.THE Contractor AGREES:

A. To provide services according to the conditions specified in Attachment(s) I.....

SECTION 4 ENROLLMENT AND DISENROLLMENT
4.1 Enrollment Procedures

A. When a person is determined to be both financially and clinically eligible and chooses to enroll in this project, CARES staff will refer the person to the selected contractor by completing a project enrollment form.

B. CARES staff will forward the approved enrollment forms to the selected contractor, with the effective date of enrollment. Upon receipt, the contractor will log in and date stamp the CARES enrollment package.

C. The contractor will forward the enrollment information to the Medicaid fiscal agent through the Proprietary Enrollment and Disenrollment Uploaded File or in the HIPAA approved format This information must be transmitted to the fiscal agent by the monthly reporting deadline (usually the Wednesday preceding the next to last Saturday of the month) in order to be effective for the subsequent month.

D. The contractor is responsible to check monthly Medicaid eligibility through the Medicaid Eligibility Verification System (MEVS). This includes the following:

1. Recipient address is located in the same county as the contractor's provider service area
2. Recipient program codes (should be MS, MMS, or MWA)

3. Residing in a nursing home
4. Current enrollment in a Medicaid HMO
5. Current enrollment in the MediPass Program
6. Has presence of Medicare Parts A & B

Please note that if a recipient does not have Medicare Parts A & B on MEVS, then the recipient is not eligible for the program. Once the presence of Medicare Parts A & B is on MEVS, then the recipient can be submitted for electronic enrollment.

E. Additionally, the contractor will not be allowed to deny enrollment to reinstated enrollees.

F. The contractor accepts individuals eligible for enrollment in the order in which they are received from CARES without restriction (unless authorized by the CMS Regional Administrator), up to the limits set under the contract (if applicable). The contractor will not discriminate against individuals eligible to enroll on the basis of race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on any basis including but not limited to race, color, or national origin.

4.2 Effective Date of Enrollment

Enrollment is effective at 12:01 a.m. on the first day of the calendar month that the enrollee's name appears on the report for payment issued by the Medicaid fiscal agent. Enrollment is in whole months except in the case of those enrolling in hospice care pursuant to Section-409.912(33), Florida Statutes.

The Finding of Fact establish that the petitioner applied for enrollment in the Long Term Community Care Diversion Program. This is a waiver program requiring eligibility determinations by the Department of Children and Families, the Department of Elder Affairs, and a contract provider. The Department of Elder Affairs has the ultimate responsibility of developing a packet that is sent to the contractor of services for enrollment with the Medicaid fiscal agent. That enrollment occurs no later that the Wednesday before the next to the last

Saturday of each month. Enrollment is effective the first day of the following month.

The evidence establishes that forms needed by the CARES unit to complete the "packet" were held up by the failure of the Department to forward the form to CARES. The contractor received the forms but did not forward to CARES either. The petitioner's representatives complained on multiple occasions about the delay. It was not until October 11, 2006 that the error was discovered. The packet was expedited at that point to meet the enrollment date for services to begin effective November 1, 2006.

The petitioner argues that enrollment should go back to at least October 2006 accepting that the forms were completed but delayed. The agencies argue that there is no provision for retroactive enrollment despite the delay. The evidence establishes that the packet contains other forms besides the delayed forms. The above cited law and contract establish that enrollment cannot occurs until all conditions are met and the effective date is a future month. Despite the obvious loss to the petitioner, there is no more favorable decision permitted by the above-cited laws.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file

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

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

in Tallahassee, Florida.

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

Copies Furnished To

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

APPEAL NO. 06N-00265

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 6, 2007, at 8:17 a.m., at the Clearwater Center, in Clearwater, Florida. The petitioner was present. Resident present on behalf of the petitioner were and . The respondent was represented by administrator, and social services director.

The record was left open for additional evidence. The additional evidence was due by the close of business on March 6, 2007. On March 6, 2007, a police report was received and entered into record as Respondent Exhibit 20. The record was closed on March 6, 2007.

ISSUE

The respondent will have the burden to prove by a preponderance of evidence that the petitioner's discharge in the notice dated November 27, 2006 is in accordance with the requirements of Code of Federal Regulation at 42 C.F.R. § 483.12(a):

> (2)(iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;

FINDINGS OF FACT

The petitioner is a resident at the facility. He ambulates with the use of a wheelchair. The respondent entered into evidence records incidents by the petitioner. The documentation included Progress Notes, Sign Out/Sign In documents, medical report, and consultative reports. Incidents that were documented in the medical record for the petitioner's inappropriate behavior with other residents was the petitioner kissing female residents, tying to touch female resident and buying lingerie for one female resident, assisting residents to smoke that are not allowed to smoke without staff present, to trying to getting money from other residents, and his behavior when he was allegedly drunk. Incidents documented in the medical record in which the petitioner endangered his own health and safety were smoking marijuana; drunkenness; unauthorized leave from the building and late hours after signing out. There were also documented incidents of the petitioner swearing and yelling at the staff. The facility tried to redirect that behavior with observation and counseling.

There was a Concern Report completed on November 10, 2006. This report indicated that the petitioner was trying to give pills to a resident and was smoking "a joint". The police were called and the police search the petitioner's cabinet with permission. The police found marijuana and the petitioner was arrested for drug possession.

The petitioner was given notification on November 27, 2006 advising him of the facility's decision to discharge the petitioner, on the basis that the safety of other individuals is endangered and the health of other individuals in the facility is endangered. The treating physician signed the discharge notice and annotated the medical record.

The petitioner rebutted that the reports are all fictitious. He opined that the two female residents he was kissing and touching was not inappropriate. He attested that he only smoked marijuana at the facility twice. The marijuana found in his cabinet was not his. After smoking with a friend, he took the friend's cigarette pack. He attested that had he known the marijuana was in the cigarette pack, he would never have given permission for the police to search his cabinet. He considers the money he gets from other residents is loans and that he intends to pay them back. He has a checking account with $10.00 balance. He did not report the checking account to the Department of Children and Families. He attested that he did not know he had to report his assets. He attested that only once did he return to the facility drunk.

CONCLUSIONS OF LAW

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

> (2)(iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered

The facility documented in the medical record for the petitioner's inappropriate behavior with other residents which presented a danger to other resident and incidents that endangered the petitioner's own health and safety. No evidence was brought forth that contradicted the fact that the petitioner's treating physician signed the discharge notice. This indicates that the petitioner's treating physician concurred with the discharge and the discharge location. Therefore the discharge is consistent with the recommendation of the treating physician.

Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is correct and in accordance with Federal Regulations.

DECISION

This appeal is denied as facility's action to discharge the petitioner is correct and in accordance with Federal Regulations. The facility may proceed with the discharge, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of March 2007,

in Tallahassee, Florida.

Linda Jo Nicholson

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

Copies Furnished To

Care Admin

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

APPEAL NO. 07F-00583

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 27, 2007, at 8:45 a.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by her mother

The agency was represented by Halina Glassberg, program operations administrator. Present on the telephone from Kepro was Dr. Galdino Silvaineto, physician, and Susan Ziebell and Theresa Ashey, review operations supervisors.

ISSUE

At issue is the agency's January 10, 2007 action of reducing the petitioner's private duty nursing services from 504 hours for a two month certification period to 96 hours for a two month certification. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a nine-year old child, date of birth July 1, 1997. She has been receiving private duty nursing services of 8 hours per day for a 5 day school week, and 12 hours per day on non-school days. A Recipient Denial Letter, dated December 28, 2006, was sent stating that the request for private duty nursing services for the petitioner from December 25, 2006 to February 22, 2007 was denied.

Since the December 28, 2006 Recipient Denial Letter did not have the petitioner's address, another Recipient Denial Letter, dated December 29, 2006, with the petitioner's address was sent, stating the same that the December 28, 2006 Recipient Denial Letter said. A Recipient Reconsideration Denial Letter was sent, dated January 10, 2007, stating that the petitioner's private duty nursing services was approved for 96 hours effective December 25, 2006. At the hearing, the respondent's representative explained that upon reconsideration, this is 12 hours every other weekend.

The notices sent to the petitioner explained that it was determined by Kepro that the medical care of the private duty nursing services of 96 hours was determined to be medically necessary. The petitioner is receiving the private duty nursing services at the previous level of 504 hours until a decision is made in this appeal. Included in the evidence is a copy of a Kepro Internal Focus Review Finding report on the petitioner, dated December 18, 2006.

According to this Kepro report, the petitioner was diagnosed with Infantile Cerebral Palsy, unspecified delay in development, lack of expected normal physiological development, feeding difficulties and mismanagement, attention to gastostomy, a presence of a cerebrospinal fluid drainage device, V/P shunt placement and replacement

in 12/03, Scoliosis, impaired physical mobility, a feeding disorder, a history of constipation and bowel impaction, a history of reactive airway disease, and a history of failure to thrive.

Included in the evidence is a copy of a Kepro Synopsis of Case report, stating that as of December 20, 2006, the petitioner was attending school from 7:00 a.m. to 2:00 p.m. It was recommended that instead of providing the petitioner with private duty nursing after school, that she would go to PPEC, and that she would receive the services of a home health aide. PPEC is Prescribed Pediatric Extended Care, which is after school medical care. The home health aide services of 240 hours was approved so that there is coverage of care for the petitioner until her mother comes home from work in the early evening.

The petitioner's mother does not want her to go to PPEC because she is concerned that the petitioner would contact an infection from other children in PPEC. The case was reviewed by a board certified pediatrician, who upheld the reduction of private duty nursing services for the petitioner. According to Dr. Galdino Silvaineto at the hearing, he agrees with the reduction of the private duty nursing services for the petitioner.

CONCLUSIONS OF LAW

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

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Fla. Admin. Code 59G4.290 discusses skilled services, and states in part:

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. The petitioner is receiving private duty registered nursing services of 8 hours per day for a 5 day school week, and 12 hours per day on

non-school days, which is 504 total hours. It was determined that these services would be reduced to 12 hours every other weekend, which is 96 total hours. The physician that testified at the hearing agrees with this determination. After careful consideration, it is determined that the agency's action to reduce the private duty nursing services, is upheld.

DECISION

This appeal is denied and 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 29th day of March 2007,

in Tallahassee, Florida.

Stuart Imberman

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

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

APPEAL NO. 07F-00561

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 27, 2007, at 10:05 a.m., in Fort Lauderdale, Florida. The petitioner was present with her mother . The respondent was represented by Nicole Griffin, program operations administrator, and Gloria Moreno, human services program specialist, from the Agency for Health Care Administration.

ISSUE

At issue is the December 2, 2006 denial of a prior authorization for a wheelchair for the petitioner, funded through the Medicaid Program. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is a recipient of Medicaid benefits, and she is seeking a new wheelchair for herself, to be funded through the Medicaid Program. The petitioner received a notice, dated December 2, 2006, informing her that her request was denied

due to her enrollment in a Provider Service Network. Included in the evidence is a copy of a Recipient Eligibility Display Screen showing that effective October 1, 2006, the petitioner was enrolled in the Florida Netpass Managed Care Program.

The petitioner did not request the wheelchair from the Florida Netpass Managed Care Program. The respondent's representatives at the hearing referred to the Florida Medicaid Provider General Handbook under managed care coverage. According to the information in the handbook, authorization must be received from the recipient's primary care provider. In the petitioner's case, that is Florida Netpass. The request for the wheelchair was denied due to Florida Netpass not making the request. At the hearing, the petitioner was directed to have Florida Netpass request the wheelchair for her.

CONCLUSIONS OF LAW

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

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

The Medicaid Provider General Handbook at page 3-9, states in part:

> **Managed Care Coverage-** Medicaid reimbursement is restricted when a Medicaid recipient is enrolled in a managed care program...For certain managed care plans such as HMO's and PSN's, the provider must receive authorization for the services that are included in the plan and bill the plan directly.

The petitioner receives Medicaid benefits, and her request for a new wheelchair, to be funded through the Medicaid Program, was denied. The petitioner is enrolled in the Florida Netpass Managed Care Program, and she did not request the wheelchair through this program. Authorization must be received from the recipient's primary care provider. In the petitioner's case, that is Florida Netpass. The request for the wheelchair was denied because Florida Netpass did not make the request. At the hearing, the petitioner was directed to have Florida Netpass request the wheelchair for her. After careful consideration, it is concluded that the denial of a prior authorization for a wheelchair for the petitioner, funded through the Medicaid Program, is upheld.

DECISION

This appeal is denied and 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 22nd day of March, 2007,

in Tallahassee, Florida.

Stuart Imberman

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

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

ND REHAB.

APPEAL NO. 07F-00196

PETITIONER,

Vs.

CASE NO. 1222172429

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Pinellas
UNIT: 88521

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 31, 2007, at 08:15 a.m., in St. Petersburg, Florida. The petitioner was present, telephonically. The respondent was represented by Suzi Jackson, economic specialist supervisor. The petitioner requested that the hearing be reconvened to have the ombudsman present and give her time to obtain documentation. The motion was granted.

The hearing was reconvened before the undersigned hearing officer on February 28, 2007, at 10:15 a.m., in Largo, Florida. The petitioner was present, telephonically. The respondent was represented by Theresa McComber and Jim Robson, senior economic specialists. The petitioner requested that the hearing be reconvened to have the ombudsman present and give her time to obtain documentation. The motion was granted, as the ombudsman was hospitalized.

The hearing was reconvened before the undersigned hearing officer on March 13, 2007, at 8:27 a.m., in St. Petersburg, Florida. The petitioner was present, telephonically. The respondent was represented by Suzi Jackson, economic specialist supervisor. , ombudsman was observing.

ISSUE

The petitioner is appealing the notice of January 2, 2007 for the respondent's action to terminate Institutional Care Program benefits for failure to verify citizenship or alien status.

FINDINGS OF FACT

The petitioner is a resident of a nursing home and was receiving Institutional Care Program benefits. The petitioner was due for recertification.

For the recertification, the respondent pended the petitioner for verification of either citizenship or alien status, on November 21, 2006. The respondent requested this verification as the Deficit Reduction Act of 2005 (passed on February 8, 2006) required all applicants and reapplicants to provide verification of United States citizenship or alien status. The petitioner was given ten days to submit the verification. After the ten day pending period, the petitioner did not verify either United States citizenship or alien status.

The respondent attempted to assist the petitioner by contacting SAVE and the Social Security Administration. The respondent was unable to access any information from SAVE without the petitioner alien number. The petitioner was given additional time by the respondent to provide verification. The petitioner did not verify either United States citizenship or alien status by January 2, 2007.

As the petitioner failed to verify United States citizenship or alien, the petitioner failed to meet the technical requirements of the Program. The respondent closed the case. A Notice of Case Action was sent to the petitioner on January 2, 2007.

The petitioner provided verification of her attempts to get the verification regarding her of United States citizenship or alien status. An additional facsimile was received on March 12, 2007 and was entered into record as Petitioner Exhibit 2. The second facsimile again addressed the petitioner's efforts to obtain verification of United States citizenship or alien status. The petitioner provided copies of college transcripts. College transcripts provide verification of college; however, they are not verification of United States citizenship or alien status. To date, no verification of United States citizenship or alien status was received.

CONCLUSIONS OF LAW

The Florida Administrative Code sets forth the coverage group for institutionalized individuals at Fl. Admin. Code 65A-1.710, "SSI-Related Medicaid Coverage Groups":

> (2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and income as provided in 42 C.F.R. § § 435.211 and 435.231. Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

Eligibility criteria is set forth in the Florida Administrative Code at Fl. Admin. Code 65A-1.705 and states for citizenship:

> (3) The individual must be a citizen of the United States or a qualified alien as defined in Title IV-A, Public Law 104-193...

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, also known as Public Law 104-193, was signed the provisions into law on August 22, 1996. Policy Transmittal No.: 97-06-00003, "Noncitizen Policy for Temporary Cash Assistance and Medicaid, Including SSI-Related Medicaid", indicated that the effective date of this provision would be July 1, 1997. This transmittal restated Public Law 104-193 for the conditions to be considered a qualifying alien for Medicaid:

> Qualified aliens are defined in Public Law 104-193 as lawful permanent resident, refugees, asylees, parolees for at least one year, those whose deportation is withheld, and conditional entrants arriving prior to 1980...
> Qualified aliens who entered the country prior to August 22, 1996, may be potentially eligible to receive temporary cash assistance and Medicaid benefits providing all other factors of eligibility are met...

Effective February 8, 2006, as per the Deficient Reduction Act of 2005, the Department was directed to have applicants and recipients verify citizenship as a part of eligibility.

Rights and Responsibilities are set forth in the Florida Administrative Code at 65A-1.204 and state:

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

must provide assistance in obtaining the information or documentation when requested or when it appears necessary.

The Eligibility Determination Process is set forth in the Florida Administrative Code at 65A-1.205 and states in relevant part:

(1)(a) Eligibility must be determined initially at application and if the applicant is determined eligible, at periodic intervals thereafter. The applicant is responsible to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility as determined by the eligibility specialist within time periods specified by the eligibility specialist... (d) If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, or that an assistance group member is required to register for employment services, the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated)... If the verification or information is difficult for the person to obtain, the eligibility specialist must provide assistance in obtaining the verification or information when requested or when it appears necessary. If the required verifications and information are not provided by this date, the application is denied, unless a request for extension is made by the applicant or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension based on extenuating circumstances beyond the control of the individual, such as sickness, lack of transportation, etc. When all required information is obtained, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria is met, benefits are authorized.
(2) Eligibility must be redetermined at periodic intervals.
(a) A complete eligibility review is the process in which the eligibility specialist reviews all factors related to continued eligibility of the assistance group...
(4) An applicant or recipient who fails to keep an appointment without arranging another time with the eligibility specialist; fails or refuses to sign and date the Common Application Form; fails or refuses to submit a periodic report; or fails or refuses to submit required documentation or verification will be denied benefits as eligibility cannot be established.

(5) Information provided by the applicant/recipient must be substantiated, verified or documented as part of each determination of eligibility. The term verification is used generically to represent this process. The factor of eligibility and questionable nature of information dictates whether or not substantiation, verification or documentation is required.
(a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.
(b) Verification confirms the accuracy of information through a source(s) other than the individual. Verification may be secured on the telephone, in written form, or by personal contact.
(c) Documentation establishes the accuracy of information by obtaining and including in the case record an official document, official paper or a photocopy of such document or paper that supports the statement(s) made by the individual.

The respondent pended the petitioner for verification of either citizenship or alien status, on November 21, 2006. The petitioner was given ten days to submit the verification. The petitioner did not verify either United States citizenship or alien status. The respondent attempted to assist the petitioner by contacting SAVE and the Social Security Administration. Neither source could be accessed for information regarding citizenship. The petitioner was given additional time by the respondent to provide verification. The petitioner did not verify either United States citizenship or alien status. The respondent closed the case on January 2, 2007. The hearing officer continued the hearing twice which gave the petitioner an additional 41 days to submit verification of United States citizenship or alien status. The petitioner did attempt to obtain verification of her of United States citizenship or alien status. From the date of request on November 21, 2006 to March 16, 2007, no verification of United States citizenship or alien status was received.

Based upon the above cited authorities, the respondent's action, to terminate Institutional Care Program benefits 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 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 21st day of March, 2007,

in Tallahassee, Florida.

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

Copies Furnished

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

APPEAL NO. 07N-00015

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 14, 2007, at 9:12 a.m., at the [illegible], in Adventura, Florida. The petitioner was not present, but was represented at the hearing by his daughter, . Also present on behalf of the petitioner was , ombudsman. The respondent was represented at the hearing by , administrator, . Also present as witnesses for the facility were; , risk manager; , assistant director of nursing and , director of social services, all from

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

The facility notified the petitioner on or about December 29, 2006 that he was to be discharged by January 28, 2007. The discharge location was given: "[redacted]". This location is the petitioner's daughter's address. The respondent verbally noted that they have at least two ALF's in mind for the transfer location. They verbally sited [redacted] as one of the ALF. Currently, the petitioner resides at the [redacted]. The facility's physician agreed with the discharge, Respondent Exhibit 1.

The respondent also submitted into evidence as part of Respondent Exhibit 1, copies of physician's progress notes; a copy of a level of care evaluation indicating the petitioner had been approved under placement recommendation as "temporary nursing facility" and copies of social service progress notes. The facility currently does not provide the petitioner any skilled nursing care. The petitioner is considered fully independent.

The petitioner's representative submitted Petitioner's Exhibit 1, which is a copy of a letter from one of the petitioner's treating physician, Dr. [redacted]. This letter states in part: "I believe that [redacted] fairing well status post placement of a ventriculoperitoneal shunt...He requires skilled nursing however, due to the fact that he should be left in an

ALF, he might be able to tend to his hygiene requirements (as I understand it, he is very resistant to showering). Activities of daily living may prove difficult for this patient as well. As he reportedly is living at , I would recommend he remain there indefinitely due to potential safety issues that may arise as a result of the above."

This letter also states in part: "On neurologic examination, he is awake, alert, and oriented x 3."

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 December 29, 2006 that he was to be discharged by January 28, 2007 to the petitioner's daughter's home. 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's health had improved.

The petitioner's representative argued that the facility's plan to discharge the petitioner to his daughter's home is not a safe location for discharge. The facility argued that the facility will discharge the petitioner to an ALF, but has not had cooperation from the petitioner's daughter in locating a ALF that would be suitable for her.

The petitioner's representative argued that based on her father's current medical condition; he is in need of skilled nursing care. The respondent argued that the petitioner does not need the care as provided by a skilled nursing facility and that any of the petitioner's care can be safely and properly cared for at an ALF. The petitioner's representative argued that one of the petitioner's physicians supports the petitioner staying at the facility. The respondent reiterated that the petitioner could be better served in an ALF for any of his medical conditions and that he does not need skilled nursing care as provided by the facility. The hearing officer agrees with the respondent's arguments.

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 2nd day of March, 2007,

in Tallahassee, Florida.

Robert Akel

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

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

APPEAL NO. 07N-00018

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 27, 2007, at 1:47 p.m., at the , in (St. Petersburg), Florida. The petitioner was not present. He was represented by , legal intern. Esq. was present as a consultant to . Present as witnesses for the respondent were , daughter of the petitioner, and , ombudsman. The respondent was represented by , administrator. Witnesses for the respondent were , director of nursing, and licensed practical nurse.

ISSUE

The respondent will have the burden to prove by a preponderance of evidence that the petitioner's discharge in the notice dated January 9, 2007 is in accordance with the requirements of Code of Federal Regulation at 42 C.F.R. § 483.12(a):

> (2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...
> (iii) The safety of individuals in the facility is endangered;

FINDINGS OF FACT

The petitioner is a resident at the facility. He ambulates with the use of a walker. The petitioner has a diagnosis of dementia. The medical record reflected notations of confusion and agitation.

The respondent entered into evidence portions of the medical record, Progress Notes dated December 20, 2006 and February 7, 2007 and a Grievance/Complaint report of December 21, 2006, alleging incidents by the petitioner. The petitioner stipulated to the alleged incidents documented in the petitioner's medical record.

The Progress Notes indicated that on September 11, 2006 the petitioner was "...striking out at staff - unprovoked..." The Progress Notes indicated that on December 20, 2006 the petitioner was "...Chasing CNA down the hall trying to hit her. Resident trying to force his way into other resident's rooms. Swung a cane at resident in wheelchair...". The administrator clarified that the petitioner did swing his walker at the other resident not a cane, on December 20, 2006.

The incident indicated in the Grievance/Complaint report of December 21, 2006 was the attempt by the petitioner to strike another resident on December 20, 2006. The facility tried to redirect that behavior with one on one observation, counseling, psychiatric referral and prescription for medication.

The medication prescribed for the petitioner is to be given every four hours. At the request of the petitioner's daughter the medication is not given every four hours. The medication has been given approximately six times in a month.

The petitioner was without a roommate for some time, due to outbursts. The petitioner recently got a roommate, as there are no provisions at the facility for the petitioner to have a private room.

The facility began a discharge plan and contacted several facilities for placement. The petitioner was sent notification on January 9, 2007, advising him of the facility's decision to discharge the petitioner on February 7, 2007, on the basis that his need could not be met and the safety of other individuals is endangered. The discharge notice was signed by a physician, Dr. .

The administrator opined that the petitioner's behavior is explosive and is a danger to other residents. The petitioner has put his hands on other residents several times. The administration attested that there has been and continue to be an escalating pattern of behavior for the petitioner. This continued escalation was demonstrated on February 15, 2007 when the petitioner grabbed a female resident, the female resident became hysterical and the administrator had to intervene. The administrator attested that the petitioner "slugged" her.

The director of nursing, a registered nurse, opined that after months of directing and redirecting the petitioner's behavior, the violence demonstrated by the petitioner puts other residents in the facility at risk. The petitioner's behavior is every day, sometimes minor and sometimes major. She opined that there were other places that would be better for the petitioner.

The petitioner opined that the facility can meet the needs of the petitioner. The petitioner disputed the location of discharge indicated on the notice and other locations proffered by facility.

CONCLUSIONS OF LAW

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

> (2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...
> (iii) The safety of individuals in the facility is endangered;

The facility documented incidents by the petitioner that led to the facility issuing a notice for discharge. The documentation included an incident on December 20, 2006 in which the petitioner was chasing a certified nursing assistant down the hall trying to hit her, trying to force his way into other resident's rooms and swinging a walker resident in wheelchair. The facility indicated that the petitioner's behavior was escalating. There was no evidence that the petitioner behavior has lessened. The continued escalation of the petitioner's behavior was demonstrated on February 15, 2007 when the petitioner

grabbed a female resident, the female resident became hysterical, the administrator had to intervene and the petitioner hit the administrator. Striking another individual in the facility by the petitioner demonstrates a present danger to other individuals in the facility. Based on the evidence, the hearing officer concludes that safety of individuals in the facility is endangered.

There is no evidence by statement of the treating physician that the move would be detrimental to the petitioner's health. No evidence was brought forth that contradicted the fact that a physician signed the discharge notice. This indicates that a physician concurred with the discharge. Therefore, the hearing officer concludes that the discharge is consistent with the recommendation of Dr.

Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is correct and in accordance with Federal Regulations. The facility may proceed with the discharge, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

The fair hearing requirements appearing in the Federal Regulations at 42 C.F.R. 431.200, "Basis and scope", require the state to provide a fair hearing process to implement specific sections of the Social Security Act. The Federal Regulations 42 C.F.R. § 483.200, "Statutory basis", notes that this regulatory section implements these sections of the Social Security Act and provides for an appeal process that complies with guidelines provided by the secretary. 42 C.F.R. § 483.202, "Definitions", limits the definition of a transfer/discharge to

actions taken by Medicare and Medicaid certified facilities. There is no provision in the regulations under 42 C.F.R 431.200 that that conveys jurisdiction to the hearing officer for any determination of the appropriateness of the discharge location. Therefore, the petitioner's issue regarding location of discharge is outside of the jurisdiction of this venue.

DECISION

This appeal is denied as the facility's action to discharge the petitioner is correct and in accordance with Federal Regulations. The facility may proceed with the discharge, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

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

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

APPEAL NO. 07N-00006

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened on February 27, 2007 at 3:45 p.m. at the . The petitioner represented herself with assistance from of the Long Term Care Ombudsman Council. The respondent was represented by , administrator, with testimony available from and , assistant business office manager and business office manager, respectively. , social service director was also present.

ISSUE

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

FINDINGS OF FACT

The petitioner has been institutionalized due to severe health problems since August 17, 2006. Need for nursing care is undisputed. On December 28, 2006, having determined that "bill for services has not been paid after reasonable and appropriate notice to pay" the facility issued discharge notice (Respondent's Exhibit 1). Intended location for discharge was the petitioner's daughter's home in Paisley, Florida.

On behalf of the petitioner, a hearing request was registered reflecting her daughter as representative, through the ombudsman's office (Petitioner's Exhibit 1).

Upon receipt of a hearing request, the undersigned directed that a survey be conducted by the Agency for Health Care Administration. There is no evidence showing that such a survey occurred. Such survey results would not have been controlling to the hearing process, but might have had relevance.

The petitioner's daughter has been sent billing statements, and efforts have been made by the facility and the ombudsman to involve the daughter so that payments could be achieved. As of December 15, 2006, notice of balance owed reflected $17,300.60, Respondent's Exhibit 2. Other bills were sent previously. Payment did not occur.

The daughter holds power of attorney and has not been effecting or facilitating payment to the facility. The petitioner does not physically hold her own check book or personal identification in her possession. She has not been making payments for her care since Medicare ceased coverage and her Social Security income deposits have been going to Bank of America with account number unknown by facility staff until a few days before the hearing. Facility staff and ombudsman staff believe there is a possibility that the daughter is exploiting the petitioner's finances and referrals for investigation

have been made, but they do not believe the referrals were effective. No improvement in the situation has occurred.

The petitioner is not legally incompetent. She has severe physical and mobility limitations. She appeared lucid and was involved in the hearing process.

The petitioner does not want to be discharged to home of her daughter. The respondent and the petitioner agree that the petitioner requires nursing care. Despite issuance of the notice of intent to discharge to the daughter's home, the facility does not intend to discharge the petitioner to an unsafe location and discharge would only occur with planning and orientation as required by regulation.

CONCLUSIONS OF LAW

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

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
>
> (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.
>
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...

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

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
...
(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
(iii) The location to which the resident is transferred or discharged;
(iv) A statement that the resident has the right to appeal the action to the State;
(v) The name, address and telephone number of the State long term care ombudsman;
...
(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Findings of fact show the facility has made repeated efforts at achieving payment, and repeatedly sent billing statements. Evidence has firmly established that insufficient payment has occurred. Difficulties in communications and difficulty in physically achieving payment do not provide remediation of the problem at hand. Payment simply has not occurred. Payment for a stay at a nursing facility is required.

Reasonable and appropriate notice to pay did occur and there has been insufficient payment made for services rendered. Discharge to another location has been justified so long as it is a safe location and following proper planning along with orientation.

DECISION

The appeal is denied. Intent to discharge is upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the 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 19th day of March, 2007, in Tallahassee, Florida.

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

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THE FLORIDA BAR

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August 10, 2007

Enclosed is the March and April 2007 Fair Hearings Report.

Remember, it takes approximately 30 to 60 days after the month ends for the section to receive the opinions from the Department of Children and Families, so mailings will typically be several months behind.

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If I can be of any further assistance, please do not hesitate to contact me. Enjoy your subscription, and thank you for supporting the Elder Law Section.

Sincerely,

Arlee J. Colman

Arlee J. Colman
Program Administrator