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

APPEAL NO. 07F-04789

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 07 Brevard
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on September 25, 2007, at 9:45 a.m., in Cocoa, Florida. The petitioner was not present. His mother, represented him. stepfather, was also present on behalf of the petitioner. Lisa Sanchez, human services program specialist, Area 7 Medicaid, was present representing the Agency for Health Care Administration (AHCA). Mary Wheeler, review operations manager and Dr. Robert Buzzeo, medical director, both from KePRO, appeared by telephone as witnesses for the agency.

ISSUE

At issue is the respondent's decision of July 27, 2007 to deny private duty nursing services paid by Medicaid for the period of July 6, 2007 to September 3, 2007. Prior to the action under appeal, the petitioner was receiving 208 hours. The agency holds the burden.

FINDINGS OF FACT

1. The petitioner is four years old. He weighs 34 pounds. He lives with his mother, stepfather, and seven-month-old brother. His mother presented Exhibits 1 through 3, which are her accounts of his doctor visits, hospitalizations, medical conditions, and medicines, including the dosage and time of each; these are not medical records. She reports that the petitioner is a medically complex child whose conditions include cerebral palsy, severe developmental delay and dystonia. He has no head control, or the ability to speak or communicate. He has been diagnosed with hypophosphetmic rickets with severe osteopenia and continual fractures. At the time of the hearing, he was in a spica cast because of broken bones. He has Lennox Gestaut Syndrome, which results in sleeplessness and hyperactivity at night. His mother attests that he is awake 21 hours per day. He is fed by gastronomy tube (g tube) and receives his medications by g tube. He is fed six times per day, and receives medications ten times a day. Between July 1, 2007 and September 25, 2007, he was hospitalized six times for fractures, fever, seizures, dehydration, vomiting, diarrhea, or EEG study and video monitoring. He had nine doctors' appointments during the same period.

2. The petitioner has been receiving private duty nursing (PDN) services under Medicaid. A request for 208 hours of PDN services was submitted by the provider,

Pediatric Services of America (PSA), for the period of July 6, 2007 through September 3, 2007.

3. Prior to the action under appeal, the petitioner was receiving PDN services. His mother was on leave from her job at the time of the hearing, but normally works three days a week, eight hours per day. She has been fired from two jobs because of complications from her son's health. His stepfather works three nights a week on Wednesday, Friday, and Saturday, from 2 p.m. to 4:00 a.m., or 2 p.m. to 4:30 a.m., or 4 p.m. to 4 a.m., in addition to a daily job. The requested hours of PDN are for the times when the petitioner's stepfather is at work in the evening.

4. Requests for PDN are reviewed with a contract provider who completes a prior authorization review for the requested service. The contract provider is KePRO. The request for services is submitted by the home health agency. All communication is sent between the provider and KePRO. KePRO reviews the written request for services to determine if the number of hours requested are medically necessary. If additional information is needed, KePRO contacts the provider. In this case, additional information was requested and received.

5. The Respondent's Composite Exhibit 3 contains all of the information KePRO used in making a determination of medical necessity. On July 3, 2007, KePRO received a request for 208 hours of PDN. The original request was for 400 hours, but later clarified as 208 hours based on the request for eight hours per day on Wednesdays, Fridays, and Saturdays. The initial information received by KePRO from the provider listed the petitioner's diagnosis as "abnormal central nervous system function study and failure to thrive". The medications listed are Tylenol, diaper cream,

Lactolose, Keppra, and Triptal. His functional limitations listed are bowel and bladder incontinence, endurance, ambulation, and speech. The report showed no respiratory problems, no pain, no recent hospitalizations, and his mother was able to assist with his care.

6. Additional information was submitted following a request for information that showed the petitioner also had GERD, feeding difficulties, developmental delays, and reactive airway disease. Additional medications were also reported. On July 24, 2007, a physician consultant reviewer recommended denial of the requested hours of PDN, citing "A HHA [Home Health Aide] could assist Mom when Dad not in home".

7. A Reconsideration request was submitted by PSA and reviewed by a KePRO Physician Consultant Board-Certified in Pediatrics. The provider noted that the petitioner's medical doctor ordered nursing while his stepfather is at work because his mother is the only caregiver in the home then to administer g tube feedings and medications while caring for her other son. The original denial was upheld.

8. Dr. Buzzeo, the medical director at KPRO, believed that the request for PDN that the petitioner could benefit from a HHA, not PDN. He referred to the information submitted by the provider as the basis for the denial. Dr. Buzzeo believed that the petitioner was in a spica cast because of surgery to the hips, that the petitioner's mother was not able to move him because of the cast, and that a HHA would suffice in moving him. The original submission by the provider did not contain information about his severe seizure disorder or recent hospitalizations. Dr. Buzzeo urged the petitioner's mother to contact the provider to submit another request for PDN and he would take a different approach after hearing her testimony.

9. The petitioner's mother does not agree with the decision by KePRO. She believes she did all that she could do through her provider, and believed that her son's medical records were faxed to PSA while he was in the hospital, and that KePRO should have had all of the information when considering the request for PDN.

CONCLUSIONS OF LAW

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

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

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

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

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program,** with (1)(d) describing "medical necessity or medically necessary" standards and says in relevant part: "...For purposes of determining Medicaid reimbursement, the

agency is the final arbiter of medical necessity..." Consistent with statute, Fla. Admin. Code 59.G-1.010, **Definitions**, states for medical necessity:

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

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

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

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

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

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

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

Florida Admin. Code 65-2.056 Basis of Hearings.

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

The agency denied or terminated PDN services based on information submitted by the provider in a prior authorization request for services. At the hearing, the petitoner's mother introduced medical conditions, hospitalization information, and other pertinent information not known to the contracted agency when determining medical necessity. Based on the above cited rule concerning de novo hearings, relevant new evidence can be considered. In the absence of medical documentation from the petitioner's treating physician, the undersigned is not able to make a determination of medical necessity. As such, the agency's denial action is reversed and remanded to the agency to consider the additional evidence in determining medical necessity for

PDN for the petitioner for the time period under appeal. A new notice is to be issued once the determination is made, to include appeal rights.

DECISION

The appeal is granted for the reasons stated above.

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 9 day of November, 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: Petitioner
Judy Jacobs, Area 7 Medicaid Adm.

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

APPEAL NO. 07F-05251

PETITIONER,

Vs.

CASE NO. 1263193005

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 15 Indian River
UNIT: 88500

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on October 11, 2007, at 1:10 p.m., in Vero Beach, Florida. The petitioner was not present. His sister, [illegible] represented him. [illegible] LPN, unit manager, and [illegible]a, business office manager, both of Health and Rehab, were present on behalf of the petitioner. Erika Delgado, economic specialist supervisor, represented the Department.

The record was left open until close of business on October 22, 2007, in order to receive additional evidence. It was received timely and entered into evidence as the Petitioner's Exhibit 4. The record was then closed.

ISSUE

The petitioner is appealing the Department's action to deny Medicaid benefits through the Department's Institutional Care Program (ICP) on the basis that he did not meet the disability criteria. The petitioner holds the burden.

FINDINGS OF FACT

1. The petitioner is 43 years old. His date of birth is An application for ICP Medicaid was submitted to the Department on his behalf on July 19, 2007. As part of the eligibility determination process, the petitioner, among other factors, must be determined to be disabled.

2. Following a hospital admission on May 23, 2007 for multiple medical issues, the petitioner was discharged to Health and Rehab on June 8, 2007. His diagnoses include a history of alcohol abuse, withdrawal, hypokalemia, hyponatremia, peptic ulcer disease, cellulitis of the left upper extremity, and history of alcohol related seizures. He suffers from diabetes, hypertension, and anemia. He had pseudomembraneous colitis. While he was in the hospital, he developed tachycardia and tachypnea, was intubated and started on mechanical ventilation (Petitioner's Exhibit 4). His sister explains that he had a chemical brain injury due to infection. He responded to medical treatment to resolve many of his abnormal lab test results and infections.

3. When he was admitted to , he could not perform any of his activities of daily living (ADL). While a resident in the nursing facility, he received four weeks of extensive physical, occupational, and speech therapy. He was discharged from the nursing facility on August 3, 2007 to his brother's house. The petitioner's physical

therapy discharge summary shows that he made excellent progress towards independent level of function in all aspects of mobility. The occupational therapy discharge summary shows he achieved independence in all areas but still needed some grip strengthening and restorative nursing. The speech language pathology discharge summary shows that he completed all tasks adequately. Upon his admission, he scored a rating of 75-90 in auditory comprehension, expressive language, orientation, level or arousal/alertness, and articulation/speech production. At discharge, he scored 100 in each category (Petitioner's Exhibit 4). He is walking now and able to communicate, but does not have full use of his left arm as he is not able to totally extend it.

4. As the petitioner was not 65 years old, he required a disability determination. The Department requested that the District Medical Review team (DMRT) evaluate the medical status of the petitioner. On August 20, 2007, the DMRT physician found no disability with an N34 code, which means, "Impairment was not disabling for 12 full months" (Respondent's Exhibit's 1 & 2).

5. The Department explains that the petitioner would have to meet a medical level of care and be determined disabled to be eligible for ICP benefits. The Comprehensive Assessment and Review for Long Term Care Services (CARES) unit determined the petitioner met the level of care required for a stay at the nursing facility for his entire stay (Petitioner's Exhibit 2). Without a determination of disability, the Department could not allow the ICP benefits. Notice was sent on August 24, 2007, informing the petitioner of the denial of his application (Respondent's Exhibit 4).

6. The petitioner applied for Social Security benefits in July 2007. His application was still pending a decision at the time of the hearing.

7. The petitioner is seeking ICP benefits to pay for his stay at _____. His representative inquired about Medicaid to pay for his hospital stay also. The Department explains that his application did not indicate a request for Community Medicaid, but he would still have to meet the disability requirement.

8. The petitioner has an 11th grade education. He has not worked since May 2007. His past relevant work is that of a heavy equipment operator.

CONCLUSIONS OF LAW

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

> The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy...

Fla. Admin. Code 65A-1.711 **SSI-Related Medicaid Non-Financial Eligibility Criteria** states in part:

> To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F....
>
> (2) For ICP benefits, an individual must be:

(a) Living in a licensed nursing facility, or confined to a hospital swing bed or to a hospital-based skilled nursing facility bed, or in an ICF/DD facility that is certified as a Medicaid provider and provides the level of care that the client needs as determined by the department; or living in a Florida state mental hospital and be age 65 or over; and

(b) Determined to be in medical need of institutional care services according to Rules 59G-4.180 and 59G-4.290, F.A.C., for nursing facility, hospital swing bed placements and placements in a hospital-based skilled nursing facility bed according to Chapter 65B-38, F.A.C., for ICF/DD facilities or according to Rule 59G-4.165, F.A.C., for state mental hospitals.

The Department's Fla. Integrated Pub. Policy Manual states in part:

1440.1204 **Blindness/Disability Determinations (MSSI, SFP)**

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs...

The District Medical Review Team (DMRT) handles all other necessary disability determinations (including ICP, OSS, HCBS, and PACE).

20 C.F.R. §416.909, **How long the impairment must last**, states in part:

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

20 C.F.R. §416.920, Evaluation of disability of adults, in general, states in part:

(a) *Steps in evaluating disability.* We consider all evidence in your case record when we make a determination or decision whether you are disabled...Your impairment(s) must be severe and meet the duration requirement before we can find you to be disabled. We follow a set order to determine whether you are disabled...(c) *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled...

The Social Security Administration Program Operations Manual (POMS) DI 25505.010 Duration Not Met - Impairment Prevents(ed) SGA for a Period of Less Than 12 Months states:

> When evidence shows that within 12 months of onset the individual's impairment(s) did not or will no longer prevent SGA, a durational denial is appropriate. It is necessary to consider duration in the context of the sequential process, however, since duration does not become an issue unless at some time an impairment is severe and prevents SGA.
> A. Projecting Severity and Residual Functional Capacity
> In most cases in which the evidence substantiates a finding of disability, it will be readily apparent from the same evidence whether or not the impairment is expected to result in death or has lasted or is expected to last 12 months from the onset of disability. When the application is being adjudicated before the impairment has lasted 12 months, the nature of the impairment, the therapeutic history, and the prescribed treatment will serve as the basis for determining whether the impairment is expected to result in death or will continue to prevent the individual from engaging in any SGA for the additional number of months needed to make up the required 12 months duration.

The Department uses the above federal regulations to determine disability. An individual must have a condition or combination of conditions listed in the Federal Regulations that is expected to last for at least 12 full months.

The hearing officer evaluated the petitioner's claim of disability using the sequential evaluation as set forth in 20 C.F.R. §416.920. The first step is to determine whether the individual is working. The petitioner is not working; therefore, he meets the first step.

The second step is to determine whether an individual has a severe impairment. In order to meet this definition of a severe impairment, an individual must have an impairment that is established by medical evidence consisting of signs, symptoms, and laboratory findings, and not only by the individual's statement of symptoms alone, as

per 20 C.F.R. §404.1508. In addition, such impairment "must have lasted or must be expected to last for a continuous period of at least twelve months," in order to meet the duration requirement, as per 20 C.F.R. §404.1509. Thus, in summary, in order to meet this step, an individual must have a medically diagnosed impairment(s) that meets the duration requirement.

The medical evidence submitted did not contain any evidence of the duration period. The medical evidence presented shows that the petitioner thrived after receiving several weeks of various intensive therapies and medications, and was discharged from a skilled nursing facility after his goals were met. Testimony showed that the petitioner had progressed remarkably. The hearing officer recognizes that the petitioner holds a slight burden at step two, however in the absence of any evidence showing a disabling condition with a duration of 12 months or more, the undersigned concludes that the petitioner does not meet step two of the sequential evaluation set forth above and therefore, is not determined to be disabled.

The petitioner may want to initiate contact with Vocational Rehabilitation in order to learn of any services that may be available to him.

DECISION

The 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 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 16 day of November, 2007,

in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To: Petitioner
15 DPOES, Judy Sickles

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

APPEAL NO. 07F-04558

PETITIONER,

Vs.

CASE NO. 1238232931

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 3, 2007, at 1:08 p.m., in Jacksonville, Florida. The petitioner was not present; she was represented by her son, and future daughter-in-law, Present as witnesses were administrator of facility at and business office manager of

The record was held open through October 15, 2007 to allow the Department to determine eligibility for the retroactive period of March, February and January 2007. The Department completed the determination and informed of its determination on October 15, 2007. The eligibility results were entered as Respondent's Exhibit 7.

ISSUE

The petitioner is appealing the Department's action of June 25, 2007 approving Institutional Care Program (ICP) Medicaid beginning April 2007. The petitioner is seeking ICP Medicaid coverage beginning March 1, 2006. The petitioner held the burden of proof.

PRELIMINARY STATEMENT

The hearing was requested on August 3, 2007. The only action taken by the Department within 90 days of the hearing request date was the approval action taken on June 25, 2007. The hearing officer can review the three month retroactive period related to this application of March, February and January 2007, as there was no evidence that a notice addressing these months was issued.

The prior denial action taken by the Department was April 10, 2007. Therefore, the hearing officer does not have jurisdiction to review the April 10, 2007 denial action as the petitioner was beyond the 90 day time restriction to file an appeal based on Florida Administrative Code 65-2.046.

FINDINGS OF FACT

1. A prearranged funeral agreement was purchased for the petitioner on December 9, 2005 in the amount of $6,955. The petitioner's son provided the money to purchase the prearranged funeral agreement to his sister (petitioner's daughter), who had power of attorney at that time. The contract was signed by the petitioner's daughter for her mother. The contract indicates both the purchaser and the beneficiary as Hazel Vining. The contract shows itemized services and merchandise that totals $6,955. Of these, the contract reflects $995 for the casket, $895 for the vault and $995

for the opening and closing of the grave. Page 3 of the contract under the "Terms and Conditions," number 10 states, "Refund upon cancellation is 100% of the funds paid, within the first 30 days of the Agreement date, 90% thereafter through the third year and 100% of the fourth year and after" (Petitioner's Exhibit 2 and Composite Exhibit 3).

2. The petitioner was placed in the nursing home in March 2006 under Medicare. Her daughter had been handling some of her financial affairs and required institutionalization herself. Once this happened, and after some delay, the facility began working with the Department seeking ICP eligibility. An ICP application was denied February 2007 due to the level of care denied, as the form signed by the physician was outdated. A subsequent ICP application was denied on April 10, 2007 due to assets exceeding the limit, due to the value of the Prearranged Funeral Agreement. At this time, the agreement had not been made irrevocable.

3. A reapplication was made on April 16, 2007. Because the Prearranged Funeral Agreement was made irrevocable on April 17, 2007, the assets were under the $2,000 asset limit and the ICP application was approved beginning April 2007.

4. The Department determined the appropriate ICP asset limit was $2,000 based on the petitioner's income. Her monthly income consisted of $453 Social Security and $314.25 pension from the City of Jacksonville, for a total of $767.25 (Respondent's Exhibit 4).

5. The Department requested guidance from its Program Office staff on how to apply the $2,500 burial fund exclusion policy to the Prearranged Funeral Agreement for the three retroactive months prior to the April 2007 application, for the time before the agreement was made irrevocable. The Program Office responded that itemized

expenses such as casket, headstone, opening/closing at the site could be deducted, as well as the $2,500 exclusion (Respondent's Exhibit 3). This exhibit also shows that the April 2007 application is the third one made.

6. The Department evaluated eligibility for the retroactive months of January 2007, February 2007 and March 2007, while the hearing record was held open. According to Respondent's Composite Exhibit 7, the Department began with a revocable Prearranged Funeral Agreement amount of $6,976 and subtracted $995 (casket), $1,195 (opening and closing), $990 (headstone) and the $2,500 burial fund exclusion for a countable asset balance left in the Prearranged Funeral Agreement of $1,296. The petitioner's resident trust fund amount of $1,491.59 was added, to total $2,787.59 in assets for the month of March 2007. The $1,296 left of the Prearranged Funeral Agreement was added to the petitioner's resident trust fund amount of $945.39, to total $2,241.39 for the month of February 2007. The $1,296 left of the Prearranged Funeral Agreement was added to the petitioner's resident trust fund amount of $1,245.16, for a total of $2,541.16 for the month of January 2007. Because the assets exceeded the $2,000 asset limit, the Department determined that there was no ICP eligibility for the three retroactive months prior to the April 2007 application. There was no evidence that a notice was issued.

7. Also included in Respondent's Composite Exhibit 7 is a screen print from the Florida Medicaid system showing the petitioner's coverage. From February 1, 2006 through March 31, 2007 the petitioner was covered under the Qualified Medicare Beneficiary (QMB) Program. Beginning April 1, 2007, the petitioner was covered under the ICP Medicaid coverage group reflected as "MI I."

8. The petitioner's Social Security income and her pension income are both direct deposited into her resident trust fund account. The Social Security direct deposit monthly amount is $453 and the pension direct deposit amount is $109.10 twice per month, for a total income deposit amount of $671.20. The January 2007 lowest patient trust fund balance was $1,056.74. The February 2007 lowest patient trust fund balance was $603.10. The March 2007 lowest patient trust fund balance was $925.30. The only interest shown on the three months' of patient trust fund accounts was on January 31, 2007 in the amount of .16 (Petitioner's Exhibits 6 and 4 and Respondent's Exhibit 6).

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant part:

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C...(2) Exclusions. The department follows SSI policy prescribed in 20 C.F.R. Part 416 in determining what is counted as a resource with the following exceptions, as mandated by federal Medicaid policies, or additional exclusions, as adopted by the department under section 42 U.S.C. § 1396a(r)(2)...(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.

Florida Administrative 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. $2,000 per individual...

The Department's Integrated Manual, 165-22, Appendix A-9 sets forth the income and resource standards and shows the ICP resource limit for an individual at $2,000 and the ICP-MEDS resource limit for an individual at $5,000. This same chart shows the MEDS income limit at $749 for an individual.

The Department's Integrated Policy Manual, 165-22 gives further guidance to the Department on counting burial related resources and is quoted below beginning at section 1640.0509 and ending with section 1640.0516:

1640.0509 Prepaid Burial Contracts (MSSI, SFP)

A prepaid burial contract (or special mortuary fund) is an agreement in which an individual prepays his burial expenses and the seller agrees to furnish the burial. Prepaid burial contracts should not be confused with burial insurance or burial trusts. The prepaid burial contract funds are not included as an asset if:

1. the contract cannot be liquidated without significant hardship to the individual; or
2. the contract seller refuses to revoke or liquidate the contract; or
3. the contract is irrevocable.

If the contract does not meet the above criteria, the amount the individual would receive by revoking or liquidating the contract, minus any penalties, is the amount included as an asset for the individual.

1640.0510 State Law Regarding Prepaid Burial Contracts (MSSI, SFP)

State laws may impose varying types of conditions on burial contracts. Depending on the state in which the contract was made, there may be unique provisions for:

1. the process for revoking or liquidating prepaid burial contracts;
2. the conditions required before a burial contract can be revoked or liquidated; and
3. the conditions necessary for a contract to be defined as irrevocable. Any Medicaid applicant may make an irrevocable contract and exclude this asset. District Legal Counsel may be consulted when it is necessary to determine if a contract is revocable. If the burial contract was purchased

in another state, contact the central office to determine whether the contract is irrevocable.

1640.0511.01 Revocable Prepaid Burial Contract (MSSI, SFP)

Contract provisions for a revocable prepaid burial contract may prohibit liquidation of the asset. The ESS must examine the contract and determine if it includes this type of provision.
The contract is not included as an asset if the individual would have to move out of state to liquidate the contract or if another person's consent is required and the person will not agree to liquidate the contract.

1640.0511.02 Value of the Prepaid Burial Contract (MSSI, SFP)

Unless the contract meets a condition for exclusion, ***the amount the individual would receive upon revoking or liquidating the contract is included as an asset.*** (emphasis added) This amount is often different from the face value of the contract. Guidelines for determining the amount to be received are usually set by state law and differ from contract to contract.
The contract must be examined to determine the amount to be received from liquidating or revoking the contract. If the contract is unclear, the individual or ESS must contact the funeral director to determine the amount.
The value of prepaid burial contracts liquidated by means other than revocation such as sale or transfer is the amount the individual would receive if the contract was sold on the open market.
The individual can rebut the amount with appropriate verification and documents. For example, the State Funeral Directors Association or a local funeral director may provide information showing that sellers of prepaid burial contracts can only expect to receive a percentage of the face value, or the individual may provide proof that only a certain amount was offered or that the contract was advertised for sale and no offers were received.

1640.0512 Irrevocable Burial Trusts (MSSI, SFP)

If the irrevocable burial trust is created in connection with a funeral home or funeral director, it is treated like an irrevocable prepaid burial contract. As long as it is irrevocable, the trust is not considered an asset to the individual.
If the irrevocable burial trust is not created in connection with a funeral home or funeral director, it is considered a transfer of assets. Regular burial exclusion policy is applicable to the uncompensated value of the burial trust fund. Up to $2,500 of the trust can be excluded as a burial asset. The remaining uncompensated value would count as an asset to the individual according to policies in Section 1640.0600.

1640.0513 Verification of Burial Contracts or Trust (MSSI, SFP)

A photocopy of the burial contract or trust should be obtained to document the value of the contract and whether or not it can be revoked. The case record must explain how the determination of revocability and value were made.

1640.0514 Burial Exclusion Policy (MSSI, SFP)

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

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

The individual and the individual's spouse must be given the opportunity to designate funds for burial at the time of application and at review if the maximum amount is not already designated. These funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The $2,500 limit is not reduced by the value of excluded life insurance policies or irrevocable burial contracts.

If the funds are not clearly designated for burial at the time of the application, the funds may be excluded if the individual:

1. provides a written statement that the funds are intended for the individual's burial, and
2. agrees to submit evidence that the funds are separately identifiable and designated for burial within 10 days of signing the statement.

Note: If the evidence is not provided in 10 days, the funds cannot be excluded until the information is provided.

Assets may be designated as burial funds for any month, including the three months prior to the month of application. (Burial fund accounts for prior months may be commingled with non-burial funds.)

Any increase in the value of excluded burial funds which was left to accumulate is excluded from assets. Refer to passages 1640.0596 and 1840.1000. 38 Chapter: 1600 Assets Program: MSSI, SFP

1640.0515 Burial Spaces/Plots (MSSI, SFP)

The following are considered burial spaces or plots:

1. conventional grave sites,
2. crypts,

3. mausoleums, and
4. urns.

1640.0516 Burial Spaces (MSSI, SFP)

Burial spaces owned by the individual are not considered assets as long as they are intended for the use of the individual, the individual's spouse, or any member of the individual's immediate family. For the purposes of this policy the immediate family includes the individual's:

1. minor and adult children,
2. stepchildren,
3. adopted children,
4. brothers,
5. sisters,
6. parents,
7. adoptive parents, and
8. the spouses of immediate family members.

Dependency and living in the same household are not factors.
Burial space items that are also excludable include:

1. caskets,
2. headstones, and
3. the opening and closing costs of the grave.

Burial spaces are included as an asset if:

1. they are intended for use by someone other than the immediate family; and
2. the deed for the burial space specifies that the individual can sell the property.

If any joint owner refuses to permit the sale of the space or the burial service provider requires a move from the state in order to sell the space, the space is not treated as an included asset to the individual. The ESS must document any restrictions on the sale of the space by obtaining a statement from the joint owner or a copy of the burial contract.

The Department's Integrated Policy Manual, 165-22, Section

1640.0501 Bank Accounts (MSSI, SFP)

Bank accounts refer to funds in a bank, credit union, savings and loan association or any other financial institution that are usually payable on demand. Interest earned on bank accounts is excluded as unearned income in eligibility determination.

Federal Regulations at 20 C.F.R. §416.1207, Resource determinations, states in relevant part:

> (d) Treatment of items under income and resource counting rules. Items received in cash or in kind during a month are evaluated first under the income counting rules and, if retained until the first moment of the following month, are subject to the rules for counting resources at that time.

Florida Administrative Code 65A-1.702, Special Provisions, explains retroactive Medicaid and states in relevant part:

> (1) Rules 65A-1.701 through 65A-1.716, F.A.C., implement Medicaid coverage provisions and options available to states under Titles XVI and XIX of the Social Security Act.
> (2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period). Eligibility for Medicaid begins the first day of a month if an individual was eligible any time during the month...(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
> (a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility...

The Findings show that the petitioner's gross monthly income is $767.25. Therefore her income is over the ICP-MEDS limit of $749 and she does not fall under the $5,000 asset limit; instead the applicable asset limit is the $2,000 ICP asset limit.

The Findings show that the only assets used to determine ICP eligibility (prior to April 2007) was the revocable prearranged funeral agreement and the resident trust

fund account. The findings show that the Department reevaluated eligibility while the hearing record was held open for the three month retroactive period prior to the April 16, 2007 reapplication. To determine if the assets were under the limit, the Department started with the full revocable prearranged funeral agreement amount of $6,976. The hearing officer concludes that this amount was incorrect as the findings show the full amount was $6,955. However, the findings show that the contract states if refunded through the third year, the amount refunded would be 90% (or $6,259.50).

Next, the Department subtracted $995 for the casket, $1,195 for the opening and closing, $990 for the headstone and the $2,500 burial fund exclusion. The hearing officer concludes this was in error as the findings show the casket was $995, the opening and closing was $995 and the vault was $895. There is no deduction for a headstone shown on the contract.

The Department used a figure of $1,296 for the remaining balance of the revocable prearranged funeral agreement. According to the above authorities, the amount the individual would receive upon revoking or liquidating the contract is included as an asset. The hearing officer concludes that the correct beginning balance would be the 90% or $6259.50 that would be refunded if the contract were liquidated. After the above stated deductions for the casket, vault, opening and closing cost and the $2,500 burial fund exclusion are taken from $6,259.50, the remaining balance is $874.50.

Next, the Department added the $1,296 remaining balance of the prearranged funeral agreement to the petitioner's trust fund balance for March 2007 of $1,491.59 for a total countable asset value of $2,787.59 for March 2007. The Department added the $1,296 to the petitioner's trust fund balance for February 2007 of $945.39 for a total

countable asset value of $2,241.39 for February 2007. The Department added the $1,296 to the petitioner's trust fund balance for January 2007 of $1,245.16 for a total countable asset value of $2,541.16 for January 2007. These monthly totals exceeded the $2,000 ICP asset value and the Department determined ineligibility for the retroactive period prior to the April 16, 2007 reapplication. The hearing officer concludes this step was also in error as the above authority allows the Department to use the lowest balance of the month to determine eligibility. Therefore, the findings show the lowest balance of the trust fund account as follows: $925.30 for March 2007, $603.10 for February 2007 and $1,056.74 for January 2007. The above authorities also allow the Department to subtract the petitioner's income, to include interest, from the asset (trust fund). However, even without deducting the monthly income deposited, the petitioner meets the asset limit for each of the three months at issue. Therefore, the hearing officer concludes that the Department's reevaluation of the three month retroactive period prior to the reapplication of April 16, 2007, of ineligible due to excess assets, was incorrect. The Department is to consider the asset limit met for ICP for March, February and January 2007 and determine eligibility on all other factors.

Florida Administrative Code 65A-1.702, Special Provisions, states in part:

> (7) Re-evaluating Medicaid Adverse Actions. The department shall re-evaluate any adverse Medicaid determination upon a showing of good cause by the individual that the previous determination was incorrect and that the individual did not request a hearing within the time prescribed in Chapter 65-2, Part IV, F.A.C. This provision applies only when benefits were terminated or denied erroneously or a share of cost or patient responsibility was determined erroneously.
>
> (a) Good cause exists if evidence is presented which shows any of the following:
>
> 1. Mathematical Error – The department made a mechanical, computer or human error in its mathematical computations of resources, income, or

spend down requirements for Medicaid eligibility.

2. Error on the Face of the Record – The department made an error in a Medicaid determination which caused an incorrect decision. For example, there is evidence showing that the individual's resources satisfied Florida's standard of eligibility but the application was denied on the basis of excess resources.

3. New and Material Evidence – The department's determination was correct when made but new and material evidence that the department did not previously consider establishes that a different decision should be made.

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

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

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

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

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

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

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

The above rule sets forth a provision for an individual who missed the 90 day time frame to file an appeal, to request a re-evaluation of a Medicaid adverse action. A

re-evaluation must be requested before the expiration of 12 months from the effective date of the notice of adverse action. The petitioner's representative may wish to seek a re-evaluation of the prior denials, through the Department, as the jurisdiction of the undersigned does not cover the entire period of ICP coverage sought by the petitioner. Appeal rights are afforded (if timely requested) once the Department re-evaluates the prior denial decision and issues a written notice.

DECISION

The appeal is granted in part as the Department's determination of ineligibility for March, February and January 2007 due to excess assets is incorrect and remanded. The Department is to consider the ICP asset limit met and determine ICP eligibility on all other factors for March, February and January 2007. A written notice is to be issued upon this determination.

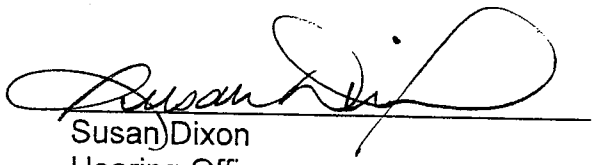
The appeal is dismissed as non-jurisdictional for months prior to January 2007. The petitioner may wish to request a reevaluation from the Department of prior denials.

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 9 day of November, 2007,

in Tallahassee, Florida.



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

Copies Furnished To: Petitioner
4 DPOES: Theola Henderson

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

APPEAL NO. 07F-5040

PETITIONER,

Vs.

CASE NO. 1083527134

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11-Dade
UNIT: BSCIP

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on October 24, 2007, at 11:50 a.m., in Miami, Florida. The petitioner, represented himself at the hearing. The respondent was represented telephonically by Kristen Russell, from the Florida Department of Health, Brain and Spinal Cord Injury Program (BSCIP) administrator. The hearing was previously scheduled for October 9, 2007, but was rescheduled at the request of both parties. The record remained open for five days in order for the petitioner to provide additional information.

ISSUE

The petitioner is appealing the respondent's action of August 7, 2007, in removing him from the Brain and Spinal Cord Injury Waiver waiting list. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner is a Medicaid recipient residing in : County. He has been on the BSCI Waiver waiting list since March 2004. The petitioner requires assistance or total help with activities of daily living, due to his spinal cord injury and other medical conditions.

The BSCIP is a waiver program that provides home and community based services, allowing individuals who would otherwise require nursing home care or other institutional care, to receive services in their own homes or in home-like settings.

According to an April 2006 promulgated rule, everyone on the Brain and Spinal Cord Injury Program Medicaid Waiver waiting list had to be screened, using a screening tool. This process was initiated in December 2006 and continues. Persons would be screened, receive a score according to their situation and placed on the waiting list according to the screening score received until an open slot is available. The Department reviews these cases that are on the waiting list periodically.

In May 2007, the Department began attempts to contact (telephonically) the petitioner in order to review his case, as he had been on their waiting list for services. The Department stated that they made "several calls" but were unsuccessful in contacting the petitioner.

The Department's records indicate that a notice (unable to produce at hearing) was sent to the petitioner in May 2007, requesting that he contact them within 21 days or he would be terminated from the BSCIP wait list.

On August 7, 2007, the Department issued a Notice of Decision informing the petitioner that "after several attempts, this office has been unable to contact you. Therefore you will be removed from the wait list." The petitioner requested the hearing on August 24, 2007.

CONCLUSIONS OF LAW

Fla. Stat. 381.76 sets forth the eligibility for the brain and spinal cord injury program and states as follows:

> (1) An individual shall be accepted as eligible for the brain and spinal cord injury program following certification by the department that the individual:
> (a) Has been referred to the central registry pursuant to s. 381.74;
> (b) Is a legal resident of this state at the time of application for services;
> (c) Has sustained a brain or spinal cord injury;
> (d) Is medically stable; and
> (e) Is reasonably expected to achieve reintegration into the community through services provided by the brain and spinal cord injury program.
> (2) If the department is unable to provide services to all eligible individuals, the department may establish an order of selection.

Fla. Stat. 408.302 provides statutory authority for the promulgation of the April 2006 Traumatic Brain and Spinal Cord Injury Waiver Services Handbook into rule and states as follows:

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

Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook (April 2006) states as follows:

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

The petitioner states that he received the denial notice of August 7, 2007 and a couple of days before, had received a letter requesting that he contact them. He states that he was not allowed the 21 days stated as it was received in early August, not May 2007 as the Department states. The petitioner states that he has had problems with his landlord and him delaying in giving him his mail. The respondent agreed to re-evaluate the petitioner and conduct a current screening.

As the Findings of Fact shows, the petitioner had been on the waiting list and a contact was initiated in May 2007, however the Department was unable to make contact

with the petitioner and issued a notice allowing 21 days for him to contact them. The petitioner did not receive the notice until the 21 days had lapsed. The Department was unable to produce a copy of the notice, nor the date of mailing. Therefore, the respondent will re-evaluate the petitioner's current situation completing and inform the petitioner of their decision.

DECISION

The appeal is partially granted as the respondent will re-evaluate the petitioner's current condition and provide him with notice of their new decision.

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 15 day of November 2007,

in Tallahassee, Florida.

A. G. Littman

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

Copies Furnished To: J . Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Florida Department of Health
Kristen Russell, Administrator BSCIP

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

APPEAL NO. 07F-5794

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 November 7, 2007, at 9:15 a.m., in Miami, Florida. The petitioner, [redacted] was not present however she was represented by her mother, [redacted]. Present, on behalf of the respondent was Monica Otalalora, program specialist with the Agency for Health Care Administration. Appearing telephonically as witnesses for the agency was Dr. Robert Buzzeo, physician reviewer and Mary Wheeler, nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez served as translator.

ISSUE

At issue is the agency's action in denying 32 hours of private duty nursing (PDN) and approving 688 hours from the requested 720 hours of PDN. The certification period is for September 13, 2007 through November 11, 2007. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is sixteen months old and a Medicaid beneficiary in the state of Florida. The petitioner's medical condition as reported to the agency was: "Charge Syndrome, Sickle Cell Trait, Perinatal Depression Reflux Disease and Respiratory Distress."

The petitioner attends Prescribed Pediatric Extended Care (PPEC) which is a medical daycare from 7 am to 4 pm, Monday through Friday (weekdays). The petitioner's mother works part time from 7 pm to 11 pm on weekdays, except for Wednesdays which she has off. The mother provides care for the petitioner from 4 pm to 7 pm daily.

On September 14, 2007, the provider (Nationwide Healthcare Services) requested 720 (12 hours daily, 7pm-7am) skilled nursing hours for the certification period of September 13, 2007 through November 11, 2007.

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

On September 18, 2007, the initial screening of the request was completed by a registered nurse reviewer which referred the case to a board-certified pediatrician for review of medical necessity for the level of service requested.

A KēPRO second physician consultant reviewed the request and partially denied the hours for Wednesdays from 7 pm to 11 pm. The physician consultant determined that the mother was not working on Wednesdays, from 7 pm to 11 pm and would be able to care for the petitioner as she has done previously. The agency did not receive justification for the approval of those hours (Wednesdays 7 pm to 11 pm) therefore, ultimately approved all hours requested except the 4 hours on Wednesdays when the mother was not working.

On October 4, 2007, a final PDN/PC Recipient Denial Letter was sent to the petitioner and provider informing them of the denial of 32 hours. The physician consultant clarified that there was a misprint in the notice where it refers to the amount of PDN hours approved, but that only 32 hours were denied and the rest approved.

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.

Fla. Admin. Code 59.G-1.010, "Definitions", states for medical necessity:

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

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

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

Fla. Admin. Code 59G-4.130 Home Health Services states in part:

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

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

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

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

The petitioner's mother states that she has one other child to care for and since her daughter still has medical issues she was concerned about the number of hours that were denied.

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The opinion of the physician reviewer was that the petitioner's mother was capable of providing care for the petitioner, as she has previously done during Wednesdays for 4 hours when she is off from work.

Based on the above cited authorities, the respondent's action to deny 32 PDN hours on Wednesdays from 7 pm to 11 pm for the period of September 13, 2007 through November 11, 2007, was within the rules of the Program and is affirmed.

DECISION

The 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 November, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: / Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

APPEAL NO. 07F-05265

PETITIONER,

Vs.

CASE NO. 1256691615

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

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on September 28, 2007, at 2:07 p.m., in New Port Richey, Florida. The petitioner is now deceased. His wife, [redacted] testified and represented his interests. The wife's cousin, [redacted] appeared as a potential witness. [redacted], a friend of the wife, observed. The respondent was represented by Suzi Jackson, supervisor at the Largo Service Center. Ms. Jackson also testified.

ISSUE

At issue is the respondent decision of June 22, 2007 to deny retroactive Institutional Care Program and Medicaid (ICP) benefits for the months of March and April 2007. The respondent believes that the petitioner had excess countable income in these months.

FINDINGS OF FACT

1. The petitioner was a patient at the on from September 15, 2006 to March 20, 2007. On March 20, 2007, the petitioner was admitted to the nursing facility. The petitioner remained in this facility until his death on A . The petitioner's wife, lives in the community.
2. On January 31, 2007, the petitioner applied for hospice benefits. The respondent denied this application based on failure to provide requested verification. The specific merit of this denial decision is not at issue in this appeal. The petitioner's income was not listed on this application, only the wife's income.
3. On March 21, 2007, the respondent received an application for ICP benefits while the petitioner was in the nursing facility. The petitioner's income was not listed on this application, only the wife's income. The petitioner received a written verification list dated March 29, 2007. This verification list did not include a request for the petitioner's income since his income was not then known to the respondent. The petitioner's wife worked 12 hours weekly in March and April 2007. The verification list included a request for proof of her wages for the last four weeks.
4. On April 11, 2007, the petitioner's wife became aware of the need for an income trust through conversation with the respondent. The petitioner's wife then telephoned her attorney to request paperwork for the income trust. The petitioner's wife received the income trust papers April 12,

2007. The petitioner's wife intended to go to the bank on April 14, 2007 with the income trust papers.

5. The petitioner passed away at the nursing home on A at 8:55 a.m. On April 16, 2007, the petitioner's wife verbally requested the respondent to withdraw the application since the petitioner had passed. The respondent then closed the petitioner's application per this verbal request.

6. On May 9, 2007, the petitioner's wife contacted the customer call center and was advised to re-apply. On May 14, 2007, the petitioner's wife re-applied for ICP benefits. The petitioner's wife only listed some of the deceased petitioner's income on this application. The petitioner received a request for verification from the respondent dated May 25, 2007. On June 22, 2007, the petitioner received notice that this May application had been denied for failure to return verification.

7. During the months of March and April 2007, the petitioner received a gross monthly Social Security income of $1,543.50. The petitioner also received a General Motors' (GM) pension of $1,147.80 in these months. The petitioner's wife also had reported Social Security income of $505 monthly in these months, along with wages of 12 hours weekly. The petitioner did not establish nor fund an income trust in March and April 2007. The petitioner seeks ICP eligibility for March and April 2007. The respondent determined the petitioner's countable income to exceed the limit for ICP eligibility in March and April 2007.

CONCLUSIONS OF LAW

Findings show the petitioner had $2,691 in combined monthly income from Social Security and a GM pension for the months of March and April 2007. This combined income is an available and countable income source, and cannot be otherwise excluded, in accord with the Code of Federal Regulations (C.F.R. § 20C.F.R.416.1123).

Since this income is countable as above, the Florida Administrative Code Rule 65A-1.713(1)(d) sets forth the income limit in the ICP Program to be 300 percent of the Federal benefit rate. The Department interprets this maximum ICP income rate for an individual as $1,869 for the applicable months of March and April 2007. This $1,869 ICP income limit is per Headquarters' policy memo I-07-02-0002 dated February 26, 2007. The petitioner's combined income of $2,691 exceeded this income limit in March and April 2007.

The language of the same Florida Administrative Code rule cited above allows individuals who would otherwise be ineligible for ICP benefits based on excess income to establish an income trust, "which meets criteria set forth in paragraph 65A-1.702(14)(a)." An income trust account was not established nor funded during March or April 2007. Income could have been be excluded if such qualified income trust had been established and funded, per the following excerpt in the Department's interpretive 165-22 manual at section 1840.0110:

> ...If an individual has income above the ICP limit, they may become eligible for Institutional Care or HCBS if they set up and fund a qualified income trust....

The respondent made the petitioner aware of the need to establish an income trust after the petitioner reported the existence of income in excess of the ICP limit. There are no other provisions that would allow for an exception to exclude otherwise countable income except for the establishment and funding of an income trust. Therefore, the amount of the petitioner's income that was in excess of the ICP income limit can not be excluded. Thus, the respondent is correct to deny ICP benefits for the months of March and April 2007, based on excess countable income.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the 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 27 day of November, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: I :I, Petitioner
Roseann Liriano, Suncoast Region

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

APPEAL NO. 07F-4786

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 October 3, 2007, at 9:14 a.m., in Miami, Florida. The petitioner was not present but was represented by his mother, C _____ . Present, on behalf of the respondent was Sandra Moss, with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the agency was Dr. Robert Buzzeo, physician reviewer and Mary Wheeler, nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez served as the translator. The hearing was previously scheduled for September 11, 2007, but was continued at the request of the petitioner.

ISSUE

At issue is the agency's action in denying 240 hours of private duty nursing (PDN) and approving 1,200 hours of the requested 1,440 hours of PDN. The certification period is for July 14, 2007 through September 11, 2007. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is four years old and a Medicaid beneficiary in the state of Florida. The petitioner's medical condition as reported to the agency was: "Poisoning by propionic acid derivatives, Convulsions, Reflux Esophagitis."

Prior to the action under appeal, the petitioner was receiving PDN services of 24 hours daily, 7 days a week and has continued receiving the service at this level throughout the hearing process.

On July 13, 2007, the provider (RGR LLC/Kidcare Nursing Services) requested 1,440 (24 hours daily) skilled nursing hours for the petitioner, for the certification period of July 14, 2007 through September 11, 2007.

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

On July 16, 2007, a preliminary screening of the request was completed by a registered nurse reviewer. The provider was requested to submit additional information and clarification, which were ultimately provided.

On July 18, 2007, the nurse reviewer determined using criterion used at this level of review, that the petitioner's request had to be referred to a board certified pediatrician reviewer for a determination of medical necessity.

The physician reviewer documents the following, "4 yr old DX seizures and reflux esophagitis. GT/JT for feeds via pump. Trach, resp tx (treatment), suctioning. MOTHER IS SELF EMPLOYED. SHE SELLS JEWELRY. MOTHER HAS TO TAKE CARE OF A 5 YEAR OLD HYPERACTIVE CHILD. MOTHER DOES OT HAVE A SET SCHEDULE OR DAYS. MOTHER IS ABLE TO PROVIDE INTERMITTENT CARE BUT IS OVERWHELMED WITH BOTH CHILDREN WHO ARE HYPERACTIVE. Requesting 24 hrs/day, 7 days/wk. Unclear why 5 yr old not in pre k, or kindergarten. Unclear why mother cannot assist 2-4 hr/dy. Recommend reduction in hours to 20hr/dy/7." "...The denial of hours is due to the fact that the Mom should be able to provide some independent care each and every day." The provider was notified of their decision.

On July 25, 2007, a second physician consultant (board-certified pediatrician) reviewed the request, as part of the reconsideration process. The record documents the information submitted by the provider as, "Reconsideration of case: Mother needs nursing care 24 hours because she is not comfortable with GT and J-tube. She is in fear of handling the gt and J-tube, giving medications and feeding. Mother has always had nursing care to give med and feedings through G-tube and J-tube. Mother can only provide personal care."

The physician reviewer testified that in the initial statements submitted by the provider, says that the mother can provide "intermittent care" but is "overwhelmed" with both (petitioner and 7 year old sibling) children. Upon reconsideration, the information provided is that the mother is not "comfortable" and in "fear" of handling the G-tube/J-tube, giving medications and feedings, which is in direct conflict with initial statements. The

physician reviewer stated that 20 hours daily, 7 days a week is sufficient hours of PDN to meet the petitioner's needs and his mother to provide 4 hours daily of care.

The physician upheld the initial approval of 20 hours daily and denial of 4 hours daily of PDN services. On July 26, 2007, a PDN/PC Recipient Reconsideration-Denial Upheld letter was issued to the provider and petitioner.

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.

Fla. Admin. Code 59.G-1.010, "Definitions", states for medical necessity:

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

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

Fla. Admin. Code 59G-4.130 Home Health Services states in part:

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

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

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

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

The petitioner's mother stated that she is divorced and has a 7 year old son that requires help with his homework. She states that her son, his father and the nurse were at present at the doctor's office for a follow-up visit, as his medical condition is delicate.

The petitioner's mother informed the hearing officer that she does not have a problem with the feedings or the J-tube, but with the gastric tube care which must be changed twice a month and requires two people to do so. She states that he is on a special formula which she has learned to mix and administer and she is asking for the 24 hours of PDN service because she needs to get another job at night.

The petitioner's mother presented letters (Petitioner's Composite Exhibit 1) from treating physicians on their recommendations for 24 hours a day of nursing care. The letters provided the petitioner's diagnosis, medical history and specific medical care needed. However, these letters do not address the issue of the reduction from 24 hours to 20 hours a day of PDN, with the petitioner's mother caring for the remaining 4 hours. The physicians do not address the reason why the petitioner's mother cannot care for the petitioner 4 hours a day, as recommended by two physician consultants.

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The opinion of the initial physician reviewer was that the petitioner's mother was capable of providing 4 hours daily care for the petitioner. A second physician consultant recommended the same. Testimony from the mother again contradicts information from the provider, as she states that her problem is with the tracheotomy that requires two people in order to change it twice a month. The respondent has approved 20 hours daily, 7 days a week to fulfill these duties. The mother goes on to say that she is asking for the 24 hours PDN, because she needs to get another job at night.

Therefore, based on the above cited authorities and the unrebutted testimony from the physician consultant, the respondent's action to approve 1,200 hours (equates to 20 hours daily) and deny 240 hours (equates to 4 hours daily) of PDN for the period of July 14, 2007 through September 11, 2007, was within the rules of the Program and is affirmed.

DECISION

The 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 15 day of November, 2007,

in Tallahassee, Florida.

A. G. Ramos

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

Copies Furnished To: [illegible] Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

APPEAL NO. 07F-04763

PETITIONER,

Vs.

CASE NO. 1211181707

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 October 25, 2007, at 1:00 p.m., in Fort Lauderdale, Florida. The hearing was rescheduled from October 10, 2007 at the respondent's request. The petitioner was not present. He was represented by , a private geriatric care manager. The respondent was represented by Lilliane Clerie, economic self-sufficiency specialist.

ISSUE

At issue is the Department's October 25, 2007 determination of his patient responsibility effective August 2007, of $759.76 in the Institutional Care Program. The respondent has the burden of proof.

FINDINGS OF FACT

Included in the evidence is a copy of a Notice Of Case Action form, that is dated October 26, 2007, stating that the petitioner's patient responsibility in the Institutional Care Program is $759.76. This is the monthly amount that he is expected to pay the nursing home. The notice was actually done on October 25, 2007, however the computer system dates it the next day, therefore the October 26, 2007 date appears on it.

On the October 26, 2007 notice, it states that the action is effective December 2007, and this is crossed out with the date of August 2007 entered on it. It was initialed by the respondent's representative, who explained at the hearing that previously the patient responsibility for the petitioner was $804.76, and then this was changed to $759.76 effective August 2007. The petitioner is a resident of the Life Care Center Nursing Home in Lauderhill, Florida, and his wife . lives in the community.

Included in the maintenance need allowance budget is $640.20 shelter costs, minus 30% of the minimum monthly maintenance income allowance (MMMIA), which is $514.00, and this equals an excess shelter cost amount of $126.20. Added to this is the MMMIA of $1,712.00, which equals $1,838.20. The community spouse's gross monthly income is her Social Security benefits of $732.00 plus a pension of $531.96, which equals $1,263.96. This amount, $1,263.96 is subtracted from $1,838.20, which equals a community spouse income allowance of $574.24.

Included in the patient responsibility budget is the petitioner's gross monthly Social Security income of $1,369.00 minus a personal needs allowance of $35.00, and minus a maintenance need allowance of $574.24, which is the community spouse income allowance, and this equals a patient responsibility of $759.76. The petitioner's position is

that the community spouse has many bills, and that she needs a total spousal diversion to help her pay her bills, which include credit cards debt, automobile payments, and automobile insurance. The Department's position is that according to the income and allowable deductions, a patient responsibility of $759.76 effective August 2007 is correct.

CONCLUSIONS OF LAW

In the Institutional Care Medicaid Program, in accordance with Fla. Admin. Code 65A-1.716(5):

> (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. § 1396r-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 × 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.
> 4. Food Stamp Standard Utility Allowance: $198.
> 5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. § 1396r-5. This standard changes January 1 of each year.

The Department determined a patient responsibility of $804.76. Then the Department changed the patient responsibility effective August 2007 in favor of the petitioner to $759.76. This reflects the budgeting methodology set forth in the above Fla. Admin. Code, however the Fla. Admin. Code 65A-1.712(4)(f) permits possible adjustment to this methodology, and the resulting income allowance as follows:

> (f) 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.

The language of the proceeding rule indicates that a couple must prove the existence of exceptional circumstances which result in significant inadequacy of the income allowance to meet their needs, before such income allowance can be upwardly revised. In examining the relative nature of what may be defined as an individual's "needs", it is necessary to define a standard of such "need" that is consistent with the intent of public assistance programs in general, and more specifically with the Institutional Care Program (ICP).

Since the ICP Program sets the Minimum Monthly Maintenance Income Allowance (MMMIA) to equal 150 percent of the Federally defined Poverty level, it is evident that the intent of the ICP Program is confined to address an individual's basic needs of food, shelter, and medical costs. Any other indicated expenses would potentially be beyond the scope of this basic need definition of the ICP Program and thus is not included or allowable in determining such basic needs. After careful consideration, it is determined that the Department's determination of a $759.76 patient responsibility is upheld.

DECISION

This 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 1st day of November, 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: [illegible] Petitioner
10 DPOES: Lisa Henson
[illegible]

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

APPEAL NO. 07F-04733

PETITIONER,

Vs.

CASE NO. 1195641133

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 14 Polk
UNIT: 88119

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 13, 2007, at 1:13 p.m., in Lakeland, Florida. The petitioner was not present. She was represented by S l , business officer manager at _... :er. The respondent was represented by Shirley Johnson, economic self-sufficiency supervisor. Present as a witness for the petitioner was .)re, assistant business office manager at - ...... Present as a witness for the respondent was Stanley Jones, economic self-sufficiency specialist.

ISSUE

At issue is the June 20, 2007 action by the respondent denying the petitioner's application for Medicaid for the month of June 2006 due to assets exceeding program limits.

FINDINGS OF FACT

1. The petitioner entered a nursing facility in March 2006. Several applications were filed for Institutional Care Program benefits and Medicaid. On October 6, 2006, the respondent approved the petitioner's application for those benefits beginning August 1, 2006. The prior months were denied due to assets exceeding program limits.

2. The petitioner died on June 17, 2007. Her representative raised the issue of Institutional Care Program coverage for the months of June and July 2007. Those months were not approved due to the balance in the petitioner's checking account.

3. Petitioner's Exhibit 1 is a copy of the petitioner's bank statement dated July 27, 2006. The statement showed a deposit to the account of $7498.91 on June 27, 2006. This brought the balance in the account to $9560.90. This balance did not change until the petitioner's social security check was deposited on July 3, 2006. A check cleared on July 3, 2006 for $8,000. Subsequently, the balance in the account fell below $2,000 by July 25, 2006.

4. The respondent determined that the petitioner's asset limit for the Institutional Care Program was $2,000. Since her bank balance with all other assets fell below this amount in July 2006, they determined that she met the asset limit for the month of July 2006. On June 20, 2007, the respondent authorized the benefits for July 2006. The respondent did not approve benefits for June 2006 as the latest balance in the account showed her balance was $9560.90.

CONCLUSIONS OF LAW

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 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.

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.

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...

The evidence establishes that the petitioner owned a checking account with a balance exceeding $2,000 the end of July 2007. The above cited laws establish that the asset limit for the Institutional Care Program is $2,000. The petitioner does not dispute the facts as presented by the respondent. However, she argues that the deposit of $7498.91 made on June 27, 2006 may not have cleared or been available as it was an out of state check. This is not supported by the evidence. The bank statement shows the balance as available. Therefore, the respondent correctly denied benefits for the month of June 2006 as assets exceeded program limits.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9 day of November 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: [redacted], Petitioner
14 DPOES: Ellen Schultz

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

APPEAL NO. 07F-4794

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 October 3, 2007, at 11:55 a.m., in Miami, Florida. The petitioner was not present but was represented by his mother, Present, as a witness for the petitioner was grandmother. Representing the agency was Sandra P. Moss and Carlos Rodriguez, both with the Agency for Health Care Administration. Appearing telephonically as witnesses for the agency was Dr. Robert Buzzeo, physician reviewer and Mary Wheeler, reviewer manager with Keystone Peer Review Organization (KēPRO) South.

ISSUE

At issue is the agency's action of August 2, 2007, in denying 240 hours and approving 480 hours of private duty nursing or home health aide services instead of the

requested 720 hours. The certification period is for July 13, 2007 through September 10, 2007. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is eleven years old and a Medicaid beneficiary in the state of Florida. The petitioner's is diagnosed with cerebral palsy, seizure disorder and has chronic digestive difficulties. Services were continued throughout the hearing process.

On July 9, 2007, the provider requested 720 hours (7:00 pm-7:00 am, 7 nights a week) of skilled nursing for the petitioner for the certification period of July 13, 2007 through September 10, 2007.

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

On July 10, 2007, an initial screening of the request was completed by the registered nurse reviewer. The provider was requested to submit additional information and clarification, which were ultimately provided.

On July 13, 2007, documentation shows that a physician consultant reviewed the information submitted and denied the request for services, "...gt tube feedings, attends PPEC school, mother is not working, stays in the house and has 2 other children, by the

patient needs and the caregiver availability the hours requested are not justified by the patient needs during the night."

On July 16, 2007, a PDN/PC Recipient Denial Letter was issued denying the request for services. The provider then submitted a reconsideration request along with additional medical and social information.

It was then determined by the second board certified in pediatrics physician reviewer, that based on the additional information provided 480 skilled nursing hours were approved and 240 hours were denied out of the 720 that were requested. Information included "Patient requires nursing care for seizures, maintaining aspiration precaution, bolus feedings that have to be done during the night time, turning and repositioning her every 2 hours." Also considered was the petitioner's attendance from 8:00-4:00 pm at PPEC (prescribed pediatric extended care) and the petitioner's father arrival home at 4:00 pm. The physician reviewer approved service from 11:00 pm-7:00 am.

On August 2, 2007, a PDN/PC Recipient Reconsideration-Denial Overturned notice was issued to the petitioner and provider informing them of the approval of 480 hours. The petitioner appealed the decision on August 14, 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 and states as follows:

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

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

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

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

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

Fla. Admin. Code 59G-4.130 Home Health Services states in part:

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

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

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

Parental Responsibility
Private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers *must* participate in providing care to the fullest extent possible. Training can be offered to

parents and caregivers to enable them to provide care they can safely render. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.

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

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

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

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

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

The petitioner's mother states that the children's father is no longer in the home since April 2007 and he was diagnosed to be bipolar. She states that she home schools her 9 year old son and cares for the 1 ½ year old. has lost 20 pounds over the last year and her condition has become more severe requiring frequent hospitalizations and supervision during the night. She states that she is sleep deprived.

The agency's physician consultant responded that if he would have had this information made available to him, he would have approved the request from 7:00 pm-7:00 am.

The petitioner's mother provided a letter (Petitioner's Composite Exhibit 1) from the treating physician stating that given the petitioner's medical needs, the household circumstances and the petitioner's mother's responsibilities, overnight nursing care of 12 hours a day, 7 days a week is a medical necessity.

After careful consideration of new information provided, along with testimony from the agency's physician reviewer stating that if he would have had the information available he would have approved the request, the hearing officer grants the petitioner's appeal. The agency's decision is reversed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 November, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 02 Bay
UNIT: 88113

RESPONDENT.
_____/

APPEAL NO. 07F-04838

CASE NO. 1131526295

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 26, 2007, at 2:00 p.m., in Panama City, Florida. The petitioner was present. He was represented by his step-daughter, [redacted] The Department was represented by Judy Rivero, economic self-sufficiency specialist I.

ISSUE

The petitioner is appealing the Department's action of August 14, 2007 to deny Institutional Care Program (ICP) and Medicaid benefits due to excess income and due to failure to follow through in establishing eligibility. The burden of proof is on the petitioner.

FINDINGS OF FACT

On July 12, 2007, the petitioner filed a Web-based application for ICP Medicaid benefits. The petitioner only reported income of $914 from Social Security

Administration (SSA). The Department conducted the application interview on July 27, 2007 over the telephone with the representative. At that time, it was determined the petitioner would require an Irrevocable Medicaid Income Trust due to additional income from Pace Industry pension of $123 and a retirement pension from International Paper Company of $224.65, not declared on the application. In addition, it was also discovered during the interview that the petitioner's gross income from SSA was $1,540.50. There was a deduction of $93.50 for Medicare, $32.90 for the Medicare prescription drug plan and $500 withheld for an overpayment recoupment. The overpayment occurred while the petitioner was incarcerated. He was not on Medicaid when the overpayment occurred, therefore the Department counted the gross SSA entitlement in the ICP budget. The overpayment recoupment will end October 2014.

The petitioner's income consisted of SSA of $1,540.50, PACE Industry pension of $123, and International Paper retirement pension of $224.65. The petitioner's total income of $1,887.65 after dropping the cents in the SSA income exceeded the income standard for the ICP program of $1,869. Therefore, he was not eligible to receive ICP benefits unless he established an irrevocable Medicaid income trust and funded the trust each month.

The petitioner was admitted to [redacted] Nursing Center on July 12, 2007 and discharged home on July 26, 2007. The Department conducted a telephone interview with the petitioner on July 27, 2007 and advised her of the need for an Irrevocable Medicaid Income Trust based on the petitioner's income. In addition, the petitioner was

pended for additional information including a copy of an Income Trust, verification that the Income Trust was funded, Level of Care, income verification, last three months' bank statements, verification of pre-need burial contract and irrevocability, face value and cash value of all life insurance policies due to the Department by August 9, 2007.

The petitioner's representative argued that she was not given enough time to set up and fund an Income Trust to qualify the petitioner for ICP benefits. However, the representative testified that she was aware of the need for an Income Trust from the petitioner's previous admission to [redacted] Nursing Home. At the hearing, the petitioner's representative presented a copy of an unsigned trust document drawn up by the representative's niece for a previous nursing home admission. She did not submit the document to the Department for a review by its legal Department and did not fund the Income Trust.

The representative was concerned that she had not been advised by the petitioner's doctor or the nursing home social worker that the petitioner should be hospitalized and then transferred to the nursing facility in order for Medicare to pay for part of his stay.

The Department received some of the pending verification. Because the Income Trust was not set up and funded and the petitioner was no longer a resident of the nursing home as of July 26, 2007, the Department denied ICP benefits on August 14, 2007. In addition, Medicaid benefits were denied because the Department did not

receive cash value for an insurance policy and bank statements by the established deadline of August 9, 2007.

CONCLUSIONS OF LAW

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

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

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

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

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

SSI-Related Medicaid Income Eligibility Criteria.
(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:...(d) For ICP, gross income cannot exceed

> 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in Rule 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in Rule 65A-1.702(14)(a), F.A.C....(2)(c) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP...(4)(b)1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month...

The Department's integrated Manual, 165-22, Appendix A-9, lists the eligibility standards for SSI-Related Programs and sets forth the ICP income limit for an individual at $1869. This limit became effective April 2007.

The Department's Integrated Manual 165-22, Section 1840.0110 in part states:

> Income Trusts (MSSI) The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice and Home and Community Based Services (HCBS). It does NOT apply to Community Hospice.
>
> To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-9 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:
>
> It is established on or after 10/01/93 for the benefit of the individual;
> It is irrevocable;
> It is composed only of the individual's income (Social Security, pensions, or other income sources); and
> The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.
>
> The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria

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

Florida Administrative Code 65A-1.205(1)(a)(d), (4) states in part:

(a) Eligibility must be determined initially at application and if the applicant is determined eligible, at periodic intervals thereafter. The applicant is responsible to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility as determined by the eligibility specialist within time periods specified by the eligibility specialist... (d) If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, or that an assistance group member is required to register for employment services, the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated) or 30 days from the date of application whichever is later. In cases where medical information is requested the return due date is 30 calendar days following the request or 30 days from the date of application whichever is later. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day. If the verification or information is difficult for the person to obtain, the eligibility specialist must provide assistance in obtaining the verification or information when requested or when it appears necessary. If the required verifications and information are not provided by the deadline date, the application is denied,...
(4) An applicant or recipient who fails to keep an appointment without arranging another time with the eligibility specialist, fails or refuses to sign and date the application form(s) described in subsection (1); fails or refuses to submit a periodic report; or fails or refuses to submit required documentation or verification will be denied benefits as eligibility cannot be established.

Florida Administrative Code 65A-1.205 (1)(a) and (f)(4) states in part:

(1)(a) Eligibility must be determined initially at application and if the applicant is determined eligible, at periodic intervals thereafter. The applicant is responsible to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility as determined by the eligibility specialist within time periods specified by the eligibility specialist....
(f)(4)An applicant or recipient who fails to keep an appointment...or fails or refuses to submit required documentation or verification will be denied benefits as eligibility cannot be established.

The Department's online Integrated Program Policy Manual 165-22, Section 2640.0115.02 states:

The countable income of an individual or couple is subtracted from the appropriate income limit to determine eligibility based on income. For the ICP, HCDA, Hospice and HCBS, the gross income is used to determine eligibility.

The Department's online Integrated Program Policy Manual 165-22, Section 1840.0903 states:

The gross benefit amount received, or anticipated to be received, is consider unearned income...Deductions for optional items such as health insurance and Medicare premiums continue to count as income.

The Department's online Integrated Program Policy Manual 165-22, Section 2440.0372 addresses Overpayments included as Unearned Income:

Unearned income includes amounts withheld by other benefit programs to recover overpayments. This policy applied to income received by a recipient as well as by a person whose income is subject to deeming. An exception to this general policy applies when another program's overpayment occurred while the individual was receiving benefits from an SSI-Related Program and the overpayment was budgeted as unearned income at that time...

The representative's position is that she was not made aware of the need to set up and to deposit funds into an income trust until July 27, 2007. There was insufficient time for her to do so in order to qualify him for July 2007. The representative also believes that she should have been informed that the petitioner be admitted to the nursing home from the hospital which would have allowed him to have part of his nursing home care paid under Medicare. The representative's argument was not persuasive as she was aware of the need for an Income Trust from a previous admission to a nursing facility. In addition, the Department did not become aware of the need for the income trust until the interview conducted on July 27, 2007, which was the date the representative was informed of the need for the income trust. The undersigned authority has no jurisdiction over the concern related to potential Medicare payment to the facility.

The above rules and regulations provide that the gross benefit amount is considered when determining eligibility for ICP and Medicaid benefits unless the overpayment occurred while the individual was receiving benefits from an SSI-Related Program. In addition, the above rule provides for the establishment of an Income Trust by an ICP applicant in order to reduce monthly income below the state income limitations. The Findings of Fact show that the Income Trust document was never provided to the Department and that the petitioner did not fund the trust to reduce the petitioner's countable income outside of the trust, to within the allowable income limits. Therefore, the petitioner's total income was available to be counted in the eligibility

determination process for the month at issue, resulting in the total income exceeding the ICP income limit.

Based on the above authorities and the evidence and testimony, the hearing officer concludes that the Department was correct to deny ICP benefits as the income trust was not set up, not approved and not adequately funded, causing the income to exceed the ICP income limit. The total gross income of $1,887.65 exceeded the ICP income limitation of $1,869 and the petitioner was not eligible to receive ICP benefits.

Also, according to the above authorities, the applicant is responsible to furnish information, documentation and verification needed to establish eligibility as determined by the eligibility specialist within time periods specified by the eligibility specialist. The Findings show that the petitioner failed to provide information regarding bank assets and insurance information within requested timeframes. Therefore, the Department's action to deny ICP and Medicaid benefits based on the contention that the petitioner failed to follow through in establishing eligibility is correct.

DECISION

The appeal on both issues is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

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

DONE and ORDERED this 1st day of November, 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] Petitioner
2 DPOES: Denise Parker
[redacted]

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

[redacted]

APPEAL NO. 07F-05856

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 25, 2007, at 11:05 a.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by his father [redacted] The respondent was represented by Lisette Rodriguez, program administrator.

The record was held open for one day after the hearing, which was through October 26, 2007, to allow the petitioner an opportunity to submit information into evidence. Information was received from the petitioner within the deadline. After the deadline, on November 1, 2007, the petitioner submitted into evidence information about hyperbaric oxygen treatments. Even though the record was not held open for this information, it was accepted into evidence based on the general description of the treatments.

ISSUE

At issue is the Agency's action of a denial of reimbursement for the cost of hyperbaric oxygen treatments, and the cost of transportation to and from the petitioner's home for hyperbaric oxygen treatments, to be funded through the Medicaid Program. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, date of birth [redacted] is one year old, and he is a recipient of Medicaid benefits in [redacted] County, Florida. According to the petitioner's father at the hearing, he is a near drowning survivor that happened on May 28, 2007. Included in the evidence are copies of invoice forms from the Ocean Hyperbaric Center showing that the petitioner received hyperbaric oxygen treatments from August 24, 2007 to October 24, 2007. The bill for this time period is $9,380.00.

Included in the evidence is a copy of a letter; dated September 24, 2007, from Dr. Morton Schwartzman, stating that the petitioner has a hypoxic brain injury due to a near drowning experience. He is on a ventilator. He believes that hyperbaric oxygen treatments are medically necessary for the petitioner to improve quality of life, and functional capabilities.

The petitioner, through his representative, requested to have the Agency, through the Medicaid Program, pay for his hyperbaric oxygen treatments, and for transportation to and from his home for the hyperbaric oxygen treatments. The Agency denied these requests. The Agency's statement of matters states, "Florida Medicaid reimburses for services that are medially necessary, and that are not experimental or investigational. There is no conclusive evidence that hyperbaric oxygen is an effective medically

necessary treatment for the diagnosis of hypoxic brain injury. Florida Statutes prohibits Medicaid payment for services that are experimental, and therefore the service is not covered for the beneficiary's diagnosis."

CONCLUSIONS OF LAW

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

> (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.

Section 59G-1.010 further explains as follows that:

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

The Agency denied the reimbursement for the cost of hyperbaric oxygen treatments, and the cost of transportation to and from the petitioner's home for hyperbaric oxygen treatments, to be funded through the Medicaid Program. Florida Medicaid reimburses for services that are medially necessary, and that are not experimental or investigational. The Agency determined that there is no conclusive evidence that hyperbaric oxygen is an effective medically necessary treatment for the diagnosis of the petitioner's hypoxic brain injury. It was determined that since this treatment for this condition is experimental, the service is not covered for the petitioner's diagnosis. After careful consideration, it is concluded that the Agency's actions are upheld.

DECISION

This appeal is denied and the Agency's actions are 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 21 day of November 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: [redacted] Petitioner
Gail Wilk, Area 10 Medicaid Adm.

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

[redacted]

APPEAL NO. 07F-4974

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 October 9, 2007, at 9:16 a.m., in Miami, Florida. The petitioner was not present but was represented by her mother [redacted]. Present, on behalf of the respondent was Monica Otaloira, program specialist with the Agency for Health Care Administration. Appearing telephonically as witnesses for the agency was [redacted]physician reviewer and Teresa Ashey, nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez, program specialist was present as an observer.

ISSUE

At issue is the agency's action in denying 72 hours of private duty nursing (PDN) and approving a total of 648 hours from the requested 720 hours of PDN. The certification period is for July 7, 2007 through September 4, 2007. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is two years old and a Medicaid beneficiary in the state of Florida. The petitioner's medical condition as reported to the agency was: "Congenital Agensis, Hypoplasia and Dysplasia of Lung, Short Gestation of Infant, 27-28 Completed Weeks of Gestation, Other Convulsions."

On August 1, 2007, the provider [redacted] Home Health) requested 720 (12 hours daily) skilled nursing hours for the certification period of July 7, 2007 through September 7, 2007.

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

On August 3, 2007, a preliminary screening of the request was completed by a registered nurse reviewer. The provider was requested to submit additional information and clarification, which were ultimately provided.

On August 14, 2007, a physician consultant (board-certified pediatrician) reviewed the request and denied PDN hours that were being requested for Saturdays and Sundays, when the parent did not work or attend school. A PDN/PC Recipient Denial Letter was sent to the petitioner and provider denying 216 hours and approving 504 hours.

On September 29, 2007, a second physician consultant (board-certified pediatrician) reviewed the request, as part of the reconsideration process. No new information was received but the reviewer did consider chores and other obligations by the petitioner's mother (caregiver) and that the child is on a ventilator. The physician reviewer approved weekend PDN for 8 hours daily. On October 1, 2007 the petitioner and the provider were sent a Recipient Recon Overturned letter.

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.

Fla. Admin. Code 59.G-1.010, "Definitions", states for medical necessity:

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

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

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

Fla. Admin. Code 59G-4.130 Home Health Services states in part:

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

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

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

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

The petitioner's mother states that her daughter's pulmonologist recommended 24 hours a day of service. However, a letter (Petitioner's Exhibit 1) presented by her during

the hearing from the pulmonologist offers no new information only medical history and offers no recommendations on the number of hours required.

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The opinion of the physician reviewer was that the petitioner's mother was capable of providing partial care for the petitioner during the weekends, when she did not work or go to school.

Based on the above cited authorities, the respondent's action to approve 648 PDN hours and deny 72 PDN hours for the period of July 6, 2007 through September 4, 2007, was within the rules of the Program.

DECISION

The 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 9 day of November 2007,

in Tallahassee, Florida.

A. G. Littman

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

Copies Furnished To: [redacted], Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

[redacted]

APPEAL NO. 07F-04481

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was scheduled for August 29, 2007. The petitioner requested a continuance. The motion was granted and the hearing was rescheduled to September 11, 2007. The petitioner was unavailable on September 11, 2007 and the hearing was rescheduled to September 26, 2007. On September 26, 2007, the petitioner appeared with counsel. The respondent requested a continuance to seek legal counsel. The motion was granted and the hearing was rescheduled to November 1, 2007.

The hearing was convened before the undersigned hearing officer on November 1, 2007, at 2:18 p.m., in [redacted] Florida. The petitioner was not present. She was represented by [redacted] attorney. Witnesses for the respondent were [redacted] the petitioner's mother; [redacted] the petitioner's father, and [redacted] M.D., the petitioner's treating physician who

is the Medical Foster Care physician. The respondent was represented by [redacted] assistant general counsel. Witnesses for the respondent were [redacted] registered nurse specialist; [redacted] Medicaid nurse specialist, and [redacted], Medicaid physician consultant who is the respondent's Medical Assessment Team physician.

ISSUE

The petitioner is appealing the notice of July 18, 2007 for the respondent's action to stop Medical Foster Care effective July 28, 2007. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner received a Notice of Right to Appeal mailed on July 18, 2007. The notice informed the petitioner that Medical Foster Care would stop as of July 28, 2007. The reasons stated that the Medical Foster Care would stop were: "The child's medical condition no longer requires the level of the intervention(s) currently provided" and "The services are no longer appropriate to meet the needs of you child".

1. The petitioner is two years old. She had been placed in Medical Foster Care and is the custody of the Department of Children and Families. The diagnosis at the time of placement was non-organic failure to thrive with gross developmental delays due to malnutrition and macrocephaly. At the time of placement, the petitioner needed monitoring by a medical foster parent.

2. A staffing for continued placement was held on July 18, 2007. Present were the petitioner's biological mother, the medical foster care parent, a Medicaid

nurse and the Medicaid physician. A Child Assessment and Plan and a Staffing Summary Report were completed. The team determined that the petitioner's non-organic failure to thrive was resolved. The petitioner was steadily gaining weight. Genetics testing was done on June 7, 2007. The interpretation was a normal female karyotype and the petitioner's large head was familial. There had been no hospitalization or emergency room visits since the last staffing. The petitioner's care needs were speech therapy and follow up provider appointments.

3. Based on the assessment and report, the respondent determined that the petitioner no longer met the medical necessity criteria for placement in Medical Foster Care. A notice stopping the Medical Foster Care was sent to the petitioner on July 18, 2007.

4. The opinion of the Medicaid nurse and the Medicaid physician was that petitioner was no longer medically fragile. The petitioner no longer met the medical necessity criteria for Medical Foster Care.

5. The parents' position is that the petitioner should remain in Medical Foster Care to prevent any future failure to thrive and for continuity of foster placement. As of the date of the hearing, the court had not returned placement of the petitioner in her biological parent's home.

6. The petitioner's treating physician proffered no medical rebuttal. His opinion was that placement in Medical Foster Care was preferred until the petitioner was returned to her biological parents.

CONCLUSIONS OF LAW

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

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

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

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

The Medical Foster Care Services Coverage and limitation Handbook for the Medical Foster Care (MFC) Program, on page 2-1, states:

> Medicaid-eligible, medically-complex, or medically-fragile children under the age of 21 are eligible to receive MFC services...
> To receive MFC services, the recipient must be:
> - Medicaid eligible;
> - In the custody of the Department of Children and Families (DCF);
> - Medically complex or medically fragile per definition in this section;
> - Under the age of 21; and
> - Medically stable and not requiring acute hospital care at the time of placement, as determined by the MFC physician.

The Medicaid physician consultant opined that the petitioner was no longer medically fragile. The petitioner no longer met the medical necessity criteria for Medical Foster Care. The Medical Foster Care physician testifying for the petitioner did not rebut those statements. He indicated that Medical Foster Care was preferred until the return of placement with the biological parents. As set forth in rule, the fact that the petitioner's physician had recommended Medical Foster Care does not, in itself, make the recommendation medically necessary or a medical necessity or a covered service. The parents' request for the petitioner to remain in Medical Foster Care as a future prevention does not meet the medically necessity criteria. The evidence submitted sets forth that the petitioner's recommended care needs could be effectively furnished by speech therapy and follow up provider appointments. No evidence to the contrary was proffered. The respondent has met their burden of proof that the petitioner no

longer meets the medical necessity criteria for Medical Foster Care placement.

Based on the above cited authorities, the respondent's action to stop Medical Foster Care was within the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21 day of November, 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: [redacted] Petitioner
Noreen Hemmen, Area 5 Medicaid Adm.
Scott Orsini, counsel for the petitioner
Bevin Brown, counsel for the respondent

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

[redacted]

APPEAL NO. 07F-05781

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 25, 2007, at 10:30 a.m., in [redacted] Florida. The petitioner was present with her mother [redacted]. The respondent was represented by [redacted], program operations administrator. [redacted], program administrator, was a Spanish interpreter. Present on the telephone from the Agency was [redacted], program analyst, and [redacted], registered nurse consultant. Present on the telephone from United Healthcare AmeriChoice was Dr. [redacted] medical director; [redacted], pharmacy director; [redacted] compliance director; and [redacted], compliance analyst.

ISSUE

At issue is the Agency's April 23, 2007 denial of the [redacted] growth hormone for the petitioner, to be funded through the Medicaid Program. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, date of birth [redacted] is a recipient of Medicaid benefits through a Health Maintenance Organization United Healthcare. Included in the evidence is a copy of a notice, dated April 23, 2007, stating that the Medicaid Program will not pay for the growth hormone Saizen Cartridge, because it does not meet medical necessity. Included in the evidence is a copy of another notice, dated July 19, 2007, stating that this denial was reviewed, and it was determined that the decision to not pay for Saizen Cartridge was upheld.

In the July 19, 2007 notice, it states that preferred alternative medications, for informational purposes only, are Humatrope, Genotropin, and Nutropin AQ. It also states that the request to use Saizen Cartridge does not meet the plan's coverage. At the hearing, the petitioner's representative, her mother did not disagree with the Agency's denial of the growth hormone Saizen Cartridge.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. The Fla. Statutes at 409.912 states:

> The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required...
> 14. The agency may require prior authorization for the off-label use of Medicaid-covered prescribed drugs as specified in the General Appropriations Act. The agency may, but is not required to, preauthorize the use of a product for an indication not in the approved labeling. Prior

authorization may require the prescribing professional to provide information about the rationale and supporting medical evidence for the off-label use of a drug.

In accordance with Fla. Admin. Code 59G-1.010:

(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..."

Section 59G-1.010 further explains as follows that:

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

The petitioner receives Medicaid benefits, and the Agency denied the request for the growth hormone Saizen Cartridge, to be funded through the Medicaid Program. At the hearing, the petitioner's representative, her mother did not disagree with the Agency's

denial of the growth hormone Saizen Cartridge. The issue is resolved in favor of the respondent, therefore this denial is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 9 day of November, 2007,

in Tallahassee, Florida.

Stuart Imberman ss

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

Copies Furnished To [redacted] Petitioner
Gail Wilk, Area 10 Medicaid Adm.
[redacted]

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

[redacted]

APPEAL NO. 07F-04677

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 25, 2007, at 9:15 a.m., in [redacted] Florida. The hearing was rescheduled from October 10, 2007, at the respondent's request. The petitioner was not present. He was represented by his mother [redacted] and his father [redacted] The Agency was represented by Rafael Copa, program administrator. Present on the telephone from Kepro was Dr. [redacted] and [redacted], review operations manager.

ISSUE

At issue is the Agency's July 23, 2007 action of approving the petitioner's home skilled nursing services of 960 hours, which is 16 hours daily, from July 24, 2007 to September 21, 2007. The petitioner has the burden of proof.

FINDINGS OF FACT

Included in the evidence is a copy of a Recipient Denial Letter, dated July 23, 2007, stating that the petitioner was approved for home skilled nursing services of 900 hours from July 24, 2007 to September 21, 2007. It also states that 268 hours of home skilled nursing services for that time period was denied for the petitioner. Also included in the evidence is a copy of a Recipient Reconsideration Denial Overturned notice, that is dated August 2, 2007, stating that the petitioner was approved for home skilled nursing services of 960 hours from July 24, 2007 to September 21, 2007. It also states that 208 hours of home skilled nursing services for that time period was denied for the petitioner.

Home skilled nursing services of 960 hours for 60 days is 16 hours daily. According to the parties at the hearing, the petitioner was previously approved for 19 hours of daily home skilled nursing services, and due to the appeal, he is continuing to receive this amount of service. According to the petitioner's representative, effective September 2007, the petitioner's home skilled nursing services were switched to the Children Medical Services (CMS), where he continues to receive 19 daily hours of home skilled nursing services.

CONCLUSIONS OF LAW

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

Fla. Admin. Code 59G-1.010 explains medically necessary, and Fla. Admin. Code 59G-4.290 explains skilled services. The petitioner is receiving home skilled nursing

services of 19 hours daily, and it was determined that for July 24, 2007 to September 21, 2007, these services would be reduced to 16 hours daily. Due to the appeal, the hours of the services were not reduced, and then effective September 2007, the petitioner's home skilled nursing services were switched to the Children Medical Services (CMS), where he continues to receive 19 daily hours of home skilled nursing services.

Fla. Admin. Code 65-2.056 explains that a hearing shall include consideration of an Agency action. The Agency did not actually take an action to reduce the number of hours of the petitioner's home skilled nursing services. It is determined that since the Agency did not take an adverse action on the petitioner's benefits, a decision is not being made, and the issue is considered moot.

DECISION

This appeal is dismissed.

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 November, 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 T[redacted] Petitioner
Gail Wilk, Area 10 Medicaid Adm.

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

[redacted]

APPEAL NO. 07F-5236

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 November 7, 2007, at 8:14 a.m., in [redacted] Florida. The petitioner, [redacted] was not present however he was represented by her mother, [redacted] Present, on behalf of the respondent was [redacted] program specialist with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the agency was Dr. [redacted] physician reviewer and [redacted] nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. [redacted] specialist with AHCA was present for observation. The hearing was previously scheduled for November 10, 2007, but was continued at the request of the petitioner.

ISSUE

At issue is the agency's action in denying 120 hours of private duty nursing (PDN) and approving 1,320 hours from the requested 1,440 hours of PDN. The certification

period is for August 5, 2007 through October 31, 2007. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is one year ([redacted] old and a Medicaid beneficiary in the state of Florida. The petitioner's is medically complex with a principal diagnosis of ectopia cordis and other diagnoses of esophageal reflux and chronic respiratory failure. Services have been continued at their prior level throughout the hearing process.

On July 19, 2007, the provider requested 1,440 hours (24 hours a day, 7 days a week) of skilled nursing for the petitioner for the certification period of August 5, 2007 through October 3, 2007.

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

On July 23, 2007, an initial screening of the request was completed by the registered nurse reviewer. The provider was requested to submit additional information and clarification, which were ultimately provided.

On August 6, 2007, the registered nurse reviewer referred the case to a board certified pediatric specialty physician consultant for review of level of care.

On August 7, 2007, a physician consultant reviewed the information submitted and denied the request for services documenting, "Pt s/p [status post] ectopia cordis repair, g-tube, trach, vent [ventilator] dependent. Dad works 7 days/wk [week] but split schedule. Mother does not work, 2 other children. Request is for 24/7. Between mom and dad they should be able to cover 1-2hr/day. Deny 24/7. Would approve 22/7." A PDN/PC Recipient Denial Letter was issued to the petitioner denying 120 (2 hours a day) hours of PDN 7 days a week. The provider then submitted a reconsideration request along with additional social information, "...Mother say she has two other children to care for and is not able to provide the care safely to [redacted] Mother states her and her husband do not feel comfortable proving [sic] the care for [redacted] due to the complexity of the care and that the husband is working most of the time and needs to rest the few free hours he has in order to go back to work."

It was then determined by a different board certified in pediatrics physician reviewer that based on the information provided, the parents had received on-going education on a daily basis in order for them to provide supplemental assistance in the care of their son. The physician reviewer testified that it was reasonable after one year, for the parents to assist by providing 2 hours daily of care of the petitioner. The original decision to approve 1,320 hours (22 hours a day) and deny 120 (2 hours a day) hours, 7 days a week was upheld by a second physician reviewer.

On September 24, 2007, a PDN/PC Recipient Reconsideration-Denial Upheld notice was issued to the petitioner and provider informing them of the approval and denial of hours. The petitioner appealed the decision on September 10, 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 and states as follows:

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

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

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

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

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

Fla. Admin. Code 59G-4.130 *Home Health Services* states in part:

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

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

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

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

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

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

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

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

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

The petitioner's mother states that she currently does care for her son in between nursing shifts "a couple of hours here and there" as the nurses run late. She states that she had a fifteen week crash course on how to provide care for her son and she does know how to care for him. However, she had to call 911 because her son pulled the g-tube and she did not know what to do in an emergency as her son's condition is medically complex. The petitioner provided letters from her son's treating physician and physical therapist where they recommend nursing services at a 24 hour level. She states that she

is going through an eviction from her home (landlord lost property to foreclosure) and does not feel she can handle a reduction in her son's care at this time. Additionally, she has two other children, one of which has learning disabilities and her husband is also working additional hours due to their financial situation.

The agency's physician consultant responded that with the information received through the mother's testimony, he "would rescind and approve the 24 hours" of service."

After careful consideration to testimony from the petitioner's mother, letters from treating physicians and testimony from the agency's physician reviewer stating that given the information made available at the hearing he would rescind and approved the request, the hearing officer grants the petitioner's appeal. The agency's decision is reversed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 November 2007,

in Tallahassee, Florida.

A. G. Littman

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

Copies Furnished To [redacted] Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

[redacted]

APPEAL NO. 07F-06217

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on November 16, 2007, at 9:00 a.m., in [redacted] Florida. The petitioner was present with her daughter, [redacted] and grandson, [redacted] The respondent was represented by [redacted], program operations administrator, and [redacted], human services program specialist. Present from Florida Netpass was [redacted] Esq. and [redacted] grievance managers.

ISSUE

At issue is the Agency's July 6, 2007 action of cancelling the petitioner's home health aide services. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner was receiving home health aide services, and these services were cancelled. She received a notice dated July 6, 2007, stating that coverage for home

health aide services were denied. The notice explains that it was determined by Florida Netpass that based on the medical documentation from the petitioner's primary care physician, there are no physical deficits that meet the criteria for the continuation of the services per the Medicaid guidelines. As a result of the denial to continue the services, the home health aide services have been cancelled.

After the hearing was held, the Agency submitted into evidence one page of information on November 16, 2007. According to the Hearings Office record, the date of the request for this hearing was on October 15, 2007. According to the information that the Agency submitted into evidence, the actually date of appeal was on October 3, 2007. This evidence shows that the petitioner requested this hearing timely, within ninety days from the date of the notice informing her about the cancellation of the home health aide services. This information was therefore, submitted into evidence.

According to the respondent's representative, when the petitioner was receiving the services, a home health aide visited her three times weekly for about four hours for each visit. The care that is provided by a home health aide is to assist with activities of daily living, such as bathing, dressing, and meal preparation. According to a Home Health Certification and Plan of Care, dated June 1, 2007, included in the evidence, the petitioner has convulsions, hypertension, and a urinary tract infection. After reviewing the Plan of Care for the petitioner, Dr. [redacted] from Florida Netpass determined that the petitioner's home health aide services should be cancelled.

CONCLUSIONS OF LAW

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

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

Fla. Admin. Code 59G-4.130 explains home health services. The Home Health Services Coverage and Limitations Handbook explains on page 2-14 that home health services must be ordered by the attending physician and medically necessary. The petitioner was receiving home health services of three visits weekly for about four hours each visit. These services were canceled because it was determined that the home health services are not medically necessary. This was determined by a physician at Florida Netpass, based on the information received from the petitioner's primary physician. After careful consideration, it is determined that the Agency's action to cancel the home health services, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Stuart Imberman SI

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

Copies Furnished To: [redacted] Petitioner
Gail Wilk, Area 10 Medicaid Adm.

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

APPEAL NO. 07F-04676

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 10, 2007, at 9:05 a.m., in Bradenton, Florida. The petitioner was present. The respondent was represented by Peggy Diaz, senior human service program specialist. Witnesses for the respondent were Jim Singleton, Medicaid program analyst; Vickie Deloatch, register nurse in quality management for Amerigroup, and Mitchell Wright, director of regulatory services for Amerigroup. Observing were , friend of the petitioner, and Kathy Wilson, registered nurse consultant for the respondent.

The record was left open for 30 days for the respondent to show proof that bills were paid. The evidence was due no later than October 7, 2007. On September 28, 2007, proof that bills were paid was received and entered into record as Respondent Exhibit 1.

ISSUE

The petitioner is appealing the notice for the respondent's action to deny payment for medical bills for September 2006, January 2007 and February 2007.

FINDINGS OF FACT

1. The petitioner was sent notices that medical bills for September 2006, January 2007 and February 2007 were denied payment. The respondent did not pay the bills due to a billing error by the providers. As Medicaid did not pay the bills, the providers billed the petitioner.

2. The petitioner was not responsible for those bills and should not have been billed. The respondent attested that as of the hearing, all of the bills in question were being processed for payment. Proof that all bills in question were paid was received on September 28, 2007.

CONCLUSIONS OF LAW

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

At the time of the hearing request, the bills were not paid. As the respondent has made payment for the bills of September 2006, January 2007 and February 2007 on September 17, 2007, no further resolution exists.

DECISION

This appeal is granted.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17 day of October, 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: ıs, Petitioner
Patrick Glynn, Area 6 Medicaid Adm.
Peggy Diaz, R.N., for the respondent
Vickie Deloatch, R.N. for Amerigroup