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

APPEAL NO. 07N-00059

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened at 3:37 on April 25, 2007 at the nursing facility. The petitioner was not present but was duly represented by her daughter, . The respondent was represented by administrator , with testimony available from: , social services; therapy manager; and by telephone, , financial service manager. The record remained open a few days to receive additional information from the petitioner. Upon receipt, it was labeled Petitioner's Exhibit 2, was shared with the respondent under separate order, and the record was closed.

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 would have the burden of proof.

FINDINGS OF FACT

1. The petitioner has been institutionalized at the nursing care facility due to significant health problems since April 26, 2006.

2. Therapies such as speech therapy and wheelchair instruction occurred and were discontinued by June 26, 2006. Following admission, and while receiving therapies, Medicare coverage existed. As of June 26, 2006, Medicare eligibility stopped.

3. In addition to Medicare, the petitioner had medical insurance, but facility financial staff noted that the contract between facility and insurance carrier precluded their submitting claim for coverage if Medicare coverage (part A) ended, which it had. Therefore, insurance reimbursement did not occur once Medicare coverage ended. During hearing, the daughter requested the facility to submit an insurance claim for additional coverage, but facility staff declined to accommodate that request.

4. Bills for care between late June 2006 and the end of March 2007 were Respondent's Exhibits 4 and 5. These bills were issued to the petitioner's representative. Facility notes about payment problem were Respondent's Exhibit 2. The primary problem was alleged bill nonpayment for services between June 26 and August 1, 2006. Effective after that date, Medicaid coverage occurred. As of March 16, 2007, which was the date of discharge notice, balance owed was "10,146.64" shown in Respondent's Exhibit 1.

5. As of date of hearing, balance owed was $8232.99. Although bills reflected a somewhat higher figure, anticipated Medicaid reimbursement reduced amount owed to the $8232.99 figure, according to testimony of the administrator.

6. Upon receipt of hearing request (Petitioner's Exhibit 1), the Office of Appeal Hearings directed a survey be conducted by the Agency for Health Care Administration (AHCA). That was done on April 3, 2007 with no deficiency found. While the survey might not be controlling for hearing purposes it could be relevant. The document was shared with the parties and labeled Hearing Officer Exhibit 1.

7. Location for intended discharge is to another licensed nursing facility in the same county. The petitioner's representative did not believe the new intended location was as highly rated as She did not want the petitioner to be discharged to the alternative facility and she wanted discharge, if necessary, to be close to her home. staff was willing to assist in locating another facility, but intent to discharge remained.

8. The petitioner does not have funds available with which to pay the bill. There was some dispute about a $1783 check. However, with or without successful payment of that figure, the facility did not wish to rescind discharge intent, based upon contention that a significant unpaid balance remained.

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;
...

Findings of fact show the facility repeatedly issued billing statements. Some payments were received in past months, with Medicaid coverage and some insurance coverage as well, and those are noteworthy factors. Moreover, the petitioner is not known to have the personal funds to pay the bill and her representative would prefer her to stay where she is because she believes it a superior placement. However, evidence has firmly established that insufficient payment occurred and past payments did not achieve resolution of the problem. Facility administration does not wish to have care

and placement continued under current financial circumstances. There is no regulation that would require a facility to retain a resident under such circumstances.

Difficulties achieving insurance coverage, anticipation of insurance coverage approval, lack of funds, as well as obstacles encountered by the petitioner do not provide remedy for the problem at hand. Rating of one facility as superior to another does not provide a remedy for this sort of problem so long as the new location is acceptably certified/licensed by the appropriate administrative agencies. Based upon findings, it must be concluded that sufficient payment simply has not occurred. Under regulations, adequate payment for continuing stay at a nursing facility is required. It is concluded that reasonable and appropriate notice to pay occurred and was followed by insufficient payment for services rendered. Despite the unfortunate circumstances and the understandable desire to remain at a facility which has provided good care, discharge to another licensed nursing facility has been justified under regulatory requirements.

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 15th day of May, 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 To

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

APPEAL NO. 07N-00044

PETITIONER,

Vs.

CASE NO.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was held before the undersigned hearing officer on April 6, 2007, at 1:27 p.m., at the nursing facility. The facility was represented by the business office manager, who also testified. The petitioner was not present, but was represented by his grand-daughter and power of attorney, who also testified. The facility administrator, appeared as a witness for the facility. facility social services director, also appeared as a witness for the facility.

ISSUE

At issue is the correctness of the facility's discharge action of February 16, 2007, to discharge the petitioner based on non-payment. The nursing facility has the burden of proof.

FINDINGS OF FACT

1. The petitioner was admitted to the respondent nursing facility on October 4, 2006. The petitioner's representative grand-daughter and power of attorney, provided care prior to the petitioner's nursing home admission.
2. applied for Institutional Care Program and Medicaid (ICP) Medicaid benefits for the petitioner three times since the petitioner was admitted to the nursing home. Each of these applications was denied. The petitioner was not approved for ICP Medicaid benefits as of the hearing date.
3. In July or August 2006, the petitioner transferred one-half ownership of his home to by quit-claim deed. It is not known whether or not this transfer action may impact potential ICP Medicaid eligibility.
4. The petitioner owes $25,340.24 for facility room and board charges alone, through the period ending March 16, 2007. has received billing statements from the facility advising of amounts due. had not made any payment on the past due balance as of the hearing date. However, proposed a partial settlement of $2,000, and the petitioner's Social Security and Veteran's Administration checks to rescind

the discharge action. The facility did not accept this partial settlement offer.

5. The petitioner's representative was provided notice of the intended discharge action on February 16, 2007. The discharge location is listed as the petitioner's prior residence, which is also the joint residence of [redacted] believes the petitioner can not receive needed care at their joint residence.
6. The petitioner remains a resident of the facility pending the outcome of this instant appeal decision. The petitioner desires to remain at this facility.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42C.F.R.§431.200. Federal Regulations limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility because of non-payment. Federal Regulations do permit a discharge for this reason, as set forth at 42C.F.R. §483.12(a)(2)(v), as follows:

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

The Findings of Fact establish that the petitioner has not been determined eligible for ICP Medicaid benefits. The petitioner had an unpaid past due balance of $25,340.24 for room and board alone, owed to the facility as of March 16, 2007. The facility did not accept the petitioner's offer of partial settlement of this past due balance. Findings further establish that the petitioner's representative grand-daughter received billing statements during the petitioner's stay at the facility. Therefore, it is concluded that the petitioner received "reasonable and appropriate" notice to pay for his stay at the facility, as required in the language of the above federal regulation.

The Code of Federal Regulations at 42 C.F.R.§483.12(a)(6)(iii) requires the content of the discharge notice to include "the location to which the resident is transferred or discharged." Further, paragraph (a)(7) entitled "Orientation for transfer or discharge" shows that the facility "must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility." The facility listed the petitioner's prior community home address as the discharge location, which is also the address of his grand-daughter.

In summary, the respondent nursing facility has valid reason to discharge the petitioner based on non-payment. However, the nursing facility must provide the petitioner sufficient preparation and orientation to a suitable discharge location before proceeding with this discharge action. Therefore, the nursing facility is concluded to have met its burden of proof in this specific discharge action based on non-payment.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 23rd day of May, 2007,

in Tallahassee, Florida.

Jim Travis
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-00024

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 25, 2007, at 2:45 p.m., in Miami, Florida. The petitioner was not present but was represented by his wife, . The respondent was represented by tt, executive director, . A continuance was granted on behalf of the petitioner for a hearing previously scheduled on March 28, 2007.

ISSUE

At issue is the January 26, 2007 action by the facility proposing to discharge the petitioner because his health has improved sufficiently so that he no longer needed the services provided by the facility. The respondent has the burden of proof to establish that the discharge action is consistent with the federal regulations.

FINDINGS OF FACT

The petitioner is sixty eight years old and has been a resident of since December 2006. He was diagnosed with Cerebral Vascular Accident (CVA) and dementia. The nursing facility, on January 26, 2007, issued a discharge notice to advising him that he would be discharged on February 26, 2007, as he no longer needed the services of a skilled nursing facility. The discharge location given was l

The testimony and documentation submitted at the hearing indicates that the petitioner is no longer in need of nursing care. The respondent explained that there is no activity of daily living that he cannot perform. The respondent noted that the petitioner ambulates without assistance, feeds himself, dresses himself, bathes himself, follows simple commands and goes to bed when he wants to. In addition the respondent explained that from the medical management perspective the petitioner does not have any medical criteria that require professional monitoring. The respondent acknowledged that he requires supervision for his dementia and for his medication, but asserts that this could be provided by an ALF.

The petitioner's representative feels that her husband needs medical care. She purported that she does not know what is wrong with her husband because nobody has given her any information concerning his medical condition. She explained that she has been unable to speak with her husband's attending physician. The petitioner's representative expressed that she would prefer for him to stay at this facility, but if this is

not possible, she needs extra time to look for another location. The petitioner's representative feels that an ALF is not a proper discharge location for her husband.

CONCLUSIONS OF LAW

Federal Regulation limits 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 from in accordance with Code of Federal Regulation at 42 C.F.R. § 483.12(a)(2)(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...

The requirements for documentation are set forth in the Code of Federal Regulation at 42 C.F.R. § 483.12(a):

> (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...

The resident's clinical record must be documented and that documentation must be made by the resident's physician when transfer or discharge is necessary when health has improved sufficiently so the resident no longer needs the services provided by the facility. The petitioner is no longer receiving skilled care and the petitioner's treating physician documented the clinical record that the petitioner may be discharged. Based upon the evidence, lack of evidence to the contrary and the above cited authorities,

Center's action to discharge the petitioner was in accordance with Federal Regulations. The petitioner may be discharged

DECISION

This appeal is denied as Center's action to discharge the petitioner was in accordance with Federal Regulations. The facility may proceed with the discharge.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 14th day of May, 2007, in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
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850-488-1429

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

APPEAL NO. 07N-00039

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 27, 2007 at 10:15 a.m., at the Jacksonville, Florida. The petitioner was not present. However, he was represented by his brother, at the hearing. The nursing facility was represented by Director of Nursing, , Social Service Director and , LPN Unit Manager.

ISSUE

At issue was the facility's action to transfer the resident to a hospital. The petitioner also wished to appeal the respondent's action not to readmit the petitioner to the facility when he was ready for discharge from the hospital. As will be discussed in

the conclusions of law, this is not an issue that is within the jurisdiction of this hearing officer.

FINDINGS OF FACT

The petitioner was admitted to the nursing home in August 2001. On January 23, 2007, the petitioner was transferred to the hospital based on physician's orders for a medical emergency. There was no evidence submitted that would show the transfer was not a medical emergency.

There was no notice of transfer provided with the transfer to the hospital.

CONCLUSIONS OF LAW

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

> This subpart--
> (c) Implements sections 1919(f)(3) and 1919(e)(7)(F) of the Act by providing an appeals process for any person who--
> (1) Is subject to a proposed transfer or discharge from a nursing facility...

Additionally 42 C.F.R. §483.12(a)(1) states in part:

> 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.

These regulations only provide for a hearing of actions to transfer or discharge a resident. The language does not give the hearing officer the authority to review an action of the facility related to its bed hold policy in admitting or readmitting a resident. Concerns relating to a bed hold and admitting or readmitting a resident are beyond the

scope of the hearing officer's jurisdiction and would more properly be addressed to the Agency for Health Care Administration (AHCA) for resolution.

The regulation 42 C.F.R. §483.12, further states in part:

> (a) Transfer and discharge--...
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...

The findings show that the petitioner was transferred to a hospital based on physician's orders. The transfer was an allowable transfer under the regulations.

The need for a transfer notice is addressed at 42 C.F.R. §483.12(a) as follows:

> (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...
> (5) Timing of the notice.
> (ii) Notice may be made as soon as practicable before transfer or discharge when--
> (A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;..
> (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or...

Although 42 C.F.R. §483.12 requires the facility to issue a notice of transfer at the time of transfer, or as soon as possible thereafter, the transfer was correct under the regulations. The failure to provide the notice of transfer was a harmless error.

DECISION

This appeal is denied as the action to transfer the resident was in accordance with controlling regulations.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11th day of May, 2007,

in Tallahassee, Florida.

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

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

APPEAL NO. 07N-00029

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 19, 2007, at 9:00 a.m., in Deerfield Beach, Florida. The petitioner was not present. She was represented by her niece . Also present was Gloria Goodman, from the Long Term Ombudsman Council. The respondent was represented by David Wingrove, administrator of the Home. Also present from the facility was s, regional director for health services, , director of social services, director of nursing, and

ISSUE

The petitioner is appealing the facility's action of not giving her the option of returning to the facility after she voluntarily left. The petitioner has the burden of proof.

FINDINGS OF FACT

On January 25, 2007, the petitioner was provided with a notice informing her that she would be transferred from the . because her needs could not be met at that facility. According to the information provided at the hearing, she entered the facility on January 2, 2007, and she has Alzheimer's disease. A preliminary order was done to dismiss the appeal because before the petitioner was transferred from the facility, she voluntarily left on March 3, 2007. The appeal was not dismissed because the petitioner's representative objected to the dismissal, and requested for the hearing to take place.

Included in the evidence is a copy of a page of Nurse's Notes describing that the petitioner's representative voluntarily took her out of the facility with her belongings on March 3, 2007. The petitioner's representative did not disagree with this at the hearing. According to her, the petitioner is in an Assisted Living Facility in West Palm Beach, Florida, and she requested that the facility give her an option of returning to the facility. When asked if it would be ordered for the petitioner to return to the facility, the petitioner's representative's response was that she would talk it over with family members to decide if she would return to the facility.

CONCLUSIONS OF LAW

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

circumstance where the individual's substantial interest has been affected by the Department's action.

The Federal Regulations at 42 C.F.R. § 483.206, states in part:

(b) A resident has appeal rights when he or she is transferred from—
(1) A certified bed into a noncertified bed; and
(2) A bed in a certified entity to a bed in an entity which is certified as a different provider.
(c) A resident has no appeal rights when he or she is moved from one bed in the certified entity to another bed in the same certified entity.

The petitioner received a notice informing her that she was going to transferred from the facility, however she voluntarily left the facility before the transfer took place. According to the petitioner's representative, she is in an Assisted Living Facility, and she requested that the facility give her an option of returning to the facility. When asked if it would be ordered for the petitioner to return to the facility, the petitioner's representative's response was that she would talk it over with family members to decide if she would return to the facility.

A proper appeal is when the petitioner objects to a transfer or discharge, however since the facility did not transfer or discharge the petitioner, it is determined that the criteria to appeal has not been met. The hearing proceeded to allow the parties an opportunity to be heard. A request for the facility to give the petitioner an option of returning after voluntarily leaving, is not an issue that can be appealed, therefore the request for a hearing is denied.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Stuart Imberman

Stuart Imberman
Hearing Officer
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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-06700

PETITIONER,

Vs.

CASE NO. 1222007312

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 07 Brevard
UNIT: 88981

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 29, 2007, at 9:00 a.m., in Cocoa, Florida. The petitioner passed away in November 2006. His son , was present and was represented by Billy Thomas, Esq. petitioner's ex-wife, was also present. Stacy Robinson, senior attorney, represented the respondent. David Jeczala, economic specialist I, and Bobbie Van Cott, economic specialist supervisor, were witnesses for the respondent.

Four continuances were granted for prior scheduled hearings: three for the petitioner and one for the respondent.

An Order of Prehearing Instructions was issued on December 5, 2006. On March 5, 2007, the undersigned received the respondent's unilateral Response to Order of Prehearing Instructions and Proposed Prehearing Statement. On March 19, 2007,

the undersigned received the Respondent's Amended Response to Order of Prehearing Instructions and Proposed Prehearing Statement. No response was received from the petitioner.

ISSUE

The Department took action on September 18, 2006 to change the Medicaid Institutional Care Program patient responsibility to $1787.22 effective October 2006. The petitioner's son is appealing the action taken by the Department to not include alimony payments as a deduction from his father's patient responsibility. He is seeking reimbursement of approximately $6000 in withheld alimony payments to his mother.

PRELIMINARY STATEMENT

The petitioner's son was the power of attorney for his mother and his father. When the Department determined the petitioner's patient responsibility, it did not allow a deduction for future alimony. The petitioner's representative believes that the Department ignored a court order by forcing his son to choose to not pay his mother's alimony so he could pay his father's patient responsibility to the nursing facility. This is not the venue to seek relief for reimbursement of monies paid to a nursing facility. A challenge of the Department's rule is not appropriate for this venue. A rule challenge could be requested from the Division of Administrative Hearings.

The undersigned has jurisdiction in matters affecting Medicaid eligibility. There are no months of ICP ineligibility or outstanding medical bills to be addressed in this appeal. Mr. [redacted] is the Medicaid recipient and is therefore the sole focus of this appeal. A review of the amount of the petitioner's patient responsibility will be the only issue reviewed in this appeal.

FINDINGS OF FACT

On August 2, 2005, an application for Institutional Care Program (ICP) and Medicaid was submitted on the petitioner's behalf. His marital status was listed as divorced. His income was from Social Security and two additional pensions. His assets were listed as a savings account with a balance of $7373.27, prepaid cremation at [redacted] Funeral Home, and Medicare Supplemental Insurance at United Teacher's Association Insurance Company. In Section G, Expenses, he listed court ordered alimony he paid to his ex-wife of $650 per month (Petitioner's Exhibit 1).

The petitioner's asset values exceeded Program standards for ICP benefits. He prepaid alimony until February 2, 2006, which reduced his assets to allow ICP eligibility.

The petitioner's patient responsibility was adjusted on several occasions either because of a change in income or his Medicare supplemental premium amount. On September 18, 2006, the Department sent a Notice of Case Action informing the petitioner that his ICP patient responsibility was $1787.22 effective October 2006. The new amount was determined because of a change in his income (Respondent's Exhibit 1).

To determine the ICP patient responsibility, the Department considered the petitioner's income of Social Security of $1535, and $178.57 from an American General pension, in addition to $315 he received from Central States Southeast and Southwest Areas Pension Fund. His total gross income was $2028.57. A $35 personal needs allowance and $206.35 for a Medicare supplemental insurance policy was subtracted to leave a patient responsibility of $1787.22 (Respondent's Exhibits 1 and 5). Deductions are allowed for the personal needs allowance and uncovered medical expenses

according to the Respondent's Exhibit 4, an excerpt from the Department's Integrated Public Assistance Policy Manual, passage 2640.0117.

The petitioner's representative believes that if alimony can be used to reduce an asset, it should also be used to reduce a patient responsibility. He believes that if the alimony payments were factored in the patient responsibility, alimony would have been paid after February 2, 2006. He challenges the validity of the rule. He believes that an ex-spouse should have the same rights as a community spouse when determining available income.

CONCLUSIONS OF LAW

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

> The Hearing shall include consideration of:
> (1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.
> (2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.
> (3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision.

Fla. Admin. Code 65A-1.701, Definitions, defines a commuity spouse as:

> (6) Community Spouse: The non-institutionalized legal spouse of an institutionalized person.

Fla. Admin. Code 65A-1.701 defines patient responsibility as:

> (23) Patient Responsibility: That portion of an individual's monthly income which the department determines must be considered as available to pay for the individual's institutional care, ALW/HCBS or Hospice care.

Fla. Admin. Code 65A-1.710, SSI-Related Medicaid Coverage Groups, defines ICP as:

> (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.

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

> (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:
> (a) In-kind support and maintenance is not considered in determining income eligibility.
> (b) Exclude total of irregular or infrequent earned income if it does not exceed $30 per calendar quarter.
> (c) Exclude total of irregular or infrequent unearned income if it does not exceed $60 per calendar quarter.
> (d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.
> (e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional programs.

20 C.F.R. §416.1123, How we count unearned income, states in relevant part:

> (a)(2) We also include more than you actually receive if amounts are

> withheld from unearned income because of a garnishment, or to pay a debt or other legal obligaton, *{sic}* or to make any other payment such as payment of your Medicare premiums.

The Department's Integrated Policy Manual, 165-22, section 1840.0705, Alimony (MSSI, SFP), states:

> Alimony is court ordered payment by a spouse or former spouse to an individual. An individual's countable income cannot be reduced because the court has ordered part of that income to be paid to a spouse. Court ordered support received by the spouse is unearned income. This applies even if the individual is institutionalized.

Fla. Admin, Code 65A-1.7141, SSI-Related Medicaid Post Eligibility Treatment of Income, defines allowable deductions from income to determine patient responsibility and states:

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called 'post eligibility treatment of income'.
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance...
> (d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses...
> (g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.

The amount of the petitioner's ICP Medicaid patient responsibility is the only issue under the hearing officer's jurisdiction.

The above-cited rules allow for specific deductions from income to determine a patient responsibility. The petitioner is divorced. The petitioner's ex-wife does not meet the definition of a legal spouse of an institutionalized individual and therefore, does not qualify for an income diversion to a community spouse. No provision could be found to allow alimony as a deduction in determining ICP patient responsibility. The above federal regulation directs that income will be counted even if it is more than the individual actually receives due to paying a debt or other legal obligation. A personal needs allowance and actual amounts of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, are the only allowable deductions found in the above authorities for a single individual in the petitioner's situation. The Department allowed both a personal needs allowance and an insurance premium when determining patient responsibility.

After a review of the Department's policies, and the pertinent rules, the hearing officer finds the Department correctly determined the petitioner's patient responsibility when determining his eligibility for ICP benefits.

DECISION

The appeal is denied. The Department determination of the petitioner's patient responsibility 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 31st day of May, 2007,

in Tallahassee, Florida.

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

Copies Furnished To:

7 DPOES: Janet DeChristopher
Billy Thomas, Esq.
Stacy Robinson, Esq.

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

APPEAL NO. 07F-02069

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 9, 2007, at 11:15 a.m., in Miami, Florida. The petitioner was not present, but was represented by her parents, [redacted]. The agency was represented by Erica Woodard registered nurse specialist, Agency for Health Care Administration (AHCA). Present as witnesses for the agency from Keystone Peer Review Organization (KePRO) were Dr. Robert A Buzzeo, medical director and Theresa Ashey, review operations supervisor. Dr. Buzzeo and Ms. Ashey appeared by telephone.

ISSUE

At issue is whether the agency was correct to cancel/terminate the petitioner's request for continued private duty nursing services (PDN) for the period of February 13,

2007 through April 13, 2007, because the medical procedure as described to them is not medically necessary. The agency has the burden of proof.

FINDINGS OF FACT

Prior to the action under review the petitioner was in receipt of PDN services. These services have continued pending the outcome of this hearing.

The petitioner, ., a two-year old recipient of Medicaid benefits who has been diagnosed with respiratory complications, esophageal reflux, failure to thrive, prematurity and chronic lung disease. The petitioner is currently enrolled with Nationwide Healthcare Services.

On February 15, 2007, Nationwide Healthcare Services, as the provider, submitted a request on behalf of the petitioner for eight hours a day, Monday through Friday and sixteen hours a day on Saturday and Sunday of skilled nursing (SN) for skilled observation and assessment, respiratory treatment and medication administration.

The agency has contracted KePRO to determine the number of service hours for private nursing. Private duty nursing is reviewed every 60 days.

On February 16, 2007, a KePRO registered nurse reviewed the information submitted by the provider and determined that it did not meet the InterQual criteria under Pediatric Home Health Care Skilled Nursing Clinical Assessment. The case was referred to a board certified pediatric specialty physician consultant who determined that there was no medical necessity supporting the request for PDN. On February 17, 2007 the initial denial letter was sent to the petitioner.

During the reconsideration process, the request was reviewed by a second board certified pediatric specialty physician consultant who had not issued the initial denial. This physician upheld the denial noting that the information submitted did not support PDN as requested.

The petitioner was notified on February 24, 2007 that the request for reconsideration had been upheld pursuant to rule 59G-4.130.

At the hearing, Dr. Buzzeo explained that for the certification period of February 13, 2007 to April 13, 2007, the agency took into account the clinical and social information concerning the petitioner for that specific period of time. The information submitted to the agency by the provider indicates that the petitioner has no trach, no g-tube, no pain and not sign of any neurological impairment. The provider did not mention the use of any oxygen. The provider also informed the agency that the petitioner does not attend PPEC (prescribed pediatric extended care) and that her parents do not work, although they were limited in their ability to care for the child. Dr. Buzzeo asserted that the agency's decision was correct based on the petitioner's medical condition and the information as provided by the petitioner's service provider.

The petitioner's father noted that [redacted] still going to PPEC. He explained that must of the time he is not at home, and that his wife sometimes needs to go to see her doctor because she suffers from high blood pressure and bleeds through her nose. Mr. [redacted] expressed that her daughter is still premature for her age and cannot cope for herself. Mr. [redacted] purported that when her

daughter was hospitalized for six months her doctor told them that she would require nursing care until five years of age. No evidence was provided to support such allegation.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.901(14) **Definitions** states in part:

> "Medicaid agency" or "agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

Fla. Stat. ch. 409.905 states in relevant part:

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided **only when medically necessary** and in accordance with state and federal law

Fla. Admin. Code 59G-1.010, which applies to the Florida Medicaid Program 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.

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

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

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

As shown in the Findings of Fact, the agency, through KePRO, took action on February 17, 2007 to cancel/terminate the petitioner's request for continued private duty nursing services for the period of February 13, 2007 through April 13, 2007. This action was based on the information provided by the petitioner's nursing service which did not show medical necessity for the service.

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 to cancel/terminate the petitioner's request for continued private duty nursing services for the period of February 13, 2007 through April 13, 2007.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
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

PETITIONER,

APPEAL NO. 07F-01636

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 2:53 p.m. on April 3, 2007. The petitioner was represented by his foster mother, assisted by his legal guardian, . The respondent was represented by Gwendolyn Mathis, RN specialist, with telephone testimony for Agency for Health Care Administration (AHCA) presented by Theresa Ashy, KePRO review operation supervisor and Dr. Galdino Silva-Neto with KePRO, under contract with AHCA.

ISSUE

At issue was whether or not AHCA correctly intended to reduce home health care private duty nursing services from ten hours per day to eight hours per day based upon medical necessity. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner (date of birth , 2003) has received Medical Foster Care (MFC) in his medical foster mother's home since July 2005. The home is a qualified medical foster care home and there are other impaired children living there. Provider qualifications included requirement for twenty four hour availability. His foster mother received specialized training.

2. Health problems include chiari malformation, apnea, seizures, spina bifida, shunted hydrocephalus, left hemiparesis, esophageal reflux, and kidney reflux. His foster mother provides close supervision, monitoring and care. To assist her, AHCA had authorized coverage for home health care services of ten hours daily private duty nursing service (Respondent's Exhibit 6, page 2-10 addresses private duty nursing).

3. The respondent conducted an eligibility review. At review of January 26, 2007 (Respondent's Exhibit 1) and February 9, 2007 reconsideration (Respondent's Exhibit 2) by a different physician, eight hours of daily nursing services were determined medically necessary. This was a decrease.

4. The reviewing doctors were board certified pediatricians. They determined that procedural standards (Respondent's Exhibit 6, 2-10) justified a non-parent "awake caregiver at night to provide continuous or frequent intervention or medically necessary observation." They also determined medical need standards for such care giving (Respondent's Exhibit 5) could be achieved with eight hours in-home nursing service per day, provided at night so the parent could rest. The agency determination was based upon review of materials in section C of Composite Respondent's Exhibit 8.

5. Initial submission from the providers reflected total assistance in all activities of daily living, frequent oral suctioning, copious oral secretions causing desaturations, continuous pulse oximetry, tube feeding (nothing taken orally), catheterization, use of wheelchair, oxygen and chest physiotherapy along with several medications, including those for skin care. Additional information submitted by the provider reflected seizures and frequent fevers. The fevers had prevented tonsillectomy and no hospitalization or emergency room care or primary provider appointments were noted in the 60 days before January 2007 review.

6. On June 8, 2006 the Deputy Secretary for Medicaid issued clarification (Respondent's Exhibit 7) to Medicaid Providers explaining that:

> MFC providers are responsible for the overall care of the children assigned to them...When a child has medically necessary needs that cannot be met by the MFC parent who is trained in their care, the child may receive PDN (private duty nursing) or PC (personal care) services. The use of these support services in the MFC home is intended to meet medical needs of the child that cannot be met by the MFC parent. Support services will be reimbursed by Medicaid for the following:...A child's medical condition requires an awake caregiver at night to provide continuous or frequent intervention (usually limited to 8 hours per night)...

7. On December 11, 2006, the petitioner's doctor wrote to the guardian (Petitioner's Exhibit 2, page 2) describing need for "constant monitoring" with "medical instability" and an "increased risk for sleep apnea." Dr. Thorpe concluded "long term licensed care in the ...Medical Foster Home is in the best interest" of the petitioner. Placement with the foster parent is not a matter in dispute. Undated correspondence from Children's Medical Services (CMS) faxed on April 2, 2007, showed the Medical Foster Care nurse supervisor believed the petitioner was "at a very high risk for seizures, apnea, and sudden death..." She described the current provision of "close

supervision and quick intervention" as sustaining him and preventing life threatening events. She urged continuation of the 10 hours daily private duty nursing at night to "cover early evening and early AM times that he has demonstrated cluster apnea episodes..." According to testimony, the petitioner has a tendency to remove his oxygen in the period just before and after his deep sleep. Sleep apnea episodes were confirmed in page 3 of Petitioner's Exhibit 2, from the epilepsy center, January 26, 2007. Plan to increase Keppra (seizure medicine) was noted along with the mother's report of 2 to 3 episodes of apnea per night. Event logs in the exhibit reflected 311 apnea episodes between December 15, 2006 and February 6, 2007.

CONCLUSIONS OF LAW

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

Florida Statute 409.905 addresses **Mandatory Medicaid services** with section (4) informing that *HOME HEALTH CARE SERVICES* can be covered. Under subsection (b) the following information is relevant:

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

Thus, it is concluded that the agency needed to review need for nursing service.

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

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

Additionally relevant is Fla. Admin. Code 59G-4.130 stating:

> **Home Health Services.**
> (1) This rule applies to all home health agencies licensed under Chapter 400, Part IV, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.
> (2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

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

The Home Health Services Coverage and Limitations Handbook (page 2-2) defines **Medically Necessary** standards saying: "Medicaid reimburses services that are medically necessary for the treatment of a specific documented medical disorder, disease or impairment, do not duplicate another provider's service..." The Handbook continues with information appearing in Florida Administrative Code previously noted. The Medical Foster Care Services Coverage and Limitations Handbook, Chapters 1 and 2, inform in relevant part as follows:

CHAPTER 1 ... PROVIDER QUALIFICATIONS AND ENROLLMENT
...
Purpose
The purpose of MFC services is to enable medically-complex children under the age of 21, whose parents cannot care for them in their own homes, to live and receive care in foster homes rather than in hospitals or other institutional settings.
Medicaid Reimbursement
Medicaid reimburses Medicaid-enrolled MFC providers for medically necessary services rendered by the provider to children in foster care and children in shelter care who are assigned to the provider's care by CMS.
...
Provider Qualifications
To be eligible to enroll as a Medicaid MFC provider and to maintain enrollment, an individual must: ...
Be available to provide MFC services 24 hours per day (this would not preclude the use of other medically necessary services if additional medical needs are present)...

CHAPTER 2 ... COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS ...

Support Services
Private Duty Nursing and Personal Care ...
Examples of situations when PDN may be authorized are: ...

A child's medical condition requires an awake caregiver at night to provide continuous or frequent intervention or medically necessary observation

After careful review of all relevant facts and the governing statutes with interpretive guidelines, it is concluded that with a qualified foster parent available around the clock, and achieving evening relief with eight hours of private duty nursing service, the child should receive his medically necessary services under Medicaid. More than that would be a duplication of service. It is recognized that such a reduction would require a significant family adjustment, and this is unfortunate.

However, evidence did not support a greater amount of nursing hours under the circumstances. Continuing the additional hours would continue to achieve parental relief on a daily basis, but the additional hours cannot accurately be described as medically necessary in a medical foster care situation. The qualified foster parent is charged with responsibility to be available around the clock, and the eight hours of nursing relief should suffice for purpose of rest. While the situation evokes empathy, the medical necessity standards were not demonstrated. Thus, it is concluded reduction has been justified as issued.

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 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 24th day of May, 2007, in Tallahassee, Florida.

J W Alper

J W Alper
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To:

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

APPEAL NO. 07F-01043

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 5, 2007, at 2:44 p.m., in Sarasota, Florida. The petitioner was present. He was represented by his grandmother and caretaker, The Agency was represented by Pat Brooks, program operational administrator. Present as a witness for the petitioner was Alan Lovesky, Custom Medical Systems Inc. Present as a witness for the Agency was Jody Winter, surgical therapy consultant.

ISSUE

At issue is the October 27, 2006 action by the Agency denying the petitioner's request for Medicaid to pay for a motorized standing wheelchair.

FINDINGS OF FACT

The petitioner is 12 years old and a Medicaid recipient. He has Duchennes Muscular Dystophy. On October 30, 2005 a physical therapy evaluation for a custom wheelchair was performed by Ouida Wellenberger. Her report was completed on February 10, 2006. On March 30, 2006, a prior authorization packet was submitted by the Durable Medical Equipment provider (DME) to Medicaid requesting a powered lifting wheelchair.

On May 1, 2006, a Medicaid reviewer faxed a memorandum to the DME provider. It stated that the requested equipment was not the least costly alternative that could meet Michael's mobility needs. The reviewer requested that the provider revise the request to a power wheelchair that met Medicaid's criteria as defined in the DME handbook. The reviewer found that there was insufficient justification to show that: this was the least costly base that could meet the petitioner's needs; that there was insufficient justification for a combination stander component to the wheelchair; that there was insufficient justification for a seat elevator; and there was insufficient justification to show that a pressure relieving cushion would not continue to meet his pressure management needs. The memorandum requested that the DME provider submit a request for a powered wheelchair base with appropriate seating components without the powered positioning components. The provider was allowed 10 days from the date of the memorandum to respond or the request would be denied as not the least costly alternative that could meet the petitioner's needs.

On July 13, 2006, the Medicaid reviewer received a request for clarification and an extension of time to provide the information until August 14, 2006. On August 14, 2007 additional clarification was provided to the DME provider. Specific models of wheelchairs that have been approved for individuals with the same diagnosis were identified in the interests of expediting the process. This memo clearly states that a power wheelchair and a separate standing device are the least costly alternative to provide both powered mobility and the benefits of upright posture/standing.

On September 27, 2007, the provider submitted another proposal for a wheelchair after consulting with the reviewer. That request was denied on October 15, 2006. The chair was rejected for the following reasons:

- The wheelchair requested was not the least costly alternative that could provide powered mobility. A separate standing device could be provided for the medical benefits of upright posture and weight bearing. The requested device costs $29,510. Based on the documentation submitted, a powered wheelchair that would meet the petitioner's mobility and seating needs would cost $6,921.19. Based on the documentation of his positioning needs in a wheelchair, the reviewer developed a sample price quote for a stander. The standing device could be provided for approximately $4,300.

- The requested wheelchair includes powered recline. There was insufficient justification that this was a medical necessity. This component was bundled with the standing component by the manufacturer. The reviewer determined that this provision was in excess of the recipient's needs.

- A powered seat elevator was requested. The justification was that he would be able to transfer independently to his bed. However, the physical therapy evaluation documented that he is able to perform standing transfers independently already. Therefore, this feature would be in excess of his medical needs.

- Medicaid does not reimburse for items that are for the convenience of the recipient or caregiver. It was discussed that a separate standing device would require transfer out of the wheelchair. This is an issue of convenience and does not meet the criteria for medical necessity.

Finally, the Medicaid reviewer noted that they would authorize payment for a powered wheel chair with appropriate seating supports. If requested, Medicaid would fund a standing device. The combined price of these items would be considerably less than the requested customized wheelchair.

The petitioner has pain in his lower extemities. He cannot stand to get into a stander. Therefore he would require assistance. His caretaker is 59 years old and has physical limitations. They do not use a lift. The wheelchair requested would provide him more independence from the assistance of others.

CONCLUSIONS OF LAW

The Medicaid Program only provides for medical services that are defined as being "medically necessary," or of "medical necessity" as set forth in the Florida Administrative Code Rule 59G-1.010(166)(a). The care, goods or services must meet the conditions as follows:

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

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

The Florida Administrative Code Rule section 59G-4.070 states in part:

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

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

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

Medicaid may reimburse for a standard wheelchair if the recipient is confined to a bed or chair. Reimbursement may be made for the following: ...A motorized wheelchair required when medical needs cannot be met by a less costly alternative.

This handbook, page 2-58, continues and states in part:

Medicaid may reimburse for a customized wheelchair that is specially constructed (K0008, K0013, K0014). Prior authorization is required.
Medicaid will not approve a customized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established.
For a customized wheelchair, the following information must be submitted with the prior authorization request:

- medical necessity;
- written documentation describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive abilities, coordination, and activity limitations;
- wheelchair evaluations performed by either a registered physical or occupational therapist or a certified physiatrist;
- what physical improvement(s) can be anticipated;
- what physical deterioration can be prevented;
- a list of each customized feature required for unique physical status;
- specify the medical benefit of each customized feature;
- identify the principle places of use;
- an itemized invoice listing actual costs for parts and labor;
- list the source(s) of purchased accessories and modifications; and
- documentation of home accessibility is required for an oversized, heavy duty,

Medicaid will not approve a motorized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established. When a motorized wheelchair is prescribed the documentation must establish that the device is a safe method of mobility.

The recipient must meet all of the following conditions:

- documented, severe abnormal upper extremity dysfunction or weakness;
- sufficient eye/hand perceptual capabilities to operate the chair and the cognitive skill to guide it independently;
- capable of some activity to which the motorized chair will provide access;
- an environment conducive to the use of a motorized wheelchair;
- clinical documentation of a power wheelchair trial must accompany any first request for a power wheelchair; and
- documentation of home accessibility is required in a prior

Authorization request for an oversized, heavy-duty or power customized wheelchair.

The Findings of Fact show that the petitioner requested that Medicaid pay for a customized motorized lifting wheelchair that is also a stander. The wheelchair costs $29,510. The motorized wheelchair plus a standard purchased separately would cost approximately $11,221.19 ($6921.19 + $4300). The request was submitted through the Agency's prior authorization review process. In that process consideration is given to the medical necessity of the item in that it is not in excess of what the recipient needs to meet their needs, and not primarily for the convenience of the petitioner or his caretaker. The hearing officer concludes that the petitioner did not establish the required medical necessity for the requested customized wheelchair that reclines and elevates as opposed to the suggested separate motorized wheelchair and stander. Therefore, the prior authorization reviewer correctly denied the request as it was in excess of the petitioner's needs.

DECISION

This appeal is denied. The Agency'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 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 3rd day of May, 2007,

in Tallahassee, Florida.

Terry Oberhausen

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. 07F-01903

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 2:35 p.m. on May 11, 2007. The petitioner was not present but was represented by his mother, [redacted], with RN, family nurse practitioner and LPN, also present on his behalf. The respondent was represented by Cynthia Barge, RN specialist, with telephone testimony available from AHCA-contracted KePRO staff, Board-certified Pediatrician Rakesh Mittal, and Review Operation Supervisor Theresa Ashey.

ISSUE

At issue was whether or not it was correct for AHCA to reduce private duty nursing hours from 24 hours daily to 17 hours twice weekly and 8 hours daily five times a week. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner had received 24 hours daily private duty nursing service. The respondent conducted review and reduced hours. On March 19, 2007, the respondent issued notice reducing hours to 17 daily twice a week and 8 hours five times a week.

2. The parties discussed the situation in the absence of the hearing officer. Upon reconvening, the respondent declared that 24 hours service were medically necessary. Thus, it is found the petitioner requires 24 hours service daily.

CONCLUSIONS OF LAW

Fla. Admin. Code 65-2.060, regarding evidence, informs as follows:

> (1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

Because of this rule, burden of proof was on the respondent and would not be considered met. Notice of reduction is not supported by evidence at this time. In view of the stipulation setting forth favorable resolution and describing plan to restore 24 hours daily nursing service, it is appropriate to conclude that intent to reduce nursing hours has not been justified. This conclusion is favorable to the petitioner.

DECISION

The appeal is granted and nursing hour reduction is set aside.

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 24th day of May, 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 To:

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

APPEAL NO. 07F-00052

PETITIONER,

Vs.

CASE NO. 1151291480

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was scheduled before the undersigned hearing officer on January 23, 2007. Both parties stipulated to a reschedule to seek resolution. The administrative hearing was rescheduled for February 13, 2007. The petitioner requested and was granted a continuance as resolution was still be sought. The hearing was rescheduled to March 6, 2007.

The administrative hearing was convened before the undersigned hearing officer on March 27, 2007, at 11:04 p.m., in St. Petersburg, Florida. The petitioner was not present. The petitioner was represented by his step children,

The respondent was represented by Suzi Jackson, economic specialist supervisor.

ISSUE

The petitioner is appealing the notice of December 13, 2006 for the respondent's actions to cancel Institutional Care Program benefits and impose an ineligibility period until October 13, 2013. As this is a cancellation of Institutional Care Program benefits, the respondent has the burden of proof. The petitioner also requested an appeal for hardship.

FINDINGS OF FACT

The petitioner reapplied for Institutional Care Program benefits on October 13, 2006. The respondent cancelled the petitioner's Institutional Care Program benefits on December 13, 2006 due to an improper transfer of assets.

1. On September 27, 2006, the respondent sent the petitioner an Interim Contact Letter which was the form to be completed for the petitioner's October 2006 recertification.

2. Prior recertifications were completed for the petitioner by the petitioner's wife. Real property was indicated in prior recertifications as the homestead and income producing rental property. The step-daughter became the power of attorney and authorized representative for the petitioner after the petitioner's wife died on March 8, 2004. The step-daughter and the step-son of the petitioner are the children of the petitioner's wife and are not disabled.

3. The step-daughter called the respondent on October 2 and October 9, 2006 for information on the completion of the recertification form. The recertification form was completed by the step-daughter indicating no changes to

inquiries regarding assets. Rental income was indicated as zero. The recertification form was submitted on October 13, 2006.

4. Upon review of the recertification form, the respondent noted that the rental property was no longer income producing. The respondent called the Property Appraiser's Office. The Property Appraiser notified the respondent that the petitioner and the petitioner's wife quit claimed the homestead and the rental property to step-daughter and step-son. The Quit Claim Deeds were signed on March 2, 2004, six days prior to the petitioner's wife's death from cancer on March 8, 2004. The petitioner and his wife deeded the properties each for $10. The rental property now was owned by the step-daughter. The homestead property was sold by step-daughter and the step-son for $263,000.

5. The transfer of the homestead and rental property from the petitioner and petitioner's wife to petitioner's step-daughter and step-son was not reported to the Department. The petitioner was sent a Notice of Determination of Resource/Income Transfer on October 13, 2006. The evidence was due on October 30, 2006. The notice indicated that the petitioner must "present clear and convincing evidence that show you did not transfer resources or income to become eligible for Medicaid." The notice specifically stated the evidence to produce. If no evidence was presented that petitioner would be ineligible for Institutional Care Program benefits until October 13, 2013.

6. On October 30, 2006, the petitioner received a letter from the step-daughter. The step-daughter disputed that the transfer was in order to obtain Medicaid benefits. No evidence was submitted to support this assertion.

7. The respondent sent the petitioner a Request for Information notice on November 2, 2006, as the step-daughter disputed the transfer was not to obtain Medicaid benefits. The respondent requested verification of fair compensation received by the petitioner for the transfer of the property, proof from a knowledgeable source of the fair market value of the property at the time of transfer, explain in detail of how the petitioner was compensated for the transfer of assets and the value of compensation to the petitioner. This verification was due on November 13, 2006.

8. On November 9, 2006, the step-son requested an extension of time to provide the requested evidence and verification. An extension was granted to November 29, 2006. On November 29, 2006, the respondent received a letter from the step-daughter that she was unable to obtain any of the documents requested and that the market analysis and mortgage information would be provided the next week. In the November 29, 2006 letter from the step-daughter, the respondent was advised that the petitioner was in the late stages of Alzheimer's disease and was unable to respond in any capacity on his own.

9. The respondent gave the step-daughter an additional week to provide evidence and verification of proof of compensation for the transfers or proof that the funds were used for the petitioner or the petitioner's wife's benefit.

10. As of December 12, 2006, no requested evidence or verification was received, not even the analysis and mortgage information. No evidence or verification of proof of compensation for the transfers or proof that the funds were used for the petitioner or the petitioner's wife's benefit was received. The

respondent cancelled the petitioner's Institutional Care Program benefits on December 13, 2006 due to an improper transfer of assets.

11. On March 1, 2007, the step-son submitted to the respondent a copy of the Quit Claim Deeds for homestead and the rental property, the recording of the deeds, a Settlement Statement for the sale of the homestead property and a handwritten explanation of how the proceeds from the sale were spent.

12. As a result of the hearing request, the petitioner's Institutional Care Program benefits were reinstated. The petitioner remained in the nursing facility. The petitioner's Medicaid Program benefits continued. The step-son requested that the transfer penalty not be imposed due to hardship, as no funds remained from the sale of the homestead property.

CONCLUSIONS OF LAW

The Florida Administrative Code 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria" sets forth the determination of transfer and length of ineligibility period for Institutional Care Program benefits:

> (3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing facility care services or HCBS waiver services. The look back period is 36 months...
> (d) Except for allowable transfers described in 42 U.S.C. § 1396p(c)(2), in all other instances the department must presume the transfer occurred to become Medicaid eligible unless the individual can prove otherwise...
> (e) Each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the purpose of qualifying for Medicaid eligibility. No period of ineligibility shall be imposed if the individual provides proof that they intended

> to dispose of the resource or income at fair market value or for other valuable consideration, or provides proof that the transfer occurred solely for a reason other than to become Medicaid eligible...
> (g) Periods of ineligibility based on transfer policy are calculated beginning with the month in which the transfer occurred...

The rule sets forth that if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the Department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing facility care services or HCBS waiver services. The transfer was not for the individual's blind or disabled child, or a disabled individual under age 65. No evidence of compensation to the petitioner was received. The respondent has met their burden of proof.

The rule sets forth that each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the purpose of qualifying for Medicaid eligibility. The rule does set forth that no period of ineligibility shall be imposed if the individual provides proof that they intended to dispose of the resource or income at fair market value or for other valuable consideration, or provides proof that the transfer occurred solely for a reason other than to become Medicaid eligible. All pending notices sent by the respondent and statements from the respondent to petitioner indicated that evidence, proof, verification and documentation would be needed to rebut the transfer of assets. Prior to the cancellation of the benefits on December 13, 2006, no evidence was received. The documentation received on March 1,

2007, did not include evidence of compensation for a transferred asset. No evidence of compensation for the transferred asset was received at the hearing. The petitioner has not met their burden of rebuttal. Therefore, the respondent's actions to cancel Institutional Care Program benefits and impose an ineligibility period until October 13, 2013 were in accordance with the rules of the Program.

The step-son requested that the period of ineligibility not be imposed due to hardship. The Florida Administrative Code 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria" sets forth that a transfer penalty shall not be imposed if the Department determines that the denial of eligibility due to transferred resources would work an undue hardship on the individual and that an undue hardship exists when imposing a period of ineligibility would deprive an individual of food, clothing, shelter or medical care such that their life or health would be endangered. The respondent had not received or made a determination on a hardship request. Therefore, the request for an appeal for hardship is premature. The respondent is directed to make a hardship determination based on the March 27, 2007 request for hardship.

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 2nd day of May, 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 To:

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

APPEAL NO. 07F-01378

PETITIONER,

Vs.

CASE NO. 1025186133

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Okaloosa
UNIT: 88176

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 26, 2007, at 9:40 a.m., in Ft. Walton Beach, Florida. The petitioner was not present but was represented by her daughter and co-legal guardians, [redacted] and [redacted] The Department was represented by Jon Ann Painter, economic self-sufficiency specialist I.

The hearing was originally scheduled to be held on April 10, 2007 but was continued at the request of the petitioner's representative.

ISSUE

The petitioner is appealing the Department's action of January 16, 2007 to deny Institutional Care Program (ICP) and Medicaid benefits based on the contention that she had assets in excess of allowable program limits. The petitioner holds the burden of proof.

FINDINGS OF FACT

On September 15, 2006 the petitioner (age 77) filed an application for Institutional Care Program (ICP) and Medicaid benefits. The petitioner had been a resident of [redacted] assisted living facility prior to her placement at [redacted] Nursing Home in June 2006. The application also requested retroactive ICP and Medicaid coverage for June 2006 through August 2006. The petitioner reported net income from Social Security (SSA) of $1,116.10 and interest income on her checking account. On November 3, 2006, the Department mailed a Notice of Case Action denying ICP and Medicaid based on the contention that the petitioner failed to provide requested information necessary to determine eligibility. The petitioner did not request a hearing within 90 days of this Notice of Case Action.

On November 20, 2006, the petitioner's representative filed a Request for Assistance (RFA) for ICP and Medicaid benefits retroactive to June 2006. Retroactive Medicaid benefits may be requested for a three month period prior to the date of application. The retroactive months from the November 20, 2006 application would be August through October 2006.

The petitioner reported a checking account at First City Bank with a balance of $20,005.91 in July 2006, $6,136.95 for August 2006, $7,186.90 in September 2006, and $8549.70 in October 2006 (Respondent's Exhibit 2). The balances in the checking account reflect deductions of the petitioner's SSA and interest income direct deposited to her checking account. At the hearing, the representative also indicated that there

were no outstanding checks not considered by the Department. In addition to the checking account, the petitioner had a savings account. The amount in the savings account was not verified. The petitioner's representative indicated that the savings account had been closed and the remaining funds transferred into the checking account on September 15, 2006 (Respondent's Exhibit 2). There were other assets reported but based on the information provided by the petitioner's representative and the checking account bank statements, the Department determined the petitioner had resources in excess of allowable program limits. The Department determined that the applicable asset limit for ICP was $2,000 and for the Medically Needy Program the asset limit was $5,000.

The total assets attributed to the petitioner's checking account alone exceeded the asset limit of $2,000 for ICP and Medicaid during the months at issue. Therefore, the petitioner was not eligible to receive ICP and Medicaid benefits for those months.

On January 16, 2007, the Department notified the petitioner that her ICP and Medicaid benefits were being denied for August through December 2006 and for January 2007 based on excess assets.

At the hearing, the petitioner's representative provided a checking account statement showing a balance of $4,299.39 as of April 9, 2007. The petitioner's representative was concerned that there were many unpaid medical bills and additional legal expenses associated with legal guardianship. Because she did not know the best course of action with regard to spending down the petitioner's resources, the

representative continued to retain the funds in the petitioner's checking account. In addition, the representative believed that when she reduced the money remaining in the petitioner's account, the petitioner would be eligible for ICP and Medicaid retroactive to June 2006. Finally, the representative relied on the nursing home staff to follow through with the application process.

CONCLUSIONS OF LAW

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

> Time Limits in Which to Request a Hearing. (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
>
> (a) The date on the written notification of the decision on an application.
>
> (b) The date on the written notification of reduction or termination of program benefits.
>
> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

The Findings of Fact show that the petitioner applied for ICP benefits on September 15, 2006 and again on November 20, 2006. The Findings also show that the Department denied the petitioner's ICP benefits on November 3, 2006 and again on January 16, 2007 because resources exceeded program eligibility limits. The petitioner requested a Hearing on February 26, 2007. According to the above authorities, an individual must request a hearing within 90 days of the date of the written notification of

the decision. In this case, written notification of the decision on the application dated September 15, 2006 was mailed to the petitioner on November 3, 2006. On February 26, 2007, the petitioner requested a hearing as she disagreed with the decision. This request was not filed within 90 days of the written notification as required by the above rule. Because the hearing request was not timely filed, the hearing officer has no jurisdiction over the matter. Therefore, the correctness of the denial of the application for ICP for the months of June and July 2006 cannot be addressed. The hearing officer can only address the correctness of the application dated November 20, 2006 which includes the three month retroactive period of August through October 2006, as the notice was dated January 17, 2007 and was timely appealed.

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

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

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

Florida Administrative 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-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant part:

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

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

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

Florida Administrative Code 65A-1.702(1)(9) states in part:

> Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services...

Florida Administrative Code 65A-1.716 sets forth the asset limit in the SSI-Related Medically Needy Program at $5,000 for an individual and $6,000 for a couple.

The Findings of Fact show that the petitioner had a checking and saving account at the First City Bank. The Findings of Fact also show that the bank balances on the checking account from August through December 2006 and January 2007 exceeded the asset limit of $2,000 for the ICP Program and $5,000 for the Medically Needy Program. According to the above authorities, 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 Findings also show that the Department applied the proper asset limit of $2,000 to the ICP program and $5,000 for the Medically Needy Program.

The resources exceeded the applicable limit for the months at issue, therefore, the Hearing Officer concludes that the petitioner was not eligible for ICP and Medicaid benefits. The Department correctly denied her ICP and Medicaid benefits from at least August through December 2006 and January 2007.

DECISION

The appeal is denied. The Department's action for August through December 2006 and January 2007 is affirmed. The appeal on the correctness of the Department's action for the retroactive months of June through July 2006 is dismissed as non-jurisdictional.

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 May, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

APPEAL NO. 07F-00697

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 3, 2007, at 8:41 a.m., in St. Petersburg, Florida. The petitioner was present. The petitioner was represented by Mizel Campbell, Esq., Advocacy Center for Persons with Disabilities Inc. Witnesses for the petitioner were the petitioner's physician, Christine Burns, M.D.; a provider of private duty nursing, Barbara Whetzel, R.N.; the petitioner's mother, [redacted] and the petitioner's father, [redacted] The respondent was represented by Brevin Brown, Esq., general counsel Agency for Health Care Administration. Witness for the respondent from the Agency Health Care Administration was Kathleen Freeman, registered nurse specialist. Witness for the respondent from Keystone Peer Review Organization South (KePRO) was Galdino Silva-Neto, M.D. Dr. Silva-Neto was represented by his own counsel,

Vance Smith, Esq. Theresa Ashey, review operation supervisor for Keystone Peer Review Organization was observing. Court reporter, Vanessa Andrew, was present and provided transcript of the proceedings.

A motion was made for the record to be left open for the submission of Proposed Final Orders. The motion was granted and the record was left open for fifteen days. Any Proposed Final Order was due no later than April 20, 2007. A Petitioner's Proposed Final Order was received on April 20, 2007. The record was closed on April 25, 2007. The respondent did not submit a Proposed Final Order.

ISSUE

The petitioner is appealing the notice of January 23, 2007 for the respondent's action to deny 480 hours private duty nursing for the 60 day period of January 14, 2007 through March 14, 2007. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner's requested 960 hours of private duty nursing for the 60 day period of January 14, 2007 through March 14, 2007. On January 23, 2007, the respondent denied 480 hours and approved 480 hours for the 60 day period of January 14, 2007 through March 14, 2007. The petitioner is appealing the denial of 480 hours.

1. The petitioner is a medically complex infant currently receiving Medicaid. Petitioner resides with his parents and two older siblings. His father works at his own business as a realtor. His mother provides home schooling for

his seven year old brother. The petitioner's four year old brother is disabled and has a similar medical condition as the petitioner.

2. Maxim Healthcare Services Inc. is the petitioner's provider for private duty nursing. The petitioner had been receiving 960 hours of private duty nursing for the 60 day period that ended January 13, 2007. On January 12, 2007, Maxim Healthcare Services Inc. submitted a request for 960 hours of private duty nursing for the 60 day period of January 14, 2007 through March 14, 2007.

3. The respondent has contracted KePRO to determine the number of service hours for private duty nursing. Private duty nursing is reviewed every 60 days. KePRO reviewed the request. Maxim Healthcare Services Inc. left several of the sections of the questionnaire blank. The sections that were blank were Durable Medical Equipment, Diet, Functional Limitation, Activities Permitted, Mental Status, Respiratory Status, Pain and Caregiver. A board certified pediatric specialty physician consultant reviewed the documentation on January 21, 2007. Based on the documentation, the physician consultant denied the 960 hours of private duty nursing. The physician consultant indicated that the mother was not working and medical necessity was not demonstrated for 960 hours of private duty nursing. The respondent sent a denial notice on January 21, 2007.

4. Maxim Healthcare Services Inc. requested a reconsideration. Maxim Healthcare Services Inc. submitted additional information.

5. KePRO completed the Internal Focus Review Findings using subsequent records received. An Internal Focus Review Findings is a written report of the documentation received from the provider, the information from the

Utilization Form and determination of the physician consultant. The petitioner's diagnoses indicated were convulsion, microcephalus, dysphagia, development dyslexia, esophageal reflux and bilateral occipital polymicrogyria. The durable medical equipment was oxygen concentrator or oxygen tanks, pulse oximeter and suction machine. The functional limitations are muscle tone and level of activity has not progressed for his chronologic age. Muscle tone is floppy and uncoordinated. The petitioner has severe developmentally delay, minimal head and neck control, unable to roll, unable to sit on his own, unable to hold toys, seldom tracks with eyes, seldom smiles. His activity of daily living status is infant. The petitioner requires total care and all needs are dependent on caregivers and family. The petitioner uses a wheelchair for ambulation. The petitioner's respirator status was indicated as increasing respiratory distress with and without feeds with naso-phayrngeal congestion and coughing/choking episodes related to congestion. During seizure the petitioner will experience apnea and oxygen desaturation to 40 or 50 percent. The petitioner receives hyperbaric therapy and monitoring with oximeter.

6. A second board certified pediatric specialty physician consultant reviewed the documentation on January 23, 2007. Based on the documentation, the physician consultant approved 480 hours of private duty nursing and 480 hours of private duty nursing were denied. The physician consultant indicated that the mother was not working and medical necessity was not demonstrated for private duty nursing above the 480 hours. The respondent sent a denial notice was on January 23, 2007.

7. A "re-reconsideration" was requested and additional information was submitted by Maxim Healthcare Services Inc. The additional information submitted was that the mother was a certified school teacher who home school's the seven year old sibling. The mother is responsible for all medical appointments and therapy for both disabled children. The time of the appointments and therapies varies for each child, as the petitioner's disabled sibling is in school.

8. The re-reconsideration was denied. The physician consultant believed the mother was not working therefore; medical necessity did not demonstrate support of private duty nursing above the 480 hours.

9. The evidence presented at the hearing confirmed that in addition to home schooling the petitioner's seven year old sibling, the petitioner's mother works. The mother has a cleaning business with varying hours. The mother also works with the petitioner father at the realtor business fifteen hours a week. This information had been provided to Maxim Healthcare Services Inc.

10. Additional diagnosis of the petitioner included infantile spasms and cerebral palsy. The petitioner currently receives all food and medication by mouth which increases the risk of aspiration, choking and breathing distress. The petitioner cannot swallow water. The petitioner's seizures are difficult to control by testimony of the petitioner's treating physician. The petitioner has many seizures with severe choking and aspiration. Suction and medication is needed. Administration of the medication prevents trip to the emergency room

for intravenous medication. The petitioner's mother is not comfortable operating the suction machine.

11. The hearing officer finds as follows. Maxim Healthcare Services Inc. failed to complete several of the sections on the questionnaire relating Durable Medical Equipment, Diet, Functional Limitation, Activities Permitted, Mental Status, Respiratory Status, Pain and Caregiver. Maxim Healthcare Services Inc. failed to notify KePRO that the petitioner's mother was working. Maxim Healthcare Services Inc. failed to notify KePRO all of the petitioner's medical conditions.

CONCLUSIONS OF LAW

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

The Florida Administrative Code 59.G-1.010 defines medical necessity:

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

> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider...
> (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.

Private duty nursing is defined in the Home Health Services Coverage and Limitations Handbook on page 2-15:

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

Nursing services including parental responsibility are set forth in the Home Health Services Coverage and Limitations Handbook on page 2-15:

> 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.
> Medicaid does not reimburse private duty nursing for respite care.

The Home Health Services Coverage and Limitations Handbook provides that for private duty nursing, prior authorization must be received (at page 2-16)

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

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

> Who Submits the Request The request for prior authorization must be submitted by the provider who plans to furnish a service...

The hearing officer found that Maxim Healthcare Services Inc., as the provider, failed to provide to the respondent sufficient documentation regarding the mother work status and the petitioner's medical diagnosis. This documentation/information was available. The petitioner's physical condition, the mother's work and care for her other child are considered when determining the private duty nursing hours and the care needs of the petitioner. The decision by the KePRO medical professional to deny 480 hours of private duty nursing was based on insufficient information.

A hearing officer may consider new and additional information that is present at a hearing as set forth in the Florida Administrative Code.

> 65-2.056. Basis of Hearings.
>
> The Hearing shall include consideration of...
> (3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the department in making its decision.

Therefore, looking at the evidence that was presented at the hearing regarding the mother's employment and the petitioner's diagnosis, medical necessity was not established for the reduction of private nursing hours.

Since this is a reduction of services, the respondent bears the burden of proof. The respondent had the burden to show that the hours of reduction of

private duty nursing hours was a reduction to an amount that was medically necessary. All evidence that was submitted substantiated the need for private duty nursing services with 960 hours of nursing care (16 hours a day) for the 60 day period of January 14, 2007 through March 14, 2007. Based on the above cited authorities, the respondent's denial of 480 hours of private duty nursing for the 60 day period of January 14, 2007 through March 14, 2007 is reversed.

DECISION

This appeal is granted for the service dates of January 14, 2007 through March 14, 2007.

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 24th day of May, 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 To

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

APPEAL NO. 07F-02238

PETITIONER,

Vs.

CASE NO. 1254629203

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 10 Broward
UNIT: 88139

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 24, 2007, at 8:45 a.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by [redacted] and [redacted] Medicaid consultants from the [redacted] The respondent was represented by Jackie Pughsley and Liliane Clerie, economic self-sufficiency specialists.

ISSUE

At issue is the Department's March 15, 2007 action of denying the petitioner's request for Institutional Care Program Medicaid benefits for November 2006, because the her income exceeded the program's eligibility limit. The petitioner has the burden of proof.

FINDINGS OF FACT

At the time of the hearing, the petitioner was a resident at the [redacted] in Plantation, Florida. Included in the evidence is a copy of a notice, that is dated

March 15, 2007, to the petitioner informing her that her request for Institutional Care Program Medicaid benefits was denied for November 2006, because her income exceeded the program's eligibility limit. The petitioner's monthly gross Social Security income in 2006 was $959.50. She was also receiving income from a trust account of $926.00 monthly, however this income stopped as of December 2006.

Included in the evidence is a copy of a letter from Rhoda Chaloff, attorney, dated December 2, 2006, stating that November 2006 was the last month that the petitioner received the $926.00 monthly trust account income. The petitioner's income in November 2006 was $959.50 Social Security benefits, and $926.00 trust account, which equals a total of $1,885.50.

Included in the evidence is a copy of a Wachovia Bank account statement showing that on November 30, 2006, $20.00 was deposited into the bank account. There was a closing balance of $20.00 as of November 30, 2006. This is an income trust account set up for the petitioner, so that her income can be diverted to qualify for the Institutional Care Medicaid Program. The Department included the petitioner's $1,885.50 income in the November 2006 budget, minus the $20.00 diverted income, for a total income amount of $1,865.50 for November 2006. It was determined that this exceeds the $1,809.00 income limit for the petitioner to receive Institutional Care Program Medicaid benefits, therefore the request for the benefits for November 2006 was denied.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.716 explains income and resource criteria for an individual to qualify for Medicaid benefits. The monthly income limit for an individual to receive

Institutional Program Care Medicaid benefits is $1,809.00. The Public Assistance Policy Manual at 1840.0110 explains income trust accounts, and states in part:

> A trust is considered a qualified income trust if:
>
> 1. It is established on or after 10/01/93 for the benefit of the individual;
>
> 2. It is irrevocable;
>
> 3. It is composed only of the individual's income (Social Security, pensions, or other income sources); and
>
> 4. 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.

The petitioner's request for Institutional Care Program Medicaid benefits was denied for November 2006, because her income exceeded the program eligibility limit. The reason for establishing an irrevocable income trust is to divert the petitioner's income so that it would not be included in the Medicaid budget that has an income limit of $1,809.00 for an individual.

An irrevocable income trust account was set up for the petitioner, however only $20.00 was diverted into the account from the petitioner's income in November 2006. The Department included the petitioner's $1,885.50 income in the November 2006 budget, minus the $20.00 diverted income, for a total income amount of $1,865.50 for November 2006. It was determined that this exceeds the $1,809.00 income limit for the petitioner to receive Institutional Care Program Medicaid benefits, therefore the request for the benefits for November 2006 was denied.

The petitioner's representatives argued that the petitioner's $35.00 monthly personal needs allowance should be taken into consideration, and that the policy is vague on the specific dollar amount that should be diverted. The personal needs allowance is not considered, and the specific dollar amount to be diverted is dependent on the income that the individual receives. After careful consideration, it is determined that the Department's action to deny the November 2006 Institutional Care Program Medicaid benefits, because the petitioner's income exceeded the program eligibility limit, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 2nd day of May, 2007,

in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished To

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

APPEAL NO. 07F-01392

PETITIONER,

Vs.

CASE NO. 1245231057

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Okaloosa
UNIT: 88176

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 10, 2007, at 10:00 a.m., in Ft. Walton Beach, Florida. The petitioner was not present but was represented by [redacted]. collections specialist supervisor, [redacted] The Department was represented by Jon Ann Painter, economic self-sufficiency specialist I.

The hearing was originally scheduled to be held on March 20, 2007 but was continued at the request of the petitioner's representative.

ISSUE

The petitioner is appealing the Department's action of January 10, 2007 to deny Institutional Care Program (ICP) benefits for the months of June 2006 through January 2007 based on the contention that asset value exceeded program eligibility limits. The petitioner held the burden of proof.

FINDINGS OF FACT

Prior to the action under appeal, the petitioner was a resident of an Assisted Living facility for approximately six months. She became a private pay resident of [redacted] nursing home on December 17, 2005. An application for ICP was filed on June 30, 2006. On July 6, 2006, the Department contacted the petitioner's daughter, the authorized representative, to arrange for an appointment on July 18, 2006. An appointment letter dated July 7, 2006 was sent to the petitioner's representative listing information needed to determine eligibility. The petitioner's authorized representative was unable to come to the appointment due to her health and an offer was made to conduct a telephone interview. The petitioner's representative agreed to a telephone interview the following day (July 19, 2006) but there was no contact from the representative. A telephone interview was conducted on August 29, 2006. An appointment notice/request for information was sent on August 29, 2006 requesting copies of checking account statements dated July 8, 2006 through August 2006, copy of savings account statements for March 2006 through August 2006, a signed designation of burial form and information regarding Modern Woodman of America life insurance policy [redacted] John Hancock policy [redacted] A statement from the insurance agent showing issue dates, face value, policy type and current cash surrender value was also requested. The information was due to the Department no later than September 12, 2006.

The petitioner reported gross income from Social Security of $1,504 and pension from [redacted] $264.81 totaling $1,768.81. Based on the income reported, the Department determined the appropriate asset limit for ICP benefits to be $2,000.

The Department received checking statements from Bank of America showing a countable balance as of July 25, 2006 of zero (Respondent's Composite Exhibit 1), and saving statements showing a balance $1,040 in July 2006. The face value of John Hancock life insurance was $1,000 and the cash surrender value was $2,554.45 as of September 20, 2006. The face value of Modern Woodman of America insurance policy was $3,000 and the cash surrender value was $3,583.06. As the total face value of life insurance policies exceeded $2,500, the Department considered the cash surrender value in the asset determination. The Department allowed a $2,500 burial exclusion and considered the remaining cash value as a countable resource. The total cash value of $6137.51 less the $2,500 burial exclusion deduction amounted to countable cash value of $3,637.51. The total asset value of savings $1,040, and countable cash value after application of the burial exclusion of $3,637.51 exceeded the allowable asset limit of $2,000. On October 31, 2006, the Department sent a notice advising the petitioner and her authorized representative that her application for ICP benefits had been denied because asset value exceeded program eligibility limits. The petitioner did not request a hearing within 90 days of the Notice of Case Action.

On November 30, 2006, the petitioner filed an application for ICP benefits. The retroactive months from the date of the application would be August through October

2006. The petitioner continued to have the savings and checking accounts with Bank of America and the life insurance policies with Hancock Life Insurance and Modern Woodman of America. As the petitioner still retained the life insurance policies and, based on the countable cash surrender value of the life insurance of $3,637.51, the Department determined the petitioner continued to be ineligible due to assets in excess of allowable program limits. The Department notified the petitioner, via a Notice of Case Action dated January 10, 2007, that her application for ICP benefits was denied.

CONCLUSIONS OF LAW

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

> Time Limits in Which to Request a Hearing. (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
>
> (a) The date on the written notification of the decision on an application.
>
> (b) The date on the written notification of reduction or termination of program benefits.
>
> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

The Findings of Fact show that the petitioner applied for ICP benefits on June 30, 2006 and again on November 30, 2006. The Findings also show that the Department denied the petitioner's ICP benefits on October 31, 2006 and again on January 10, 2007 because resources exceeded program eligibility limits. The petitioner requested a

hearing on February 26, 2007. According to the above authorities, an individual must request a hearing within 90 days of the date of the written notification of the decision. In this case, written notification of the decision on the application dated June 30, 2006 was mailed to the petitioner on October 31, 2006. On February 26, 2007, the petitioner requested a hearing as she disagreed with the decision. This request was not filed within 90 days of the written notification as required by the above rule. Because the hearing request was not timely filed, the hearing officer has no jurisdiction over the matter. Therefore, the correctness of the denial of the application for ICP for the months of June and July 2006 cannot be addressed. The hearing officer can only address the correctness of the application dated November 30, 2006 which includes the three month retroactive period of August through October 2006.

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.

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

Florida Administrative 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-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant part:

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

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

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

Fla. Admin. Code 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in part:

> (2)(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is $2,500 or less. (d) The individual, and their spouse, may designate up to $2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 is not reduced by the value of excluded life insurance policies or

irrevocable burial contracts. The funds may be commingled in the retroactive period.

The Findings of Fact show that the petitioner had a checking and saving account at the Bank of America. The Findings of Fact also show that the petitioner had two life insurance policies with a face value of $1,000 and $3,000. The total countable cash surrender value, after application of the burial exclusion policy was $3637.51. The combined balances in the bank accounts and the countable cash value of the life insurance policies from August through December 2006 and January 2007 exceeded the asset limit of $2,000 for the ICP Program. According to the above authorities, 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 resources exceeded the applicable limit for the months at issue, therefore, the Hearing Officer concludes that the petitioner was not eligible and the Department correctly denied her ICP benefits from at least October through December 2006 and January 2007.

DECISION

The appeal is denied. The Department's action for August through December 2006 and January 2007 is affirmed. The appeal on the correctness of the Department's action for the months of June through July 2006 is dismissed as non-jurisdictional.

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 3rd day of May, 2007,

in Tallahassee, Florida.

Linda Garton

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

Copies Furnished To
1

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

APPEAL NO. 07F-00776

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 6, 2007, at 10:08 a.m. in Lake Wales, Florida. The petitioner was present. He was represented by his parents, [redacted] and [redacted] The Agency was represented by Dena Gay, R.N. specialist. Present as witnesses for the Agency telephonically were Dr. Silva-Neto, M.D., and Theresa Ashey, review operations supervisor with KePRO. Present as an observer was Maria Diaz, R.N. specialist.

ISSUE

At issue is the February 2, 2007 action by the Agency reducing the petitioner's hours of private duty nursing hours from an average of 16 to 12 hours daily. The burden of proof is with the Department.

FINDINGS OF FACT

The petitioner is a Medicaid recipient who has been receiving private duty nursing (PDN) services. Keystone Peer Review Organization (KePRO South) is the Peer Review Organization contracted by the Agency for Health Care Administration to perform medical review for the Private Duty Nursing and Personal Care Prior Authorization Program for Medicaid beneficiaries in the State of Florida. They review to determine "medical necessity" under the terms of the Florida Medicaid Program. On January 17, 2007, the petitioner filed a request for Medicaid to pay for 16 hours of PDN services daily for the period of January 23, 2007 through March 23, 2007. On January 29, 2007, the Agency denied this request for PDN services.

The petitioner is 15 years old. He has been diagnosed with: congenital quadriplegia, scoliosis associated with other conditions, unspecified lack of normal physiological development, cerebral palsy, neuromuscular scoliosis, broncho pulmonary dysplasia, GERD, gastric dismotility, convulsions, aut ism, chronic otitis media, urinary retention, severe developmental delay, and PICA. The petitioner requires skilled observation and assessment, medication administration, tube feeding/care, catheter care, and continuous adjustment of his Clonidine. The petitioner is continuously fed even in the night hours. The petitioner attends a school for special needs children during the day.

The mother is 50 years old and employed full time outside of the home. She has a seizure disorder. His father is 51 years old and works 20 hours per

week. He has a heart condition. The father is physically better able to care for the petitioner due to his size.

On February 1, 2007, the petitioner submitted additional information to the Agency and filed a request for a reconsideration of the denial. The reconsideration request and information was forwarded to a second physician consultant who did not having any knowledge of the initial denial. That physician wrote on February 1, 2007, "I suggest we rescind any suggestion that we are fully denying all hours. Evening PDN service cover to monitor continuous feeds and reposition patient, suction etc, and coverage after school before parent come home from work is reasonable. However, I also suggest it is reasonable to request that parents provide at least three hours(3) each evening, (7pm-10pm) M-F of independent care for their child, and an additional six(6) hours on Sat and Sunday, since they are capable of providing care from 6am-3pm on these days as well. Provider has stated that both parents have medical conditions, the extent of these conditions is not known... I believe the proposal for parent participation is a reasonable one."

The parents have problems obtaining nurses who will work 3 p.m. to 7 p.m. The parents are willing to help with the petitioner's care 7 p.m. to 10 p.m., but in reality they are caring for him longer hours due to the problem in fully staffing nurses. The petitioner stipulates that they could apply for another service through the Home and Community-Based Services Waiver. Each of the parents has their own health problems in addition to the strain of caring for the petitioner as they age.

CONCLUSIONS OF LAW

The Florida Administrative Code 59G-1.010(166) states in relevant part:

"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.

The Florida Administrative Code at 59G-4.290(2)(f) discusses Skilled Services and states in relevant 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; and
6. Consistent with the nature and severity of the individual's condition or the disease state or stage.

The Home Health Services Coverages and Limitations Handbook states in relevant part on pages 2-15 and 2-16:

Private Duty Nursing Services
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 reimburses private duty nursing services for recipients under the age of 21 who:
- Have complex medical problems; and
- Require more individual care than can be provided through a home health nurse visit.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically complex.
Private Duty Nursing Requirements
Private duty nursing services must be:
- Ordered by the attending physician;
- Documented as medically necessary;
- Provided by a registered nurse or a licensed practical nurse;
- Consistent with the physician approved plan of care; and
- Authorized by the Medicaid service authorization nurse.

Parental Responsibility
Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render.
Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver. Medicaid does not reimburse private duty nursing for respite care. Examples are parent or caregiver recreation, socialization, and volunteer activities.

The Findings of Fact show that the petitioner is medically very complex. Therefore, the prior authorization contracted authority (KePRO) approved hours of private duty nursing to supplement the hours he spends in school. They specifically authorized 13 hours per day during the week and 10 hours per day during the weekend. KePRO determined that the parents could provide three hours of care daily.

The parents argue that they are frequently unable to staff some of the hours. KePRO argued that the difficulty in obtaining nursing coverage is not a consideration in determining the number of private duty nursing hours that can be established as "medically necessary". The hearing officer concludes that KePRO correctly determined that private duty nursing hours at the rate stated above using the guidelines established under "medical necessity." Hopefully, the parents can obtain additional resources through the Home and Community-Based Services Waiver Program to supplement the hours.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Terry Oberhausen
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,

APPEAL NO. 06F-08235

Vs.
AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
DISTRICT: 13 Lake
RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Tavares, Florida on April 17, 2007 at 2:50 p.m. The petitioner was present. During the hearing, the petitioner was represented by Mizell Campbell, Esquire, and (by telephone) Dana Baird, Esquire, both with the Advocacy Center. Court reporter was Lisa Kalkbrenner. The respondent was represented by Tracie L. Wilks, Esquire. Notary public for the respondent (by telephone) was Brenda Baker, executive administrative assistant. The petitioner's witnesses were her mother, [redacted] and licensed practical nurse, [redacted] Present as a witness for the respondent was Joanne Dohn, registered nurse specialist consultant. The respondent's witnesses appearing by telephone were: Marilyn Schlott, field office manager; Robert A. Buzzeo, board-certified pediatrician and medical director for private duty nursing/paraprofessional care of KePRO; George Smith and Theresa Ashey, review operation supervisors of KePRO. In lieu of live testimony, depositions of

attending doctors Maria Mena, M.D. and Ronald Davis, M.D. were Petitioner's Exhibits 3 and 5, respectively.

ISSUE

At issue was whether or not AHCA action to reduce private duty nursing services from 10 hours to 0 hours daily was correct. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner had been authorized for 10 hours a day of private duty nursing services under Medicaid. Nursing services were in place for several years. During the new KePRO review and reconsiderations, daily nursing hours were reduced from 10 to 0, for certification period January 3, 2007 to March 3, 2007. The respondent concluded that medical necessity standards were not met.

2. The petitioner resides in her home with her mother and the mother's two year old nephew. The petitioner is 15 years of age and has profound impairments. These impairments include reduction deformity of the brain, asthma, respiratory allergies, skin rashes, seizures, scoliosis, developmental delay, and microcephalus. She has contractures and involuntary movements. Menses have begun. She is incontinent. She cannot walk, talk, feed herself or attend to any activity of daily living on her own. Vision is impaired. Hygiene is a serious concern. Assistive devices include wheelchair, special car, lift system, suction machine, airway clearance breathing vest, and shower chair. She cannot be left alone at any time. This is undisputed.

3. In addition to the vest twice a day, thirty-two medications and vitamins are used (not all every day), with at least twenty requiring evaluation before administration. Except for topical, nasal and rectal applications, all are given as liquid or crushed tablets

and aspiration is a constant concern. Skin creams and ointments are taken, along with anti-seizure, congestion relief, pain relief and constipation drugs. Keppra was added at year's end for seizure control and there was some reduction in activity, although the situation deteriorated. Seizure activity logs were kept between late December and early January. Keppra was discontinued before date of hearing and the mother hopes the petitioner will resume participation in a different medication study group. The petitioner has brief and subtle seizures as well as some that are longer and more notable. Seizures were documented through the years and treatment options are evaluated during events. As an example, medical orders show that Diastat (rectal) is given for some seizure activity and dosages change depending upon recurrence status. Contacts with physicians' offices occur on occasion following evaluation by mother or nurse. Treatments are modified. Botox injections are used to ease contractures.

4. The petitioner does not receive tube feeding and has no tracheostomy. The petitioner gained more than ten pounds in the three months prior to the certification review. This was considered fat rather than muscle and adversely affected her abilities. Consistency of her food must be evaluated, monitored and altered to prevent aspiration. If aspiration occurs, treatment follows.

5. In addition to medical appointments, the petitioner attends at least two therapy treatments weekly. She lives in Eustis and many appointments are in the Orlando area. One of her doctors is in Tavares. Doctors include eye specialist, neurologist, gastroenterologist, and pediatrician specializing in pulmonary disorders.

6. The petitioner's mother has serious health problems including degenerative disc disease. She receives medical treatment. The mother cannot take the petitioner

with her when the mother attends her own medical appointments. Also, when the mother is driving the car with the petitioner in the car, the mother cannot attend to needs of the petitioner. This is a critical concern on a weekly basis as seizures occur often and the petitioner needs special attention during seizures. The mother is not always able to pull off the road to address these situations. Particularly at these times, to achieve proper care while the mother drives, the petitioner uses the nursing services. Medical appointments are scheduled upon availability of nursing service, so that the nurse will be in the car attending to the petitioner while the mother drives. Additionally, the mother needs to shop, pick up medications and attend to basic household activities.

7. The nurse and the mother feed the petitioner, clean her, medicate her, move her and evaluate her continuously throughout each day. Treatment is modified based upon their ongoing observations. The petitioner's mother cannot lift her but she uses the lift system and other appliances. She can care for the petitioner in all regards, except when she is not present or her attention is focused elsewhere, such as driving. She is not asserting inability to care for the petitioner. The nursing services that were received were received in daytime hours. This pattern of alternating care was evident during the hearing. When one testified, the other stayed with the petitioner and attended her needs.

8. The petitioner's pediatrician of "many years" informed AHCA with letter of November 14, 2006 that she strongly disagreed and was "stunned" by possibility that nursing care would be removed, even if a certified nursing assistant were authorized. The doctor said "unfortunately for ... medical needs she will definitely require a nurse...many medications that are PRN...nebulizer treatments and medications, also

PRN...tongue thrusting and swallowing problems...always the risk for aspiration." She invited further contact to address concerns. In deposition, that doctor suggested the petitioner needed "at least...5 or 6 hours" of nursing services daily. She noted a capable caregiver (mother) would be exhausted without at least that amount of nursing. She noted that less professional care would increase risk of choking, aspiration and incorrect medication dosages.

9. The neurologist said on November 16, 2006 "please allow an LPN to continue to care for ... 8 hours a day for 6 days a week in order to assess her, monitor her during seizures and give Diastat." He invited further questions and informed he would provide additional information upon request. His letter of December 22, 2006 requested "12 hours a day/6 days a week" of LPN care and "close monitoring" for the same reasons. He said the petitioner "continues to have breakthrough seizure episodes in which Diastat, Klonopin, and boluses of Phenobarbital are required to stop the seizures...must be assessed continuously..." Petitioner's Exhibit 5 included medical records, seizure logs, lab and test results. It showed many medication changes along with frequent professional contacts.

10. The respondent's summary statement of January 3, 2007 informs "we are not denying assistance...does require assistance...that could easily be provided by a HHA (home health aide) or CNA (certified nursing assistant)." The KePRO doctor opined that "intermittent" nursing service of up to "2 hours" at a time could supplement such care.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Families and Children, the Agency for Health Care Administration has

conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Florida Statute, Chapter 120.80.

Florida Statute 409.905 addresses **Mandatory Medicaid services** with section (4) informing that *HOME HEALTH CARE SERVICES* can be covered. Under subsection (b) the following information is relevant:

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

Thus, it is concluded that the agency needed to review need for nursing service.

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

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

> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider. ...
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Additionally relevant is Fla. Admin. Code 59G-4.130 stating:

> **Home Health Services.**
> (1) This rule applies to all home health agencies licensed under Chapter 400, Part IV, F.S., and certified by the Agency for Health Care Administration for participation in the Medicaid program for home health care.
> (2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.
> (3) When terminating, reducing, or denying private duty nursing or personal care services, Medicaid will provide written notification to the recipient or the recipient's legal guardian. The notice will provide information and instructions regarding the recipient's right to request a hearing.

The Home Health Services Coverage and Limitations Handbook (page 2-2) defines **Medically Necessary** standards saying: "Medicaid reimburses services that are medically necessary for the treatment of a specific documented medical disorder, disease or impairment, do not duplicate another provider's service..." In the case at hand, the new review eliminated **all** private duty nursing hours for the new certification period, based upon absence of medical necessity.

Burden of proof is on the respondent, in accord with Fla. Admin. Code 65-2.060(1). The petitioner's attending physicians, who have treated her for years and who gave credible as well as supported information, strongly declare need for nursing services at least five hours daily for at least six days a week. Their information was

useful, should be considered, and in this instance it was compellingly supported by substantive evidence. Consistent testimony and evidence established that the petitioner requires monitoring and treatment modification during feeding, seizures and at other times throughout the day in order to sustain life, prevent further illness or disability and alleviate pain. Skilled and sensitive evaluations occur frequently throughout the days. Treatment and care are modified based upon evaluation. Medications are given (and changed) based upon continuing evaluations and professional intervention.

After careful review, it is concluded that the respondent has not meet its burden of proof to show that zero hours of private duty nursing is medically necessary. The evidence clearly supported the contrary that some private duty nursing hours are medically necessary. Thus, it is concluded that authorization to reduce was not appropriate.

DECISION

The appeal is granted and reduction in private duty nursing hours is not upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 29th day of May, 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 To:

[redacted]

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

APPEAL NO. 07F-00953

PETITIONER,

Vs.

CASE NO. 1252509979

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 9, 2007, at 11:35 a.m., in Lakeland, Florida. The petitioner was not present. He was represented by his Medicaid representative, [redacted] The Department was represented by Gail Crews, economic self-sufficiency supervisor.

The Department was allowed 10 days to return further evidence. Evidence was received from the Department on March 9, 2007. It was accepted as Department Composite Exhibit 2.

ISSUE

At issue is the January 17, 2007 action by the Department approving the petitioner for benefits through the Institutional Care Program setting his patient responsibility as $1,094.85 effective January 2007.

FINDINGS OF FACT

On November 16, 2006, the petitioner filed a Request for Assistance to apply for benefits through the Institutional Care Program. He resided in a nursing facility. His spouse residing in the community is referred to as the "community spouse." On January 17, 2007, the Department approved the petitioner for Institutional Care Program benefits retroactive to August 2006. The spouse receives a monthly diversion of her spouse's income.

At the approval on January 17, 2007, the Department established the petitioner's patient responsibility as $1,094.60 monthly. The spouse was allowed a monthly diversion of $701.82 from her spouse's income. The issue under appeal is the amount of the community spouse's diversion and therefore, the amount of the petitioner's patient responsibility to the nursing facility.

The petitioner had gross monthly income of $2055.92 from his social security benefit and a pension. His spouse has gross monthly income of $948.18 from a pension, and her social security benefit. The community spouse has shelter expenses of $171.88. She was allowed a standard utility allowance of $198.

To determine if the community spouse was eligible for an income diversion from her spouse, the department considered her income and allowable expenses. Her shelter/utility expense totaled $369.88. The department compared this expense to 30% of the Minimum Monthly Maintenance Income Allowance (MMMIA) or $495. Since the petitioner's expenses did not exceed this amount, she was not entitled to an excess

shelter expense. The petitioner has gross monthly income of $948.18. The MMMIA is $1650. The Department subtracted the spouse's gross income from the MMMIA resulting in a community spouse income allowance (diversion from her spouse) of $701.82.

The department considered the petitioner's gross monthly income as $2055.92. They subtracted a personal need allowance of $35 and the community spouse diversion amount of $701.82 resulting in a patient responsibility of $1094.85. This is the amount that the petitioner must pay the nursing facility each month from his funds.

The petitioner lists her monthly expenses as the following:

Water	70.00
Electricity	117.00
Phone	40.00
Cell phone	43.16
Cable	51.19
Drug plan	23.50
House insurance	62.27
Life insurance	4.00
Gas	100.00
Food	525.00
Food Mr. Dawson	40.00
Yard	83.00
Yard spray	47.00
Medicare Supplemental	200.50
LTC Insurance	82.40
Car insurance	107.00
House and land taxes	100.00
Clothing	50.00
Co-pay for Elderly Services	49.00
Total	$1,795.02

In addition to the monthly expenses listed above, the petitioner has experienced some high car repair bills. She owns a 1999 Lincoln Town car. In January 2007, she incurred $1,728.04 in car repairs. She incurred $964.81 in car expenses in February 2007. Both of these bills have been paid.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in part:

> (4) Spousal Impoverishment. The department follows 42 U.S.C. § l396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse...(1) Either spouse may appeal the amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist.

Fla. Admin. Code 65A-1.714, SSI-Related Medicaid Post-Eligibility Treatment of Income, states in part:

> (e) The department applies the formula and policies in 42 U.S.C. §1396r-5 to compute the community spouse income allowance after the institutionalized individual is determined eligible for institutional care benefits. The standards used are in paragraph 65A-I.7I6(5)(c), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses."

Florida Administrative Code 65A-1.716, Income and Resource Criteria, states in part:

> (c) Spousal Impoverishment Standards.

1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. § l396r-5.
2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMIA *x* 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.

The Department's Integrated Manual 165-22, Appendix A-9 lists the current Eligibility Standards for SSI-Related Programs, 100% FPL for a couple effective July 2006 as $1,100. These standards change effective July 1 of each year in accordance with federal law found in Section 1924(d) of the Social Security Act.

The Department's Integrated Manual 165-22, Appendix A-3.1 lists the current food stamp standard utility allowance at $198.

The State Medicaid Manual, Part 03, Eligibility, Section 3700, states in part:

Subsequent to determining Medicaid eligibility for persons living in medical and remedial care institutions...determine how much such persons contribute to the cost of their institutional care and/or waiver services. This latter calculation is referred to as the post-eligibility process. This chapter sets forth requirements for the post-eligibility process for institutional persons...3700.1 Background – Section 1902(a)(17) of the Act is the general authority for the post-eligibility process. However, other provisions have been added to refine and clarify the rules governing this process...3701 GENERAL STATEMENT OF POST-ELIGIBILITY PROCESS. Reduce Medicaid payments to medical and remedial care institutions...by the amount remaining after specified deductions are made from the income of ***institutional persons***...Income remaining after these deductions are applied is the amount persons are liable to pay for

institutional and/or waiver services...3701.3 Determination of Amounts of Medical Expenses.—In determining the amounts of the individual's liability for the costs of institutional care, certain required and optional amounts for medical or remedial expenses are deducted from the ***individual's*** income...Determine the amounts of the medical or remedial expenses to be deducted from total income...3703.4 Maintenance Needs Of A Spouse At Home – For an individual with only a spouse at home, deduct from the individual's total income an amount for the maintenance needs of the spouse. Base this amount on a reasonable assessment of the needs of the spouse, which includes consideration of the spouse's income and resources. The amount deducted for the needs of the spouse must be reduced dollar for dollar for each dollar of the noninstitutionalized spouse's own income...3703.8 Expenses for Health Care: Deduct from the ***individual's*** total income amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including: Medicare and other health insurance premiums, deductibles, or coinsurance charges; and Necessary medical or remedial care recognized under State law but not covered under the State plan, subject to reasonable limits the agency may establish on amounts of these expenses. 3710.1 Definitions...Exceptional Circumstances Resulting in Extreme Financial Duress. Pending publication of regulations, a reasonable definition is: Circumstances other than those taken into account in establishing maintenance standards for spouses. An example is incurment by community spouses for expense for medical, remedial and other support services which contribute to the ability of such spouses to maintain themselves in the community and in amounts that they could not be expected to pay for amounts already recognized for maintenance and/or amounts held in resources...3712 MANDATORY DEDUCTIONS FROM INCOME Deduct from the total income of an institutionalized spouse the following amounts:...subject to reasonable limits you impose consistent with §3701.3, incurred medical and remedial care expenses recognized under State law, not covered under the plan, and not subject to payment by a third party...3713 MONTHLY INCOME ALLOWANCES FOR COMMUNITY SPOUSES AND OTHER FAMILY MEMBERS A. Spousal Monthly Income Allowance. Unless a spousal support order requires support in a greater amount, or a hearings officer has determined that a greater amount is needed because of exceptional circumstances resulting in extreme financial duress, deduct from community spouses gross monthly income which is otherwise available the following amounts up to the maximum amount allowed:

- A standard maintenance amount.

- Excess shelter allowances for couples' principal residences when the following expenses exceed 30% of the standard maintenance amount. Except as noted below, excess shelter is calculated on actual expenses for—
  - rent
  - mortgage (including interest and principal);
  - taxes and insurance;
  - any maintenance charge for a condominium or cooperative; and
  - an amount for utilities, provided they are not part of the maintenance charge computed above. Utility expenses are calculated by using the standard deduction under the Food Stamp program that is appropriate to a couple's particular circumstance...When there is a deficit remaining after a community spouse's gross income is compared to the total standard computed above, the remaining deficit is the amount of the community spousal income allowance. When there is no deficit, there is no monthly spousal income allowance... 3714.2 Hearings and Appeals. Hearings and appeals must conform to 42 CFR §431 Subpart E. When spousal maintenance allowances are based on amounts determined necessary by hearings officers to avoid extreme financial duress, you may: have hearing officers grant greater amounts conditioned on the existence of exceptional circumstances determined to be the cause of extreme financial duress...When hearings officers condition additional allowances based on the existence of the exceptional circumstances, it is your responsibility to monitor cases to assure that the exceptional circumstances continue to exist and that you make necessary adjustments in maintenance allowances when the special conditions no longer exist."

The department's budgeting methodology, as outlined in the Findings of Facts correctly reflects the budgeting methodology set forth in the above authorities in calculating a possible spousal income diversion allowance. However, Florida Administrative Code permits possible adjustment to this methodology and the resulting spousal diversion amount, if proof is presented of exceptional circumstances that result in financial duress.

The petitioner argued that she has additional expenses due to her husband's condition and her community expenses, causing financial duress. An exceptional circumstance resulting in extreme financial duress is defined in the State Medicaid Manual as a circumstance other than one already considered in establishing the spousal income diversion amount and in amounts that the spouse could not be expected to pay from amounts already recognized for maintenance needs or from amounts held in resources.

The rule sets the State's Minimum Monthly Maintenance Income Allowance for the Institutional Care Program at 150 percent of the federal poverty level for a family of two or $1650. Therefore, it is inherent in this concept that the intent of the spousal diversion under the Institutional Care Program is to address a community spouse's **basic** needs of food, shelter and medical costs. Expenses **other than the basic needs**, would be beyond the scope of the intent of the MMMIA under the Institutional Care Program and, thus, would not be appropriate in determining such basic needs.

Consistent with the above interpretative conclusion on the definition of basic needs, the community spouse would be allowed all of the expenses listed in the Findings of Fact with the exception of cable ($51.19), the charges for the cell phone ($43.16), the food for her spouse ($40), the payment for life insurance ($4). The community spouse may only receive benefits of an expense for insurance when it is for health or dental. Life insurance and other such policies are considered beyond the scope of basic needs.

The Unites States Department of Agriculture, Food and Nutrition Services defines a one person "Thrifty Food Plan" to be $155. Therefore the community spouse's listed $525 monthly expense for food expenses cannot be considered reasonable. The standard food stamp benefit level of $155 for one person was allowed.

The list of expenses allowed using the above methodology is as follows:

Water	70.00
Electricity	117.00
Phone	40.00
Cable	51.19
Drug plan	23.50
House insurance	62.27
Life insurance	4.00
Gas	100.00
Food	155.00
Yard	83.00
Yard spray	47.00
Medicare Supplemental	200.50
LTC Insurance	82.40
Car insurance	107.00
House and land taxes	100.00
Clothing	50.00
Co-pay for Elderly Services	49.00
Total	1341.86

The petitioner reports car repairs that are infrequent, unpredictable, and non recurring. They cannot be considered in a monthly basic need computation. Ms. [redacted] monthly income is established as $948.18. Her allowable monthly expenses of $1,341.86 minus her monthly income of $948.18 equals $393.68. This amount could be diverted monthly from Mr. [redacted] income to Ms. [redacted] using the above methodology. The methodology used by the Department provided Ms. [redacted] with

$701.82 monthly from Mr[redacted] income. As that amount is larger, it is more beneficial for the petitioner to use the Department's standard computation.

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 15th day of May, 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: