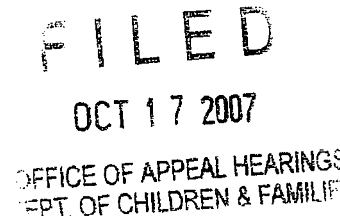

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 07F-05278

PETITIONER,

Vs.

CASE NO. 1226952984

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 2, 2007, at 3:50 p.m., in Largo, Florida. The petitioner was not present. The petitioner was represented by his daughter, Present on behalf of the petitioner was his wife, n, and director of social services at the nursing facility, The respondent was represented by Suzi Jackson, economic specialist supervisor.

ISSUE

The petitioner is appealing the notices of July 19, 2007 for the respondent's action to deny Institutional Care Program (ICP) and Medicaid benefits for February, April and June 2007. As this was an application, the petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner received Notices of Case Action denying ICP and Medicaid Program benefits for February, April and June 2007. The reason stated for the denial was: "Income is more than allowed for this Program".

1. The petitioner's attorney applied for ICP and Medicaid for the petitioner in September 2005, as the petitioner's representative. The petitioner's attorney assisted the family in establishing an Irrevocable Income Trust for the petitioner. The attorney wrote the family on September 8, 2005 and stated: "...all of the petitioner's gross income will need to be deposited into this account each and every month without exception for him to continue to qualify for Medicaid benefits...". The trust was funded in September 2005 and the petitioner was eligible for ICP and Medicaid Program benefits. As the petitioner had established an Income Trust Account, the petitioner would be eligible for ICP and Medicaid Program benefits in the months the Income Trust Account was funded (funds deposited) in an amount that would reduce the petitioner's income to below the income eligibility limit for the Program. The funds from that account could then be used to pay the nursing facility. The Income Trust Account continued to be funded in 2005 and 2006. As part of the application, the representative agreed to report any changes within ten days.

2. In 2006, the nursing home that the petitioner was living in at the time designated themselves as the petitioner authorized representative. The facility reapplied for ICP and Medicaid Program benefits for the petitioner. As part of the application, the representative agreed to report any changes within ten days.

3. The respondent contacted the petitioner through his representative, the facility, when the December 2006 recertification was due. The facility informed the respondent that the petitioner moved and they did not know where the petitioner was. No changes had been reported to the respondent by the petitioner's attorney, the facility or the petitioner's family. As the respondent was unaware of the petitioner's location and the petitioner's representatives had failed to report any change in location, the ICP and Medicaid Program benefits were closed.

4. The petitioner had entered a new nursing facility. The new facility reapplied for benefits in March 2007, as the petitioner's authorized representative. The nursing facility failed to complete the application process and the application was denied. The petitioner was not longer receiving ICP and Medicaid Program benefits.

5. The nursing facility applied for ICP and Medicaid for the petitioner on June 4, 2007. The petitioner's income in 2007 was $1,281.64 in pension and $1,079 in Social Security for a total income of $2,360.64. The petitioner died on

.

6. The respondent reviewed the application and Income Trust Account statements. The income limit for ICP benefits in 2007 was $1,869. The petitioner's gross monthly income was $2,360.64. The petitioner's income exceeded the Program eligibility limits. The Income Trust Account was sufficiently funded in January, March and May 2007, which reduced the petitioner's monthly income within the income eligibility standard. The

respondent authorized ICP and Medicaid Program benefits for January, March and May 2007. The amount of patient responsibility to the facility after subtracting the $35 personal needs allowance was $1,848.29.

7. There were no deposits in February, April or June 2007, indicating that the Income Trust Account was not funded in February, April or June 2007. As the petitioner did not fund the Income Trust Account in February, April or June 2007, the petitioner's income exceeded the Program eligibility standards in February, April and June 2007. The respondent denied ICP and Medicaid for February, April and June 2007.

8. The daughter stated that the petitioner's wife was confused. The wife did not fund the Income Trust Account in February, April or June 2007, as there were enough funds in there to pay the nursing home. The wife thought that she did not have to make any deposits, as the attorney told her not to "over fund" the Income Trust Account. The daughter opined that the problems with the ICP and Medicaid Program benefits were due to the respondent closing the benefits without informing the family first. The petitioner's witnesses indicated there were issues with the nursing facilities which added to the wife's confusion. The old nursing facility was aware of where the petitioner was transferred to as they helped with the placement to that new facility. The new nursing facility suggested that the wife place the petitioner's Social Security income in a Resident Fund account with the facility. The daughter and the wife attested that the wife did not understand what she was signing.

CONCLUSIONS OF LAW

The responsibility for the petitioner and/or their representative to report changes is set forth in the Florida Administrative Code at 65A-1.204:

> (1)...The applicant for or recipient of public assistance must assume the responsibility of furnishing all necessary facts and documentation to establish eligibility, advise the Department of any changes in his/her circumstances which might affect eligibility and/or the amount of the public assistance benefit, and to provide the department with any channel of information concerning his/her affairs that may be determined necessary.

The daughter opined that the problems with funding the Income Trust Account started with the respondent closing the case without notifying the family. The hearing officer finds that the petitioner through his representatives failed to report where the petitioner was residing. Changing facilities would be a change that would be a change that required for the petitioner to report within ten days. Florida residency and residency in a nursing home is required for eligibility for ICP benefits. The action by the respondent to close the ICP and Medicaid Program benefits was consistent with rule and policy. It is further noted that the reason for denial in the months of February, April and June 2007 was the lack of funding of the Income Trust Account.

Income limits for ICP benefits is set forth in the Florida Administrative Code at 65A-1.713 "SSI-Related Medicaid Income Eligibility Criteria":

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by

> establishing an income trust which meets criteria set forth in paragraph 65A-1.702(15), F.A.C.
> (2) Included and Excluded Income...
> (d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

The intent of the Income Trust Account is to reduce the recipient's income to an amount below the income limit. Authorized disbursement from this account is payment to the nursing home. The Income Trust Account was not intended to insure that there are sufficient funds in the account to pay the facility. For the petitioner to meet the income eligibility, the Income Trust Account would need to be funded with at least $492 each and every month. The petitioner did not make any deposits into the Income Trust Account in February, April or June 2007. As the Income Trust Account was not funded, all of the petitioner's income in those months was countable. The petitioner's gross monthly income was $2,360.64 in February. April and June 2007. The income limit for ICP benefits in 2007 was $1,869. The petitioner's income exceeded the Program eligibility standards for February, April and June 2007. The rules do not provide for any exception to meeting the income eligibility standards. Based upon the above cited authorities, the respondent's action to deny ICP and Medicaid Program benefits was within the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review.

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

DONE and ORDERED this 17th 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: Petitioner
Roseann Liriano Suncoast Region
sentative for the petitioner

FILED
OCT 22 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-03817

PETITIONER,

Vs.

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

RESPONDENT.
_______________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on August 17, 2007, at 1:50 p.m., in New Port Richey, Florida. The petitioner was present to testify and represented himself. The respondent was represented by Jackie Swarm, program operations administrator with the Agency For Health Care Administration (AHCA).

Jodi Winter, physical therapy consultant with Medicaid, testified for the respondent by telephone. Patty Miner, medical assistant for Dr. Rosario, also testified by telephone.

ISSUE

At issue is the respondent's decision of May 12, 2007 to deny funding under the Medicaid Program for a requested custom power wheelchair that contains a powered standing component. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner received a second letter dated May 12, 2007 to explain why his request for a custom standing wheelchair was denied. The letter advises that AHCA determined the requested wheelchair was not the least costly wheelchair that could meet the petitioner's mobility needs. AHCA offered to purchase a new powered wheelchair with powered tilt and powered operated legrests, along with a separate stander, if requested. The petitioner seeks the custom standing wheelchair and declined AHCA's alternative offer of the described wheelchair and separate stander.
2. The petitioner has a diagnosis C5 quadriplegia. The petitioner has been using a powered wheelchair that does not have a standing device for an approximate one-year period. Both parties agree that the petitioner needs the medical benefits attributed to standing that include improved bowel and bladder function and skin integrity. However, the petitioner believes he has a need for frequent standing to assist bowel and bladder function but the respondent believes there is a less frequent need to stand. Based on the cumulative evidence, it is found that the petitioner has a need for frequent standing to assist bowel and bladder function.
3. The petitioner requested a Permobil C500 wheelchair with powered standing, powered tilt, powered recline, and stand and drive component. AHCA determined the powered standing and "stand and drive" component did not meet medically necessary criteria. The requested C500

wheelchair with the powered standing component costs $36,951.36. As an alternative, AHCA offered a C300 wheelchair without the standing component that costs $17,843.61. AHCA also offered to approve a separate free-standing stander that costs $4,190, if requested by petitioner. AHCA contends that approval of the C300 wheelchair with the separate stander is the less costly alternative to the requested C500 wheelchair.

4. The petitioner cannot independently transfer from his wheelchair. The petitioner's father lives nearby. The petitioner's father has transferred him from his bed to the wheelchair in the morning, and his live-in girlfriend has transferred him in the evenings. No other persons are available to assist with transfers during the day. Because he has no other transfer assistance, the AHCA proposed C300 wheelchair with the separate stander would not meet his need for frequent standing. The petitioner's treating physician, Dr. Cristobal Rosario, strongly supports the petitioner's request for the C500 wheelchair with the powered stander due to recent medical issues.

5. The petitioner works full-time as a volunteer coordinator for [illegible]. This job involves managing and talking with volunteers along with computer work. No individual in this employment assists with transfers from the wheelchair to any other device. The petitioner's live-in girlfriend is not generally available to assist with transfers except at night.

CONCLUSIONS OF LAW

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

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

Paragraph 2. of the above-cited Administrative Code Rule indicates that services must be individualized, specific, consistent and must not be "in excess of the individual's needs." AHCA determines the requested powered wheelchair that contains the powered stander to be in excess of the petitioner's needs and not the least costly alternative as in paragraph 4. An excerpt from the DME/Medical Supply Services Coverage and Limitations Handbook on page 2-57 states the following, in pertinent part:

> Medicaid may reimburse for a customized wheelchair that is specifically constructed (K008, K0013, K0014). Prior authorization is required. Medicaid will not approve a customized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADL's within the home has been established.

The petitioner could independently use the requested C500 wheelchair with the powered stander to facilitate his established medical need of frequent standing. However, the petitioner could not use the alternative C300 wheelchair with the separate stander because he does not have sufficiently available support to transfer to the separate stander. Therefore, the less costly C300 wheelchair with the separate stander does not meet the petitioner's established medical need for frequent standing. Further, since the powered stander function of the requested C500 wheelchair facilitates more independence in the performance of activities of daily living (ADL's), it is not concluded that the requested wheelchair is in excess of the petitioner's needs.

The agency witness asserts that the requested wheelchair is not the "least costly alternative," as per the language listed in paragraph 4. However, the alternative C300 wheelchair with the separate stander is not an "equally effective" alternative to the requested C500 wheelchair with powered stander to meet the petitioner's need for frequent standing. Since the alternative C300 wheelchair with the separate stander is not equally effective to meet the petitioner's needs, it can not be considered an appropriate less costly alternative.

Paragraph 5 of the above F.A.C. Rule shows that a requested service under Medicaid must be "furnished in a manner not *primarily* intended for the convenience of the recipient, the recipient's caretaker, or the provider." The

provision of the requested C500 wheelchair would assist the convenience of the petitioner to have a readily available means of standing. However, it is not concluded that the requested wheelchair is *primarily* intended as a convenience, due to the significant medical benefit of frequent standing without need for assistance to transfer.

Based on the above conclusions, the request for a wheelchair with the powered stander meets the defined medical necessity criteria. The petitioner's treating physician strongly opines the need for such powered wheelchair. Therefore, the respondent is incorrect to deny the requested wheelchair based on not meeting medical necessity criteria.

DECISION

This appeal is granted. The respondent is ordered to provide funding for a requested a wheelchair that provides the powered stander component, to assist in the petitioner's independent performance of ADL's.

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 22 day of October, 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, Petitioner
Noreen Hemmen, Area 5 Medicaid Adm.

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

FILED
OCT 17 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

APPEAL NO. 07F-04976

PETITIONER,

Vs.

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

RESPONDENT.
________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 18, 2007, at 12:30 p.m., in St. Petersburg, Florida. The petitioner was not present. He was represented by his mother, ' n. The respondent was represented by Stephanie Lange, registered nurse specialist. Kathleen Freeman, registered nurse specialist was observing. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Robert Buzzeo, M.D. consulting physician, and Teresa Ashey, nurse reviewer.

ISSUE

The petitioner is appealing the notice of July 30, 2007 for the respondent's action to decrease private duty nursing from ten hours per day to eight hours per

day for the period of August 5, 2007 through October 3, 2007. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Denial Letter on July 30, 2007. The notice informed the petitioner that for the requested 600 hours of private duty nursing for the period of August 5, 2007 through October 3, 2007, 480 hours was approved and 120 hours were denied. This reduced the private duty nursing from ten hours a day to eight hours a day for the 60 day period.

1. The petitioner care is medically complex. He was receiving private duty nursing private duty nursing ten hours a day. He attends school 9:45 a.m. to 3:45 p.m. and Prescribed Pediatric Extended Care (PPEC) at the Bishop Center in the morning from 7:00 a.m. till he goes to school and after school until 6:00 or 7:00 p.m.

2. The petitioner's mother is going to school and is completing an internship. She is not working in addition to the internship. She is eight months pregnant. The petitioner has one sibling.

3. The petitioner's treating physician wrote a prescription for ten hours a day of private duty nursing. The nursing agency requested 600 hours of private duty nursing for the petitioner for the period of August 5, 2007 through October 3, 2007. This request would be ten hours a day of private duty nursing.

4. Prior authorization for private duty nursing is reviewed every 60 days. KePRO is the contract provider for the respondent for the prior authorization

decisions for private duty nursing. The request for private duty nursing is reviewed by a nurse reviewer and a physician consultant.

5. The initial nurse reviewer screened the petitioner's request for private duty nursing using the Internal Focus Finding. The Internal Focus Finding provides information to KePRO of case identifiers and additional information regarding the petitioner. This information is generated to the computer for review by KePRO from the information entered by the petitioner's home health agency via computer. The initial nurse reviewer determined that the petitioner scored 83 points on the Pediatric Home Care Guide for PDN Hourly Utilization. A score of 101-130 points is required to support the number of hours requested by the petitioner. The request was then referred to the board certified pediatric specialty physician consultant.

6. The initial physician consultant determined that it was medically necessary for the petitioner to have eight hours of private duty nursing a day in order for the petitioner's mother to have eight hours of sleep. A PDN/PC Recipient Denial Letter was sent to the petitioner on July 30, 2007. The notice informed the petitioner that for the requested 600 hours of private duty nursing for the period of August 5, 2007 through October 3, 2007, 480 hours was approved and 120 hours were denied.

7. The petitioner requested a reconsideration. The reconsideration was reviewed by a nurse reviewer and a physician consultant. The reconsideration was denied. A PDN/PC Recipient Reconsideration - Denial Upheld notice was sent to the petitioner on August 9, 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. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

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

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

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

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

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

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The medical opinion of the physician reviewer for the period of August 5, 2007 through October 3, 2007 was that the petitioner's mother was capable of providing care for the petitioner and would require a break of eight hours a day for sleep. The amount of private duty nursing the respondent authorized in order that the mother's participation in providing care for the petitioner to the fullest extent possible was eight hours a day. As set forth in rule, the fact that the petitioner's physician had prescribed private duty nursing does not, in itself, make the prescribed hours of private duty nursing medically necessary or a medical necessity or a covered service. Based on the above cited authorities, the respondent's action to approve 480 hours of private duty nursing and deny120 hours of private duty nursing for the period of August 5, 2007 through October 3, 2007 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 17th 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: [illegible], Petitioner
Noreen Hemmen, Area 5 Medicaid Adm.
Kathy Wilson

FILED
OCT 08 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-04521

PETITIONER,

Vs.

CASE NO. 1194093094

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 22, 2007, at 11:49 a.m., in St. Petersburg, Florida. The petitioner was not present. The petitioner was represented by social services director in the facility the petitioner resides. Witnesses for the petitioner were , administrator of the facility, and Elaine Mirkurak, ombudsman. The respondent was represented by Theresa McComber, senior economic specialist.

ISSUE

The petitioner is appealing the notice of April 30, 2007 for the respondent's action to terminate the petitioner's Institutional Care Program and

Medicaid benefits effective May 31, 2007. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner was sent a Notice of Case Action on April 30, 2007. The notice informed the petitioner that their Institutional Care Program and Medicaid benefits would be terminated effective May 31, 2007. The reason for the denial was: "You did not follow through in establishing eligibility".

1. The petitioner had been receiving Institutional Care Program and Medicaid benefits. The petitioner had been residing in a nursing home. The petitioner was receiving Hospice Services. The petitioner's spouse resides in the same nursing home as the petitioner had previously resided. The petitioner and his spouse have separate assistance groups. On August 29, 2007, the ombudsman informed the hearing officer that the petitioner died on August 25, 2007.

2. The petitioner was pended for information for the petitioner's continued eligibility. The requested information was not received. On April 30, 2007, the respondent closed the petitioner's Institutional Care Program and Medicaid benefits effective May 31, 2007. The notice was sent to

3. The representative conceded that the respondent's action was correct at the time. The representative requested the hearing to have new and material evidence reviewed for Institutional Care Program and Medicaid benefits effective June 1, 2007. The representative did submit an application for the petitioner in August 2007.

4. The respondent agreed to review new and material evidence and determine eligibility effective June 1, 2007. In addition to the verification requested in April 2007, the respondent has requested additional verification for the August 2007 application and retroactive benefits. This request for additional verification was based on information of a change in the petitioner situation that occurred that would be relevant to the June 2007 and any ongoing benefits. All information requested has not been submitted to the respondent and was not available for the hearing.

CONCLUSIONS OF LAW

The eligibility determination process is set forth in the Florida Administrative Code at 65A-1.205 and states in relevant part:

> (1)(a) Eligibility must be determined initially at application and if the applicant is determined eligible, at periodic intervals thereafter. The applicant is responsible to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility as determined by the eligibility specialist within time periods specified by the eligibility specialist...
> (d)...For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated)...If the required verifications and information are not provided by this date, the application is denied...
> (2) Eligibility must be redetermined at periodic intervals.
> (a) A complete eligibility review is the process in which the eligibility specialist reviews all factors related to continued eligibility of the assistance group.
> (b) A partial eligibility review entails review of one or more, but not all, factors of eligibility. Partial reviews are scheduled based on known facts or anticipated changes or when an unanticipated change occurs...
> (4) An applicant or recipient who fails to keep an appointment without arranging another time with the eligibility specialist; fails or refuses to sign and date the Common Application Form; fails or refuses to submit a periodic report; or fails or refuses to submit

required documentation or verification will be denied benefits as eligibility cannot be established.

Reevaluation of Medicaid adverse actions is set forth in the Florida Administrative Code at 65A-1.702 — Special Provisions:

> (6) Re-evaluating Medicaid Adverse Actions...
> (a) 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.

The petitioner failed to submit requested verification for the April 2007 redetermination. The respondent's action to terminate Institutional Care Program and Medicaid benefits was within the rules of the Program. The representative conceded that the respondent's action were correct at the time of the denial on April 30, 2007. The representative requested the hearing to have new and material evidence reviewed for Institutional Care Program and Medicaid benefits effective June 1, 2007. The respondent agreed to review new and material evidence and determine eligibility effective June 1, 2007 based on the hearing

request and the petitioner's August 2007 application and request for retroactive benefits for June and July 2007.

DECISION

This appeal is found as set forth 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 8th 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: [illegible] Petitioner
Roseann Liriano, Suncoast Region

FILED
OCT 0 8 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-04520

PETITIONER,

Vs.

CASE NO. 1194093094

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

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 22, 2007, at 11:49 a.m., in St. Petersburg, Florida. The petitioner was not present. The petitioner was represented by , social services director of . Witnesses for the petitioner were , administrator of the facility, and Elaine Mirkurak, ombudsman. The respondent was represented by Theresa McComber, senior economic specialist.

ISSUE

The petitioner is appealing the notice of April 30, 2007 for the respondent's action to terminate the petitioner's Institutional Care Program and Medicaid benefits effective May 31, 2007. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner was sent a Notice of Case Action on April 30, 2007. The notice informed the petitioner that their Institutional Care Program and Medicaid benefits would be terminated effective May 31, 2007. The reason for the denial was: "You did not follow through in establishing eligibility".

1. The petitioner had been receiving Institutional Care Program and Medicaid benefits. The petitioner's spouse had resided in the same nursing home the petitioner resides in. The petitioner and his spouse have separate assistance groups.

2. The petitioner was pended for information for the petitioner's continued eligibility. The requested information was not received. On April 30, 2007, the respondent closed the petitioner's Institutional Care Program and Medicaid benefits effective May 31, 2007. The notice was sent to [illegible] Center.

3. The representative conceded that the respondent's action were correct at the time. The representative requested the hearing to have new and material evidence reviewed for Institutional Care Program and Medicaid benefits effective June 1, 2007. The representative did submit an application for the petitioner in August 2007.

4. The respondent agreed to review new and material evidence and determine eligibility effective June 1, 2007. In addition to the verification requested in April 2007, the respondent has requested additional verification for the August 2007 application and retroactive benefits. This request for additional verification was based on information of a change in the petitioner situation that

occurred that would be relevant to the June 2007 and any ongoing benefits. All information requested has not been submitted to the respondent and was not available for the hearing.

CONCLUSIONS OF LAW

The eligibility determination process is set forth in the Florida Administrative Code at 65A-1.205 and states in relevant part:

> (1)(a) Eligibility must be determined initially at application and if the applicant is determined eligible, at periodic intervals thereafter. The applicant is responsible to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility as determined by the eligibility specialist within time periods specified by the eligibility specialist...
> (d)...For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated)...If the required verifications and information are not provided by this date, the application is denied...
> (2) Eligibility must be redetermined at periodic intervals.
> (a) A complete eligibility review is the process in which the eligibility specialist reviews all factors related to continued eligibility of the assistance group.
> (b) A partial eligibility review entails review of one or more, but not all, factors of eligibility. Partial reviews are scheduled based on known facts or anticipated changes or when an unanticipated change occurs...
> (4) An applicant or recipient who fails to keep an appointment without arranging another time with the eligibility specialist; fails or refuses to sign and date the Common Application Form; fails or refuses to submit a periodic report; or fails or refuses to submit required documentation or verification will be denied benefits as eligibility cannot be established.

Reevaluation of Medicaid adverse actions is set forth in the Florida Administrative Code at 65A-1.702 — Special Provisions:

> (6) Re-evaluating Medicaid Adverse Actions...
> (a) 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.

The petitioner failed to submit requested verification for the April 2007 redetermination. The respondent's action to terminate Institutional Care Program and Medicaid benefits was within the rules of the Program. The representative conceded that the respondent's action were correct at the time of the denial on April 30, 2007. The representative requested the hearing to have new and material evidence reviewed for Institutional Care Program and Medicaid benefits effective June 1, 2007. The respondent agreed to review new and material evidence and determine eligibility effective June 1, 2007 based on the hearing request and the petitioner's August 2007 application and request for retroactive benefits for June and July 2007.

DECISION

This appeal is found as set forth 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 5th 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: Petitioner
Roseann Liriano, Suncoast Region

FILED
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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs. APPEAL NO. 07F-04096

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on October 4, 2007, at 11:05 a.m., in Live Oak, Florida. The petitioner was present and represented herself. The respondent was represented by Christine Manley, senior human services program specialist. Present testifying by telephone as witnesses for the respondent were Dr. Maureen Levy, medical director, KePRO and Dianne Weller, registered nurse consultant, KePRO.

ISSUE

The petitioner is appealing the respondent's denial of a prior authorization request for inpatient hospital services for a subtotal colectomy.

The burden of proof was on the petitioner.

FINDINGS OF FACT

1. The petitioner is Medicaid eligible and resides in Suwannee County, Florida. The petitioner is 31 years old. Keystone Peer Review Organization (KePRO) is under contract with the Agency For Health Care Administration to perform medical reviews for the Medicaid prior authorization for Inpatient Hospital Medical Services Program for Medicaid recipients. KePRO determines medical necessity under the terms of the Florida Medicaid Program.

2. KePRO received a prior authorization request for the petitioner to undergo a subtotal colectomy and for five inpatient days from June 26, 2007 through July 1, 2007. The petitioner was diagnosed with colon obstruction and colon obstipation.

3. The petitioner has had problems with constipation for several years. She goes two weeks before having a bowel movement. The petitioner experiences bloating which looks like she is six months pregnant. She also has back pain and abdominal pain. The petitioner tried Zelnorm which relieved the constipation. However, it was taken off the market. The petitioner's constipation was previously treated with sigmoid resection. However, this did not work as the petitioner continues to have constipation. The cause of the constipation is unknown.

4. On October 2, 2007, the petitioner underwent a colonoscopy. During the hearing, the petitioner submitted the colonoscopy operative report and the diagnostic imaging report. These reports show no abnormalities of the wall of the colon, the movement of the colon was normal and the nerves of the colon were working well. The only abnormality was the narrowing of the sigmoid. There was no other abnormality which would be the source of the constipation.

5. On June 14, 2007 a physician consultant board-certified in surgery reviewed the petitioner's prior authorization request for a subtotal colectomy. The physician consultant denied the request because of insufficient history and clinical data to support the necessity for intervention.

6. On June 22, 2007, a Recipient Denial Letter was mailed to the petitioner denying her prior authorization request.

7. A reconsideration of the denial was requested. On July 25, 2007, a second physician consultant reviewed the petitioner's prior authorization request. The second physician consultant denied the request as documentation showed that the petitioner had been treated with only two medications and there was no documentation of dietary treatment or other treatment for the constipation. Therefore, there was no clinical indication for subtotal colectomy.

8. On June 25, 2007, a Recipient Reconsideration Denial Upheld letter was mailed to the petitioner denying her request for reconsideration of her prior authorization request.

9. During the hearing, Dr. Maureen Levy, medical director, KePRO reviewed the October 2, 2007, colonoscopy operative report and the diagnostic imaging report. According to Dr. Levy, findings in the reports did not show the source of the petitioner's constipation as there were no abnormalities in the colon that would indicate the need for a subtotal colectomy and it would be necessary to find the source of the constipation before deciding on the procedure needed.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.905 in part states:

Mandatory Medicaid services.--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.

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older; authorization of emergency and urgent-care admissions within 24 hours after admission; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceilings for fixed and property costs; and implementing target rates of increase. The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of the cost and potential for unnecessary hospitalizations represented by certain diagnoses. Admissions for normal delivery and newborns are exempt from requirements for prior authorization. In implementing the provisions of this section related to prior authorization, the agency shall ensure that the process for authorization is accessible 24 hours per day, 7 days per week and authorization is automatically granted when not denied within 4 hours after the request. Authorization procedures must include steps for review of denials. Upon implementing the prior authorization program for hospital inpatient services, the agency shall discontinue its hospital retrospective review program.

Fla. Admin. Code 59G-1.010(166) in part states:

> "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 Findings of Fact show that the petitioner requested prior authorization for inpatient hospital services for a subtotal colectomy. The request was made because the petitioner had constipation, bloating and abdominal pain. The findings show that with the medical information that was provided, the etiology of the constipation was not determined. The reviewing physicians needed clinical findings that showed the etiology of the constipation before determining whether a subtotal colectomy was medically necessary. Based on the above findings, it is concluded that the respondent correctly

denied the petitioner's request for prior authorization for inpatient hospital services for a subtotal colectomy, as medical necessity was not demonstrated.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

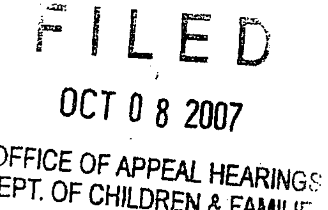
DONE and ORDERED this 17 day of October, 2007,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To: Petitioner
Marilyn Schlott, Area 3 Medicaid Adm.
KePRO South Medical Director
Diane Weller



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

APPEAL NO. 07F-04218

PETITIONER,

Vs.

CASE NO. 1013046013

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

RESPONDENT.
_______________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on August 17, 2007, at 3:22 p.m., in New Port Richey, Florida. The minor petitioner was not present. The petitioner was represented by his mother, who also testified.

The respondent was represented during the latter part of the hearing by Jackie Swarm, program office administrator with Medicaid Area 5. Ms. Swarm was also present to testify. Several individuals were present by telephone. Karen Kinser, registered nurse consultant with Medicaid Services in Tallahassee represented the respondent by telephone during the first part of the hearing. Ms. Kinser was also present as a witness. Two individuals from Kepro were present by telephone. Dr. Rakesh Mattal, pediatrician, and George Smith, review

operations specialist, both appeared as witnesses by phone. Deborah Ulrich, social worker, also testified by telephone.

ISSUE

At issue is the respondent's reconsideration decision of July 9, 2007 to terminate prior approved private duty nursing (PDN) services paid by Medicaid. The petitioner was receiving PDN services 8 hours daily, 7 days weekly. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is twelve years old. The petitioner lives with and receives care from his mother, [illegible]
2. The petitioner has diagnoses as submitted to Kepro to include: Down's syndrome, gastrostomy status, unspecified lack of normal physiological development, open cervical fracture, second level, without spinal cord injury, and reactive airway disease.
3. Due to a loss of mobility on his right side, the petitioner underwent a surgical procedure for spasmodic torticolis in the year 2006. This surgery was unsuccessful so the petitioner underwent a second surgery. The cervical area fusion did not set in the second surgery. The petitioner was required to wear a "HALO" for 5 months afterward to keep the area immobilized. The HALO was removed on June 24, 2007, and the petitioner is to wear a cervical collar for two additional months.

4. The Kepro physician reviewer makes decision on the medical need for services based on the clinical and social information provided by the nursing agency. The Kepro physician reviewer noted that petitioner had improved ambulation since removal of the HALO on June 24, 2007. The reviewer noted overall significant improvement with no medication change and only a one-time visit to the hospital.
5. Based on records review, the Kepro physician believed that the petitioner is capable of feeding by mouth. However, the petitioner continues to receive g-tube feedings 3 to 4 times daily, and only takes milk by mouth. The Kepro physician opined that the petitioner vomits food due to a behavior-related problem. The Kepro physician believed the petitioner's only remaining issues are behavioral-related and not medical. The respondent terminated prior approved PDN services based on the belief that the petitioner only had remaining behavior issues, which would not be covered by PDN services. The cumulative evidence shows the petitioner does have significant behavioral issues, but also has other remaining medical issues that continue to require treatment.
6. The nursing information contained in Respondent Exhibit 5 includes a description of ongoing treatment needs as of July 2007. Based on this information, the petitioner's g-tube feedings remain unchanged, which require assistance with feeding and/or preparation. The petitioner remains incontinent of bowel and

bladder and requires frequent peri-care to prevent skin breakdown. The petitioner is prescribed 11 different medications. The petitioner is not verbal and requires full assistance and supervision when performing all of his activities of daily living.

7. The petitioner now attends school and is only home about 3 hours daily during school days, but he is awake and requires attention many times at night. The petitioner is at home on weekends. The petitioner's mother is able to meet the petitioner's care needs. However, the petitioner's mother has anxiety and stress-related symptoms per her physician's diagnosis. The petitioner's mother has significant sores on her left arm that she believes are stress-related. The petitioner's mother's physician opines that she could benefit from help for her son. The petitioner's mother is seeking PDN services of 8 hours daily on weekends to help reduce the anxiety and stress of caregiving.

CONCLUSIONS OF LAW

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

> ...means that the medical or allied care, goods, or services furnished or ordered must:

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

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the contracted Kepro reviewing pediatrician recommended the termination of PDN services based on the belief that the petitioner had no other remaining issues that require PDN services that are not behavior related. However, findings establish that the petitioner does have remaining medical issues that, in themselves, would merit the continued provision of PDN services, if the petitioner's caregiver was not capable of providing all needed PDN services, as below.

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

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

The Findings of Fact show that the petitioner's mother and caregiver is capable to provide all needed aspects of the petitioner's care. Findings also show that the petitioner's mother has anxiety and stress related problems, and the petitioner's mother could benefit from PDN services. However, the available evidence does not reach the level to show that the petitioner is unable to provide care for certain hours due to anxiety and stress problems. Since the available evidence does not reach this level, the approval of PDN hours would be concluded as a convenience rather than meeting the above criteria. Based on this conclusion, the respondent's decision to terminate approval of PDN services is upheld.

DECISION

This appeal is denied and the respondent action affirmed. Based on the available evidence, the respondent has met its burden to prove that PDN services can be safely terminated.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 8th day of October, 2007,

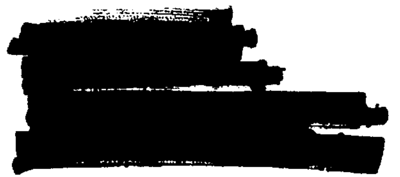
in Tallahassee, Florida.

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

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

FILED
OCT 17 2007
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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



APPEAL NO. 07F-04326

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 17, 2007, at 10:21 a.m., in Lake Wales, Florida. The petitioner was not present. He was represented by his parents, [redacted]. The agency was represented by [redacted] specialist. Present as witnesses for the agency were Dr. Rakesh Mittal, and George Smith, review operations supervisor.

ISSUE

At issue is the action by the agency reducing the private duty nursing hours from 686 to 652 for a sixty-day period. Since this is a reduction of services, the respondent bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient who has been receiving private duty nursing (PDN) services. Keystone Peer Review Organization (KePRO South) is

the Peer Review Organization contracted by the Agency for Health Care Administration to perform medical review for the Private Duty Nursing (PDN) and Personal Care Prior Authorization Program for Medicaid beneficiaries in the State of Florida. They review to determine "medical necessity" under the terms of the Florida Medicaid Program. On July 11, 2007, the petitioner filed a request for Medicaid to pay for 729 hours of PDN services daily for the period of July 22, 2007 through September 19, 2007. Both parties stipulated at the hearing that the calculation of the hours was submitted incorrectly by the provider. The requested total hours should have been 686 when calculated correctly. The breakdown of the PDN hours requested was for 12 hours per day 5 days per week, and 10 hours per day on weekends.

2. On July 16, 2007, the reviewing authority denied the request citing the reason that both parents were available on weekends. The reviewer noted that they would approve the weekday hours. However, they considered 4-6 hours reasonable for weekends.

3. The petitioner filed for a reconsideration stating "Please reconsider review of requested hours. The pt (patient) needs supervision at night because he receives a continuous enteral feeding....They both care for him on the weekends. It is not unreasonable for the parents to get 10 hours of PDN at night on the weekends so they can sleep." The request for reconsideration was forwarded to a second Physician Consultant who is Board-Certified in Pediatrics and who had not issued the initial level denial.

4. On July 19, 2007 the second reviewer determined that Kepro should approve 8 hours of PDN on the weekends. Both parties agreed that PDN was justified for 12 hours per day 5 days per week. The sole disagreement was in the number of weekend hours. On July 21, 2007, Kepro notified the provider that they approved 652 hours that included 8 hours per day on the two weekend days.

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

6. The father is the primary caregiver due to the petitioner's size and weight although both parents can provide care. His mother cannot lift him. She log rolls him with difficulty. All other care is provided by skilled nursing.

7. The petitioner receives benefits through the Developmental Services Home and Community Care Program. However, he is too medically complex for personal care services. This program does have skilled nursing services but recipients have to use all available PDN services available through the state plan Medicaid first.

8. The petitioner has to use a Vail bed due to his PICA condition. He uses a trixie lift. His condition has not deteriorated since his last review for PDN services. However, he is heavier and bigger.

CONCLUSIONS OF LAW

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

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

The Florida Administrative Code at 59G-4.290(2)(f) discusses Skilled Services and states in relevant part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
1. Ordered by and remain under the supervision of a physician;

2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury; and
6. Consistent with the nature and severity of the individual's condition or the disease state or stage.

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

Private Duty Nursing Services

Private Duty Nursing Definition

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

Who Can Receive Private Duty Nursing

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

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically complex.

Private Duty Nursing Requirements

Private duty nursing services must be:
- Ordered by the attending physician;
- Documented as medically necessary;
- Provided by a registered nurse or a licensed practical nurse;
- Consistent with the physician approved plan of care; and
- Authorized by the Medicaid service authorization nurse.

Parental Responsibility

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

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

> Medicaid does not reimburse private duty nursing for respite care. Examples are parent or caregiver recreation, socialization, and volunteer activities.

The facts establish that the petitioner requested 10 hours of PDN services on the weekend. The prior authorization reviewer approved 4-6 on the weekend nights but a second reviewer raised the authorization of PDN hours to 8. The reviewer argued that these are the most hours that would be medically necessary on weekend nights since there are two parents that are able to provide care. The PDN allowance is for the parents to obtain the required sleep hours.

The petitioner argues that the parents need more hours for sleep. However, substantive evidence did not establish the need for more than 8 hours of PDN on weekend nights. After careful consideration of the proper authorities and evidence, it is determined that the Agency's action to reduce the skilled home nursing services was correct.

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 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.

Terry Oberhausen

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

Copies Furnished To: [redacted], Petitioner
Patrick Glynn, Area 6 Medicaid Adm.
Mary Wheeler

FILED

OCT 29 2007

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-3960

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 September 19, 2007, at 8:25 a.m., in Miami, Florida. The petitioner, [redacted], was not present but was represented by [redacted], attorney with Legal Services of Greater Miami. Present, as a witness for the petitioner was [redacted] brother. Representing the agency telephonically was Tracy Wilkes, attorney for the Agency for Health Care Administration (AHCA). Present, on behalf of the agency was Oscar Quintero, program specialist with AHCA. Appearing telephonically, as witnesses for the agency, was Dr. David Porte, medical director with KēPRO South; Diane Weller, RN, KēPRO contract manager; and Teresa Ashey, KēPRO nurse reviewer. The hearing was previously scheduled for July 26, 2007 and August 21, 2007, but was continued at the request of the petitioner. The record remained open for two days in order for the respondent to provide (if requested) copies of documents to the petitioner.

ISSUE

The petitioner is appealing the July 2, 2007 denial of a prior authorization request for inpatient hospital medical services. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is forty-five years old and a Medicaid beneficiary in the state of Florida since approximately July 2007. Prior to his Florida Medicaid eligibility, the petitioner had medical coverage through private insurance and had been living in Illinois.

On January 15, 2007, the petitioner suffered an intracranial hemorrhage secondary to hypertension for which he was hospitalized through February 8, 2007.

On February 8, 2007, the petitioner began receiving acute inpatient rehabilitation from [redacted] Rehabilitation Hospital (in Illinois) for, "mobility and ADL dysfunction with neurocognitive deficits, anxiety depressive neurosis, right homiparesis, expressive aphasia, secondary to left basal ganglia thalamic infarct associated hypertension, diabetes mellitus, respiratory failure status post removal of trache tube, dysphagia with G-tube feeds, neurogenic bladder and exogenous obesity." The petitioner was discharged from acute inpatient rehabilitation on March 15, 2007.

On March 15, 2007, upon discharge from receiving acute inpatient rehabilitation at [redacted] the petitioner was then admitted to [redacted] Hospital and received inpatient rehabilitation therapy through April 25, 2007. The petitioner was discharged home with the family to receive outpatient therapy which he received, but was interrupted at some point due to transportation problems.

On May 9, 2007 the petitioner was hospitalized at [redacted] Hospital for further evaluation of hypertension. An adrenal tumor was discovered and removed and the petitioner was discharged July 7, 2007.

On June 29, 2007 while still hospitalized at [redacted] Hospital, the provider submitted a request for prior authorization for inpatient acute rehabilitation hospitalization admission on June 29, 2007 through July 6, 2007. The request was reviewed by Keystone Peer Review Organization (KēPRO), an organization under contract with AHCA to perform medical reviews of Medicaid prior authorization requests, for the Inpatient Hospital Medical Services Program for Medicaid beneficiaries in the state of Florida. This review is only for determining medical necessity, under the terms of the Florida Medicaid Program and is based on information submitted to KēPRO.

The provider submitted to KēPRO the following information: "Diagnosis: 'Acute, but ill-defined, cerebrovascular disease.' Presenting Signs and Symptoms/Treating Plan: '44 years old male was originally found unconscious on his apartment [sic] 1/15/07 with an intracranial hemorrhage secondary to hypertension resulting on a rt (right) hemiparesis [sic]. Pt was admitted to HealthSouth Rehabilitation services on 03/15/07 were [sic] he remained until 04/25/07 his functional level at discharge [sic] was eating/grooming/UE (upper extremity) dressing sup (supervision)/LE (lower extremity) dressing dep (dependent). Bathing max (maximum assist)/toilet dep/transfers max/amb (ambulation) max 3 steps. He then went to outpatient services for pt/ot/st (physical therapy/occupational therapy/speech therapy) where he was only seeing two visits [sic] were [sic] he developed hypertensive urgency admitted to [redacted] ›spital on 05/09/07 where he was found to have low potassium and elevated aldosterone with suspicion of a

aldosteronoma [sic]. Current functional level for transfers mod ass (moderate assist)/bed mobility mod ass with sliding board, able to propel w/c (wheelchair), unable to ambulate at this time, using hoyer lift for assistance/paralysis/numbness le. Pt alert and able to follow commands to the best of his physical ability answered questions well although with slow speech patterns [sic]. Rehab goals pt/ot/st to eval and treat. Increase strength [sic], endurance, balance, coordination, and gait. Educate pt and brother on safety transfers and therapeutic exercises. DC (discharge) planning to return home with brother or placement depending on progress and family support to be evaluated. LOS (length of stay) 3-4 weeks."

Upon initial screening by a registered nurse reviewer, the clinical information submitted by the provider did not meet the KēPRO Rehabilitation Guidelines in order to determine necessity for acute inpatient rehabilitation. The request was referred to a physician consultant, board-certified in rehabilitation on July 1, 2007.

The physician consultant reviewed the information submitted and denied the request for prior authorization and documents (Respondent's Composite Exhibit 1) the following: "Pt (patient) with limited progress from 1st admission with mild deficits but not significantly worse. Medical and rehab (rehabilitation) issues can be addressed in alternative care and dc may be to snf (skilled nursing facility) so can get therapy there and if improves can go home from snf." The petitioner and providers are sent a recipient denial letter on July 2, 2007 informing them that it was determined according to the information provided, "your medical care as described to us does not appear to require inpatient services."

On July 2, 2007 a second board certified physician consultant reviewed the request for inpatient acute rehabilitation hospitalization admission and upheld the original denial. The physician consultant testified that the petitioner received extensive inpatient rehabilitation therapies (02/08/07 through 03/15/07) and again admitted for inpatient rehabilitation (03/15/07 through 04/25/07). They then began therapies on an outpatient basis. The physician consultant determined that given the extensive inpatient therapy already given and the significant amount of time that had lapsed from the stroke and when they were requesting readmission, he "thought no reason to suspect that another stay of inpatient services would have any meaningful or significant effect on his recovery." KēPRO considered all clinical information made available to them by the provider on the petitioner's condition and past and current inpatient and outpatient treatments.

On July 2, 2007 a Recipient Reconsideration Denial Upheld Notice was issued to the petitioner and provider. The Notice states "...it has been determined that the medical care as described to us does not appear to require inpatient services."

On July 13, 2007, the petitioner restarted outpatient rehabilitation treatments at [redacted] Rehabilitation Hospital of three times a week. The petitioner has continued receiving outpatient therapy, through at least the day of the hearing and due to limitations would stop at some point.

The agency worked with the petitioner's brother in attempting to obtain additional information to support medical necessity for the requested service. The agency did not receive relevant information in order to approve the service. The petitioner requested a hearing on July 9, 2007.

CONCLUSIONS OF LAW

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

Fla. Admin. Code 59G-4.150 Inpatient Hospital *Services* states as follows:

> (1) This rule applies to all hospital providers enrolled in the Medicaid program.
>
> (2) All hospital providers enrolled in the Medicaid program must comply with the Florida Medicaid Hospital Coverage and Limitations Handbook and the Florida Medicaid Provider Reimbursement Handbook, UB-92, both incorporated by reference in Rule 59G-4.160, F.A.C. Both handbooks are available from the fiscal agent contractor.

The Florida Medicaid Coverage and Limitations Handbook, Hospital Services (June 2005) states as follows:

> Authorization for Inpatient Admissions-Effective March 1, 2002, Medicaid recipient admissions in Florida for medical, surgical, and rehabilitative services must be authorized by a peer review organization (PRO). The purpose of authorizing inpatient admissions is to *ensure that inpatient services are medically necessary*. ...

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...

The petitioner's brother states that he would like to see his brother receive more intense therapies such as what he would receive with inpatient rehabilitation services. He would be evaluated and receive physical, occupational and speech therapies on a daily basis for one hour each. The outpatient rehab therapies presently being received is being provided three times a week. The brother states that he believes that with inpatient services he will have more therapy and he will get stronger. He also would like to see his brother "off his medications or lower the doses."

The petitioner's representative argues that a total of four physicians recommend or agreed with the recommendation to receive inpatient rehabilitative services for the petitioner. She states that the standard for review is de-novo and all the information newly presented at the hearing be considered in the hearing officer's decision. In this case, the hearing officer conducted a de novo review.

The treating (from February 8th to March 15th) physician from [redacted] in his letter (Petitioner's Composite Exhibit 1) of July 24, 2007 states, "...Mr. [redacted] made some significant progress, but still requires some type of either post acute or outpatient rehab..." The treating physician ends his letter stating, "According to the family, I understand that he has had further medical problems... From the family description, I certainly recommend for him to receive acute inpatient rehabilitation."

A letter (Petitioner's Composite Exhibit 3) dated August 14, 2007 signed by Dr. Herrera, director at [redacted] Rehabilitation states that the petitioner at that time, had been an in the out patient rehabilitation program for one month. He states that the petitioner has "made significant progress on an out-patient basis, it was the consensus of the team that in order to attain the goals set for him, he is in need of an uninterrupted in-patient program."

An initial evaluation report (Petitioner's Composite Exhibit 4) completed by Dr. Penalba [redacted] Rehabilitation) dated August 28, 2007 states in part, "Chief Compliant: 'I need more inpatient rehab.' ...Mr. [redacted] has the potential to improve his overall strength and endurance, improve sitting and... He will benefit from acute inpatient rehabilitation readmission in order to achieve these goals."

A letter (Petitioner's Composite Exhibit 2) dated September 17, 2007 from treating (from March 15th to April 25th) physician while at [redacted] Rehabilitation Hospital states in part, "...in reading the reports of Dr. Penalba and Dr. Herrera, I am in agreement with an additional course of inpatient rehabilitation treatment to help restore physical function... ."

As the Findings of Fact shows, the petitioner had a stroke in January 2007. He received acute inpatient rehabilitation from February 8th to March 15th and then again, in another rehabilitative hospital from March 15th through April 25th. The petitioner then began outpatient therapy (three times a week) on an outpatient basis and continued through at least the day of the hearing.

On June 29, 2007, the provider submitted a request for prior authorization for inpatient acute rehabilitation hospitalization admission, along with the petitioner's medical history. On July 2, 2007, the nurse reviewer screened the request and referred the case to a board certified physician consultant, which issued a denial notice stating "your medical care as described to us does not appear to require inpatient services."

A reconsideration of the original request was done and a second board certified upheld the original denial. The physician testified stating that given the clinical information provided, he "thought no reason to suspect that another stay of inpatient services would have any meaningful or significant effect on his recovery."

In this case, the petitioner had two consecutive inpatient rehabilitation admissions and continued on an outpatient basis and all reports and letters provided, including testimony from the petitioner's brother states, the petitioner has and continues to make progress. All (Petitioner's Comp. Exh. 1 through 4) recommend or state that the petitioner would "benefit" from inpatient rehabilitation services.

In order to authorize inpatient services, the five conditions of medical necessity must be met and the services could not be "effectively furnished more economically on an outpatient basis or... ." The evidence presented did not develop these requirements therefore; the petitioner has not met his burden. Based on the evidence presented the

hearing officer affirms the agency's denial, as medical necessity was not demonstrated as required for the authorization of inpatient service.

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 October, 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: [redacted], Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Beth Papir Haspel, Esq.
Tracie Wilks, Esq.
Health Systems Development Administrator

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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-04188

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 09 Palm Beach

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 17, 2007, at 10:30 a.m., at the Lake Worth Service Center, in Palm Beach County, Florida. The petitioner was not present, but was represented at the hearing by her son, who was present via the telephone. is located in New York. The Agency was represented at the hearing by Mark Pickering, field office manager, Agency For Health Care Administration (AHCA). Present as a witness for the Agency was Meridith Tennant, care manager supervisor, American Eldercare. Barbara Miller from the Department of Elder Affairs was also present on behalf of the Agency. Present, via the telephone, as an observer was Joy Styrtula. The hearing was left open for thirty additional days in order for the petitioner to submit additional information and for another seven days for the Agency to respond, for a total of

thirty seven days. The petitioner did not submit any additional information within the time frame allotted.

ISSUE

At issue is the Agency's action to stop payment of Medicaid-Nursing Home Diversion Services for the period of May 4, 2007 through May 9, 2007, based on the lack of medical necessity for the petitioner.

FINDINGS OF FACT

The petitioner currently resides in an assisted living facility (ALF).

American Eldercare has been contracted by Medicaid or the Agency For Health Care Administration (AHCA) to provide nursing home diversion services to Medicaid/Medicare eligible recipients who meet certain level of care criteria.

In March 2007, the petitioner was living at the [redacted] ALF; a facility for higher level functioning individuals. Based on the petitioner's medical condition at that time, she was temporarily placed at the [redacted] nursing facility, on March 31, 2007, to receive physical therapy. On April 20, 2007, it was determined that based on her medical condition, the petitioner could not return to the higher level functioning ALF. On April 23, 2007 the social worker at the nursing facility reported to American Eldercare that the petitioner was alert times three; walking at least eighty feet with the help of a walker and was refusing the physical therapy.

On April 25, 2007, American Eldercare stopped payment of the service starting April 28, 2007 for the petitioner's physical therapy. American Eldercare has an internal hearing process. The petitioner's representative requested one of these internal hearing based on the above. It was decided through American Eldercare internal hearing process

that a notification error had occurred. American Eldercare determined that payment of the service was to be restored for the period of April 28, 2007 through May 3, 2007. The payment was stopped for the period of May 4, 2007 through May 9, 2007. The petitioner was discharged from the nursing home facility on May 9, 2007. The petitioner was discharged to another ALF, [redacted], which is considered a facility for not so high functioning residents.

The Agency submitted into evidence while the hearing was left open, copies of American Eldercare "logs" in reference to the petitioner, Respondent Exhibit 1.

CONCLUSIONS OF LAW

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

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

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

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

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

(3) Skilled Services Criteria.

(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.

(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:

1. Ordered by and remain under the supervision of a physician;

2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.

3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;

4. Required on a daily basis;

5. Reasonable and necessary to the treatment of a specific documented illness or injury; and

6. Consistent with the nature and severity of the individual's condition or the disease state or stage.

As shown in the Findings of Fact, the Agency or its agent, American Eldercare stopped payment of Medicaid-Nursing Home Diversion Services for the petitioner for the

period of May 4, 2007 through May 9, 2007, based on the lack of medical necessity of the service for the petitioner.

The petitioner's representative argued that the petitioner, based on her medical condition, should have had the service paid for. He argued that the treating physician at the facility had advised him that the service that was being provided for the petitioner at the facility was medically necessary for the petitioner and that she should have not been discharged from the facility.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the Agency's action to stop payment of Medicaid-Nursing Home Diversion Services for the petitioner for the period of May 4, 2007 through May 9, 2007, based on the lack of medical necessity.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 8th day of October, 2007,

in Tallahassee, Florida.

Robert Akel

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

Copies Furnished To: [redacted] Petitioner
Mark Pickering, Area 9 Medicaid Adm.
[redacted]

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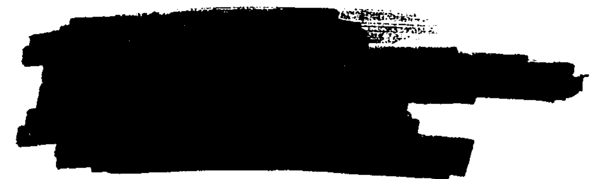
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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



APPEAL NO. 07F-04378

PETITIONER,

Vs.

CASE NO. 1127011740

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Hillsborough
UNIT: 88333

RESPONDENT.

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FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on August 23, 2007, at 3:37 p.m., in Florida. The petitioner was not present. He was represented by his niece by marriage, . The respondent was represented by supervisor. The petitioner's sister-in-law by marriage observed. senior eligibility processor with the respondent, also observed.

ISSUE

At issue is the respondent's action of August 2, 2007 to determine the petitioner's patient responsibility amount in the Institutional Care Program (ICP) to be $382.31 monthly.

FINDINGS OF FACT

1. The petitioner is a resident of the [redacted] nursing facility in [redacted] [redacted] The petitioner's wife, [redacted] is a resident of an Adult Living Facility (ALF), [redacted]
2. The petitioner has been approved to receive assistance through the respondent Institutional Care Program (ICP) and Medicaid benefits. Under the ICP, the respondent determined the petitioner responsible to pay the nursing home $382.31 from his income. The petitioner believes that there should be no patient responsibility amount due to exceptional circumstances.
3. The combined total amount of the petitioner's Social Security and three pensions is $2219.31 monthly. $425.60 monthly is subtracted from this amount and deposited into an income trust account to permit ICP eligibility. The petitioner's wife, [redacted], receives $739 Social Security. These are the couple's only income sources.
4. Petra owes $2,406 monthly is described "ancillary services" costs to the ALF where she lives. The respondent considers this $2,406 ancillary cost as an included shelter cost. The respondent subtracted thirty percent (30 %) of the "Minimum Monthly Maintenance Income Allowance (MMMIA)" from the $2,406 to leave an excess shelter cost of $1,892. The respondent added back the total MMMIA of $1,712 for a balance of $3,604. The respondent subtracted [redacted] income of $739 from the asserted maximum shelter expense deduction of $2,541 to leave a

balance of $1,802. This $1,802 is defined as the community spouse income allowance. The respondent subtracted this $1,802 amount, along with a $35 personal needs allowance, from the petitioner's total $2,219.31 income for a balance of $382.31. The respondent considers the $382.31 to be the petitioner's patient responsibility owed the nursing facility.

5. [redacted] diagnosed with moderate to severe stage dementia. She needs daily supervision and assistance with activities of daily living in the ALF where she lives. This assistance includes hands-on assistance with bathing and dressing, frequent verbal direction, incontinence, meals, diminished dexterity and medication supervision. The ALF has determined [redacted] to need an average of two hours daily certified nursing assistance, and 30 minutes daily licensed practical nursing assistance to manage daily activities. The monthly cost of these nursing services is $1,232.50. The respondent does not consider the cost of these nursing services to determine the patient responsibility amount to the nursing facility. [redacted] also has pharmacy expenses.

6. The petitioner believes the patient responsibility amount should be eliminated due to the circumstances and financial needs described above. The respondent asserts that only a hearing officer can make such decision.

CONCLUSIONS OF LAW

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

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

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

> (e) The department applies the formula and policies in 42 U.S.C. §1396r-5 to compute the community spouse income allowance after the institutionalized individual is determined eligible for institutional care benefits. The standards used are in paragraph 65A-l.7l6(5)(c), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses.

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

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

The Department's Integrated Manual 165-22, Appendix A-9 lists the current Eligibility Standards for SSI-Related Programs, 100% FPL for a couple

effective July 2007 as $1,141. These standards change effective July 1 of each year in accordance with federal law found in Section 1924(d) of the Social Security Act.

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

> Subsequent to determining Medicaid eligibility for persons living in medical and remedial care institutions...determine how much such persons contribute to the cost of their institutional care and/or waiver services. This latter calculation is referred to as the post-eligibility process. This chapter sets forth requirements for the post-eligibility process for institutional persons...3700.1 Background – Section 1902(a)(17) of the Act is the general authority for the post-eligibility process. However, other provisions have been added to refine and clarify the rules governing this process...3701 GENERAL STATEMENT OF POST-ELIGIBILITY PROCESS. Reduce Medicaid payments to medical and remedial care institutions...by the amount remaining after specified deductions are made from the income of institutional persons...Income remaining after these deductions are applied is the amount persons are liable to pay for institutional and/or waiver services...3701.3 Determination of Amounts of Medical Expenses.—In determining the amounts of the individual's liability for the costs of institutional care, certain required and optional amounts for medical or remedial expenses are deducted from the individual's income...Determine the amounts of the medical or remedial expenses to be deducted from total income...3703.4 Maintenance Needs Of A Spouse At Home – For an individual with only a spouse at home, deduct from the individual's total income an amount for the maintenance needs of the spouse. Base this amount on a reasonable assessment of the needs of the spouse, which includes consideration of the spouse's income and resources. The amount deducted for the needs of the spouse must be reduced dollar for dollar for each dollar of the noninstitutionalized spouse's own income...3703.8 Expenses for Health Care: Deduct from the individual's total income amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including: Medicare and other health insurance premiums, deductibles, or coinsurance charges; and Necessary medical or remedial care recognized under State law but not covered under the State plan, subject to reasonable limits

the agency may establish on amounts of these expenses. 3710.1 Definitions...Exceptional Circumstances Resulting in Extreme Financial Duress. Pending publication of regulations, a reasonable definition is: ***Circumstances other than those taken into account in establishing maintenance standards for spouses. An example is incurment by community spouses for expense for medical, remedial and other support services which contribute to the ability of such spouses to maintain themselves in the community and in amounts that they could not be expected to pay for amounts already recognized for maintenance and/or amounts held in resources***...3712 MANDATORY DEDUCTIONS FROM INCOME Deduct from the total income of an institutionalized spouse the following amounts:...subject to reasonable limits you impose consistent with §3701.3, incurred medical and remedial care expenses recognized under State law, not covered under the plan, and not subject to payment by a third party...3713 MONTHLY INCOME ALLOWANCES FOR COMMUNITY SPOUSES AND OTHER FAMILY MEMBERS A. Spousal Monthly Income Allowance. Unless a spousal support order requires support in a greater amount, or a hearings officer has determined that a greater amount is needed because of exceptional circumstances resulting in extreme financial duress, deduct from community spouses gross monthly income which is otherwise available the following amounts up to the maximum amount allowed:

- A standard maintenance amount.
- Excess shelter allowances for couples' principal residences when the following expenses exceed 30% of the standard maintenance amount. Except as noted below, excess shelter is calculated on actual expenses for—
  - rent
  - mortgage (including interest and principal);
  - taxes and insurance;
  - any maintenance charge for a condominium or cooperative; and
  - an amount for utilities, provided they are not part of the maintenance charge computed above. Utility expenses are calculated by using the standard deduction under the Food Stamp program that is appropriate to a couple's particular circumstance...When there is a deficit remaining after a community spouse's gross income is compared to the total standard computed above, the remaining deficit is the amount of the community spousal income allowance. When there is no deficit, there is no monthly spousal income allowance... 3714.2 Hearings and Appeals. Hearings and

> appeals must conform to 42 CFR §431 Subpart E. When spousal maintenance allowances are based on amounts determined necessary by hearings officers to avoid extreme financial duress, you may: have hearing officers grant greater amounts conditioned on the existence of exceptional circumstances determined to be the cause of extreme financial duress...When hearings officers condition additional allowances based on the existence of the exceptional circumstances, it is your responsibility to monitor cases to assure that the exceptional circumstances continue to exist and that you make necessary adjustments in maintenance allowances when the special conditions no longer exist.

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

The petitioner's wife has additional nursing and pharmacy medical expenses that are not included in the respondent's budgeting methodology in the spousal income diversion allowance and resulting patient responsibility calculation. The petitioner's wife's medical condition and residence at an ALF is an exceptional circumstance for a community spouse. [redacted] medical expenses do present extreme financial duress as defined in the State Medicaid Manual, and is an allowable consideration. Since the amount of [redacted] needed nursing expenses, $1,232.50, was not considered in the patient responsibility calculation, and this amount exceeds the patient responsibility amount calculated by the respondent, $382.31, the patient responsibility amount should be eliminated.

DECISION

This appeal is granted. The respondent is ordered to eliminate the petitioner's current patient responsibility obligation to the nursing facility based on a conclusion of significant financial duress. The respondent is ordered to periodically review the petitioner's circumstances to assess whether or not [redacted] continues to have the described exceptional financial circumstances while living in the ALF.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of October, 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: [redacted] Petitioner
Roseann Liriano, Suncoast Region
[redacted]

FILED

OCT 0 4 2007

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-03631

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_______________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on August 1, 2007, at 9:51 a.m., in , Florida. The minor petitioner was not present. The petitioner was represented by with . Ms. was also present as a witness. The petitioner's parents, were present as witnesses for the petitioner. registered nurse with , appeared as a witness for the petitioner. , owner operator of also appeared as a witness for the petitioner.

The respondent was represented by attorney with the Agency For Health Care Administration (AHCA). registered nurse specialist with AHCA, appeared as a witness for the respondent. Two individuals from Kepro South were present by telephone. Dr. physician, and

[redacted] review operations specialist, both appeared as witnesses by phone.

ISSUE

At issue is the respondent's reconsideration decision of May 21, 2007 to reduce private duty nursing (PDN) services paid by Medicaid from 24 hours daily, 7 days weekly, to 20 hours daily, 7 days weekly. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is fifteen years old with a birth date of [redacted] The petitioner lives with and receives care from his mother, [redacted] and father, [redacted]
2. The petitioner has diagnoses to include microcephaly, and poorly controlled seizure disorder. The petitioner is incontinent of bowel and bladder, has contracture, paralysis, endurance limitation, non-ambulatory except by wheelchair, non-verbal, legally blind, and dyspnea with minimal exertion. The petitioner requires gastrostomy (G tube) feedings. The petitioner has a tracheotomy and a j-tube for medications. The petitioner requires frequent suctioning and is at high risk for aspiration. The petitioner has almost constant seizure activity. It is not disputed that the petitioner requires constant supervision and intervention 24 hours daily, 7 days weekly.

3. The petitioner has treatment needs that include tracheotomy care, g-tube, suctioning, nebulizer treatment, and repositioning. The petitioner's condition can change on a daily basis. The petitioner has had decreased incidences of hospitalization when he received PDN care of 24 hours daily, 7 days weekly.
4. Dr. [redacted] is a pediatrician who provides a physician review for requested medical services for the contracted Kepro organization. Dr. [redacted] relied on social and clinical information in the care planner to determine the need for requested PDN hours.
5. The petitioner was receiving 24 hour daily, 7 day weekly PDN care. On May 21, 2007, Kepro initially reduced PDN hours to 20 hours daily 5 days weekly, with 16 hours daily approved for Saturdays and Sundays. Upon reconsideration that included review of the parents' described work hours, the contracted Kepro reviewer determined approved PDN hours should be increased to 20 hours daily, 7 days weekly. Kepro believed that the petitioner's parents could perform needed care for the remaining four hours daily. Kepro did not know that the parents could not perform certain required treatment duties when the amount of PDN hours was determined.
6. The petitioner's mother is not a medical professional, has not received medical training, but is certified in CPR. She speaks limited English. She is employed as a nanny 5 days weekly, 8 to

10 hours daily with some hours on Saturday. The petitioner has a 6 year old sibling who receives tutoring services two to three times weekly. The petitioner's mother has changed the petitioner's tracheotomy one time with direct instruction. She does not insert the petitioner's j-tube. The petitioner's mother does perform suctioning treatment around the petitioner's mouth, but does not perform deep suctioning. The petitioner's mother has a slight back problem and can not lift the petitioner. The petitioner weighs 65 to 75 pounds.

7. The petitioner's father is employed full-time as truck driver. He also works some weekends at a second temporary job, when work is available. The petitioner's father may also work infrequently at night. He is able to use a ceiling lift and bathe the petitioner. However, he has not been able to follow the steps necessary for safe changing of the petitioner's tracheotomy. The petitioner's father once called 911 when he was unable to insert the petitioner's g-tube and j-tube. There are no other natural supports available to provide needed care for the petitioner.

CONCLUSIONS OF LAW

The Florida Administrative Code Rule 59G-1.010 addresses relevant definitions within the Medicaid Program, which also apply to this Medicaid decision on the private duty nursing services at issue. Subsection (166) of the

Florida Administrative Code Rule defines "medically necessary" care, goods or services, as follows:

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

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the contracted Kepro South reviewing pediatrician recommends the reduction of PDN services from 24 to 20 hours daily, 7 days weekly.

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

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

The Findings of Fact show that the petitioners' parents, as caregivers, do not have sufficient knowledge, skills and abilities necessary to safely provide all needed aspects of the petitioner's care. Findings show that both of the petitioner's parent caretakers do not have sufficient skills for safe j-tube, g-tube and tracheotomy care. There was no rebuttal evidence to show that the petitioner's caregivers had been trained in these areas. Findings further establish that the parents' present work and family schedule may preclude time available to provide this needed care to the petitioner for four hours daily, seven days weekly. In view of the parents' lack of sufficient skills to safely provide certain treatment needs with the limited number of available hours to provide such care, the respondent action to reduce approved PDN hours to 20 hours weekly is not upheld.

DECISION

This appeal is granted. The respondent has not met its burden to prove that PDN services can be safely reduced to the amount at issue, 20 hours daily.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 4th day of October ,2007,

in Tallahassee, Florida.

Jim Travis

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

Copies Furnished To [redacted] Petitioner
Patrick Glynn, Area 6 Medicaid Adm.
[redacted]

FILED

OCT 1 7 2007

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

APPEAL NO. 07F-04154
CASE NO. 1240747331

Vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
AREA 7, ORANGE COUNTY

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in ████, Florida at 2:20 p.m. on September 13, 2007. The petitioner (a minor) was represented by his mother, ████, via telephone. ████ and ████, senior human service program specialists, represented the respondent. Pursuant to prior order, exhibits had been shared between the petitioner and the respondent before the hearing.

ISSUE

At issue was whether or not nonpayment for out of state hospital care was correct based upon insufficient documentation of emergency status. As an applicant, the petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner was born on ████ He had intestinal surgery in February 2006 to treat Meckel's diverticulum. As a Florida resident he was also a Medicaid recipient on June 5, 2006. At that time, he was visiting ████ with his family.

2. In late May, early June 2006, the petitioner suffered high temperature, sore throat and wheezing, particularly while visiting in [redacted] His family consulted with a source they believed reliable for advice about how to handle the medical problem while they were in [redacted]. They were unsure as to what was causing the health problems and did not want to jeopardize health of the petitioner following such serious surgery. They were advised to take the petitioner to a nearby hospital and seek emergency care. They took the petitioner to [redacted] Regional Hospital emergency room in [redacted] where he was treated on June 5, 2006.

3. As a result of the medical care, prescriptions were Penicillin and Zyrtec. The family believed the petitioner had a strep throat infection. That understanding was consistent with summary of visit showing patient instructions (Respondent's Exhibit 1, page 23). Neither that document nor any other reflected laboratory findings or clinical results of testing information.

4. Before June 2007, the family received no bill for service from the [redacted] facility. Petitioner's Exhibit 1 narrates events and Petitioner's Exhibit 2 page 18 shows the June 20, 2007 $286.70 bill for service of June 5, 2006. The family made a partial payment for the service. On August 13, 2007, a collection specialist confirmed payment of $146 on the account (page 24 of Petitioner's Exhibit 2).

5. The hospital submitted a reimbursement request to AHCA in summer 2006. AHCA reimbursement was initially declined on September 13, 2006 (page 13 of Respondent's Exhibit 1). AHCA then requested additional information from the provider and more information was received during May 2007 (pages 19-23 of Respondent's Exhibit 1).

6. A registered nurse-AHCA staff member reviewed the additional information in the normal course of AHCA business. In June 2007, during additional AHCA review, emergency status was again declined (page 16 of Respondent's Exhibit 1). From AHCA's perspective, absence of clinical confirmation as to strep infection precluded a determination of emergency medical condition sufficient to justify payment for out of state care. The [redacted] medical records established no objective clinical confirmation of a strep infection.

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.

Florida Statute **409.912** addresses **Cost-effective purchasing of health care** in relevant part as follows:

> The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. ...

Florida Statute **409.913** addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) describing "medical necessity" or "medically necessary" standards and informing that "...For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity." Thus, decisions regarding Medicaid reimbursement to providers become part of an administrative review process. The out-of-state emergency room care situation under challenge is a situation of this nature.

In accord with statutes, Fla. Admin. Code 59G-4.160 informs as follows:

59G-4.160 Outpatient Hospital Services.
(1) This rule applies to all hospital providers enrolled in the Medicaid program.
(2) All hospital providers enrolled in the Medicaid program must comply with the provisions of the Florida Medicaid Hospital Services Coverage and Limitations Handbook, June 2005, and the Florida Medicaid Provider Reimbursement Handbook, UB-92, April 2004, updated August 2005, both incorporated by reference in this rule. Both handbooks are available from the Medicaid fiscal agent by calling Provider Enrollment at (800)377-8216 or from the fiscal agent's website at http:// floridamedicaid.acs-inc.com. Click on Provider Support, and then on Handbooks.
(3) The following forms that are included in the Florida Medicaid Provider Reimbursement Handbook, UB-92, are incorporated by reference: The UB-92 Claim Form, UB-92 HCFA 1450, one page double-sided; State of Florida, Florida Medicaid Authorization Request, PA01 04/2002, one page; Medically Needy Billing Authorization, DF-ES 2902, June 2003, one page; State of Florida, Sterilization Consent Form, SCF 7/94, one page; State of Florida, Hysterectomy Acknowledgment Form, HAF 07/1999, one-page; State of Florida, Exception to Hysterectomy Acknowledgment Requirement, ETA 07/2001, one page; State of Florida, Abortion Certification Form, August 2001, one page. All the forms are available from the Medicaid fiscal agent by calling Provider Inquiry at (800)289-7799 or from its website at http://floridamedicaid.acs-inc.com. Click on Provider Support, and then on Medicaid Forms.

The AHCA **Hospital Services Coverage and Limitations Handbook** addresses *Covered Services and Limitations* regarding **Emergencies** and at page 2-6 informs:

Outpatient emergency room services, dressing, splints, oxygen, and physician ordered services and supplies medical necessary for the clinical treatment of an emergency medical condition are reimbursed...
Hospitals must send such claims to the area Medicaid office for processing. The area Medicaid office staff may request medical records to support payment.

That guideline further addresses **Emergencies: Out-of-State Hospitals**:

Emergency services provided to Florida recipients in out-of-state hospitals are reimbursable in the following instances:
- An emergency arises from an accident or illness.
- The health of the recipient would be endangered if the care or services were postponed until he returned to Florida.
- The health of the recipient would be endangered if he undertook travel to return to Florida.

Florida Medicaid Provider General Handbook addresses ***Out-of-State Enrollment*** at page 2-32 regarding **Reimbursable Out-of-State Services:**

> Florida Medicaid will reimburse out-of-state providers who provide services under the following circumstances:
> • An emergency arising from an accident or illness that occurs while the recipient is out of state;
> • The recipient's health will be endangered if the care and services are postponed until returning to Florida...

That handbook continues at page 2-33, addressing **Claims for Emergency Treatment** informing: "The provider must attach documentation to the claim justifying the emergency." The handbook defines an **Emergency Medical Condition** as:

> A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, including a pregnant woman or a fetus; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Based upon careful review of evidence and guidelines described herein, it is concluded that AHCA has discretion to evaluate the material submitted by a provider for justification of claim reimbursement. Within AHCA guidelines, the agency may request additional medical records and AHCA has the responsibility to determine whether those records adequately verify an emergency. In the case at hand, AHCA issued an initial rejection and made a reasonable request to the provider for more documentation. When additional records were received by the reviewing agency, it was apparent the family was instructed to treat the situation as if it were strep infection, but there was no objective clinical confirmation of such and there was insufficient verification of a medical emergency using Florida standards. AHCA maintained the position that insufficient

justification of an emergency was established. In view of evidence and guidelines cited herein, denial of provider reimbursement was a reasonable determination.

DECISION

The appeal is denied and the respondent's action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17 day of October, 2007, in Tallahassee, Florida.

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

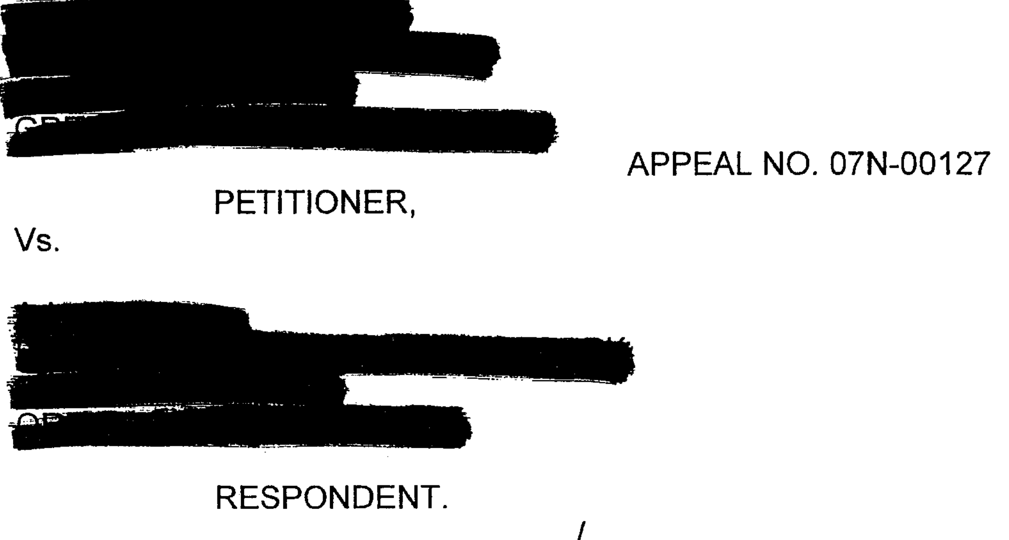
Copies Furnished To: [redacted] Petitioner
Judy Jacobs, AHCA, Medicaid

FILED

OCT 17 2007

OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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



APPEAL NO. 07N-00127

PETITIONER,

Vs.

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 19, 2007, at 10:10 a.m., at Orange Park, Florida. The petitioner was not present. The petitioner was represent by daughter. friend of appeared as potential witness. The respondent was represented administrator. business office manager appeared for the respondent. ombudsman observed the proceeding.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of June 28, 2007 is in accordance with the requirements of 42 C.F.R. § 483.12(a):

(2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

FINDINGS OF FACT

On July 20, 2007, the petitioner was given a Nursing Home Transfer and Discharge Notice. The reason listed in the discharge was "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".

1. The petitioner was admitted to the facility on April 4, 2007. The petitioner began her application for Medicaid benefits. The facility agreed that the bill for services rendered would be as if the Medicaid benefits had been approved. It was determined that the patient responsibility for the bill would be $2,546.

2. The following payments were made on the account:

Date	Amount Owed	Amount received
5/14/07	$2,546	$2,546
5/22/07	$20	$20
6/13/07	$2,546	$200
7/11/07	$4,615.61	$2,649
7/19/07	$1,966.61	$20
8/15/07	$4,512.61	$2,649
8/28/07	$1,863.61	$11
9/10/07	$4,610.11	$2,640

The balance owing on the account at the time of the hearing was $1,970.11

3. The respondent asserted that additional amounts might be owed if the Medicaid benefits are not approved for April and May. Since the parties have not received notice of approval or denial of benefits by the hearing date, that issue will not be addressed in this order.

4. The respondent sent the petitioner notification on July 20, 2007 advising her of the facility's decision to discharge the petitioner on August 27, 2007. The basis of that discharge was that there had been lack of payment of her bill for services and after reasonable and appropriate notice, the financial situation had not been resolved.

4. The petitioner's daughter believes that the discharge location noted on the discharge form is not a safe location. The location is the daughter's home. The respondent agreed that alternative locations would be identified prior to discharge and appropriate discharge planning would be done if the discharge is upheld.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255 F.S. The matter that is considered at this type of hearing is the decision by the facility to discharge the patient. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that she would be discharged from facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a):

(2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

The facility has given the petitioner and her family reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial arrangement have not resulted. Based upon the above-cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is in accordance with federal regulations. The respondent may proceed with the discharge to an appropriate location as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

DECISION

This appeal is denied. The respondent may proceed with the discharge, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17th day of October, 2007,

in Tallahassee, Florida.

Deborah Kleinman Robinson
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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

FILED

OCT 15 2007

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07N-00141

PETITIONER,

Vs.

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 1, 2007 at 9:05 a.m. at [redacted] The petitioner represented herself and the respondent was represented by [redacted] administrator, with testimony available from [redacted] business office manager and [redacted] assistant business office manager.

ISSUE

At issue was whether or not intent to discharge was correct based upon nonpayment for service after reasonable and appropriate notice to pay. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner has been a resident of the health care facility for an extended time, due to medical need for such placement.

2. On August 21, 2007, the respondent issued to the petitioner a Nursing Home Transfer and Discharge Notice declaring intent to discharge the petitioner to a nursing facility in St. Petersburg due to "bill for services at this facility has not been paid after reasonable and appropriate notice to pay." The notice was included in Respondent's Exhibit 1.

3. The August 31, 2007 nursing facility statement of account reflected an outstanding past balance of $527 was unpaid at that time. The statement was issued to the petitioner. She was aware of the respondent's position on the matter of payment.

4. The petitioner requested a hearing as shown in Petitioner's Exhibit 1, asserting that "check #292 dated 11/03/06" was previously given to the facility. She requested a particular witness be available for the hearing, but such was unnecessary as the respondent readily acknowledged receipt of and awareness of such a check at approximately that time. However, check #292 was not written for $527. At that time, the petitioner had incomplete awareness of what her share of responsibility would be as related to Medicaid eligibility. She affirmed as the respondent did, that the check was written for $517. It is found that the petitioner proffered a check for $517 to the respondent during November 2006.

5. As things turned out, that $517 November 2006 check was not posted to the petitioner's account. Moreover, the check was ultimately mislaid or misrouted, with no accounting of it. As of date of hearing, it had not been cashed, but a stop order had not been placed upon it. As noted by facility staff, although some staff saw it, the check was not retained as acceptable payment because it was not the full amount owed. Facility staff agreed it would have been rejected because the facility did not wish to

accept less than full $527. In any case, what is significant is that neither $517 nor $527 was posted to the account as of date of hearing.

6. The respondent testified that the facility would be willing to pay for placing a stop order on the $517 November 2006 check. The respondent further testified the account would only be satisfied, and residence could only continue, if the full amount of $527 were paid.

7. The petitioner alleged the discharge location was too far away from her family in Orange County. She described additional costs that long distance telephoning would place on her personal budget. The respondent declared the petitioner had special needs and placement at a special facility in St. Petersburg would meet those individual needs. Evidence regarding location concern was not fully developed.

CONCLUSIONS OF LAW

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

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
> ...
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid...
> ...
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
...
(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
(iii) The location to which the resident is transferred or discharged;
(iv) A statement that the resident has the right to appeal the action to the State...

Findings of fact show the facility issued billing statements and notified the petitioner of the $527 charge. While recognizing that significant payments have occurred, and much of the petitioner's income has been used toward bill payment over the months, facility staff does not wish to continue providing care under current financial circumstances. There is no regulation requiring a facility to retain a resident under such circumstances. Regardless of who misplaced the check or where it presently is, the crucial matter is that full payment of the $527 amount has not occurred after reasonable and appropriate notice of such. The petitioner's attempt to achieve payment for $517 at the end of 2006 does not achieve payment in full.

Based upon findings, and despite the unfortunate circumstances, it must be concluded that sufficient payment simply has not occurred. Under regulations, adequate payment for continuing stay at a nursing facility is required. It is concluded that reasonable and appropriate notice to pay was followed by insufficient payment for services rendered. Additionally, despite the understandable desire of the petitioner to remain near family, discharge to an alternative location has been justified under regulatory requirements. Regulations are silent as to adjudication on the subject of appropriateness of the intended location. So long as discharge location does not violate state or federal regulations, laws, or an Agency for Health Care Administration (AHCA)

requirement, the discharge may proceed as set forth in notice for the reason given on the notice.

DECISION

The appeal is denied. Intent to discharge is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of October, 2007, in Tallahassee, Florida.

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

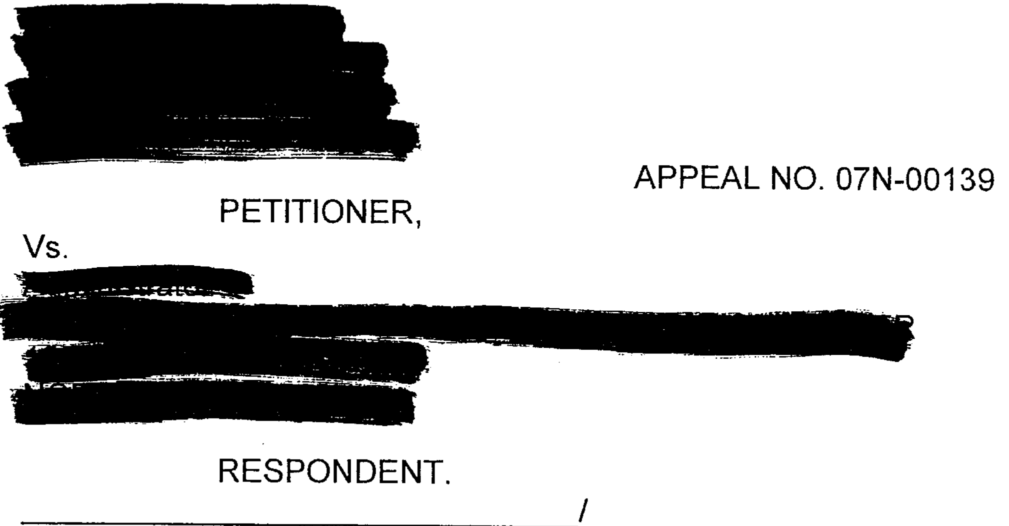
Copies Furnished To: [redacted] Petitioner
[redacted] Respondent
[redacted] Agency for Health Care Administration

FILED

OCT 15 2007

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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



APPEAL NO. 07N-00139

PETITIONER,

Vs.

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 1, 2007, at 9:41 a.m., at the [redacted] in North Miami, Florida. The petitioner was not present but was represented at the hearing by [redacted] ombudsman. The respondent was represented at the hearing by [redacted] administrator, [redacted] Testifying on behalf of the facility was [redacted] LPN; [redacted] CNA; and [redacted] CNA. The hearing record was left open for two additional days in order for the respondent to submit additional information and for another two more days for a total of four days, for the petitioner's representative to respond. The respondent submitted additional information within the time frame allotted.

The petitioner's representative responded to the information provided by the respondent during the time frame allotted.

ISSUE

The respondent notified the petitioner that she was to be discharged for the following reason: "The safety of other individuals in the facility is endangered..." The respondent will have the burden of proof to establish by clear and convincing evidence that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and Fla. Stat. ch. 400.0255.

FINDINGS OF FACT

The facility notified the petitioner on or about August 15, 2007 that she was to be discharged by September 15, 2007. The discharge location was indicated as "[redacted]." Currently the petitioner resides at [redacted]

The discharge notice was not signed by the petitioner's treating physician. The respondent indicated that this omission was an oversight and requested additional time to provide a statement from the petitioner's treating physician concerning the discharge. The petitioner's representative objected to the submission of any statement from the facility's physician as it would be submitted "after the fact".

The petitioner's objection is overruled. The facility was allowed to present a copy of the facility's physician's statement, while the hearing was left open. The statement provided has been accepted as Respondent Exhibit 2. This physician's statement states in part: "As medical director and former attending physician for [redacted], I have observed and can attest that she is non-compliant and is physically and verbally abusive

to staff. Based on clinical experience, [redacted] poses an immediate threat to staff, and it is hereby recommended that she be sent to a facility that can manage this type of patient."

It should be noted that the Notice of Discharge, which is an AHCA provided notice, indicates that a physician's orders or his signature is required for the reason for the discharge for the case at hand.

The respondent submitted as evidence, Respondent Exhibit 1, which contain copies if nursing notes concerning the petitioner. One of the respondent's witnesses testified that the petitioner had verbally attacked her; making disparaging comments about her country of origin. She testified that the petitioner spit on her and had slapped her hand. She also testified that the petitioner had repeatedly told her that she will get her fired from this job.

Another respondent witness testified the petitioner had slapped her face. They all testified that they had requested to their facility administration that they either had to have a witness with them when dealing with the petitioner or if they could be removed from their work duty with the petitioner.

CONCLUSIONS OF LAW

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

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

This regulation continues and states in part:

> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v)

of this section, the resident's clinical record must be documented. The documentation must be made by-

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

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

(4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident... (6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following: ...(iii) The location to which the resident is transferred or discharged...

As shown in the Findings of Fact, the facility notified the petitioner on or about August 15, 2007 that she was to be discharged by September 15, 2007, based on: "The safety of other individuals in the facility is endangered...". The respondent provided testimony from the staff at the facility concerning the petitioner's verbal and physical attack against the facility's staff.

The petitioner's representative argued that the Discharge notice was defective as the petitioner's physician or any physician had not signed off on the discharge. He also argued that the statement by the facility's physician was a potential violation of the appropriate authorities of nursing home discharges. He argued that the physician's statement, as not being part of the original record; was a clear unilateral move by the facility's administrator.

Though the notice of discharge was not signed by the petitioner's physician, the hearing officer finds this omission as a harmless error. The physician's statement meets the intent of the above noted federal regulation.

The respondent argued that the discharge notice was not signed by the physician was an oversight, but the physician had written some notes concerning the verbal and physical actions the petitioner had shown to the facility's staff. She argued that the facility has a very difficult time getting staff to work with the petitioner, based on her verbal and physical abuse toward the staff. She argued that the staff is endangered by the petitioner and the petitioner could be better served at an appropriate other nursing facility. The hearing officer agrees with the respondent's last argument.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that the facility's action to discharge the petitioner is appropriate as the safety of other individuals in the facility is endangered. The facility has met its burden of proof and is in compliance with the appropriate federal regulation noted above for the discharge.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

Respondent

[redacted]
Agency for Health Care Administration
[redacted]

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OCT 15 2007

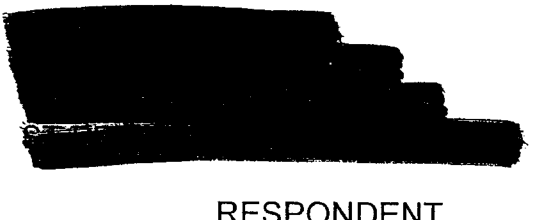
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07N-00114

PETITIONER,

Vs.



RESPONDENT.

_____________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 27, 2007, at 2:00 p.m. at in St. Petersburg, Florida. The petitioner was not present. The petitioner was represent by ombudsman. The respondent was represented administrator.

Both parties requested a 30 days continuance to seek resolution and apply for Medicaid Program benefits. The motion was granted.

The hearing was reconvened on October 9, 2007, at 9:30 a.m. at in St. Petersburg, Florida. The petitioner was not present. The petitioner was represent by ombudsman. The respondent was represented administrator. Witness for the respondent was social service director.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of June 28, 2007 is in accordance with the requirements of 42 C.F.R. § 483.12(a):

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

FINDINGS OF FACT

On June 18, 2007, the petitioner was given a Nursing Home Transfer and Discharge Notice. The reason listed in the discharge was: "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".

1. The petitioner was admitted to the facility on October 17, 2004. The petitioner's income was Social Security, Veteran's Administration (VA) pension and a retirement. [redacted] the petitioner's granddaughter and power of attorney, was receiving the petitioner's VA pension and retirement. The facility was directly receiving the petitioner's Social Security for payment of services. In 2007, the petitioner's income was $1,364 in Social Security, $1,801 in VA benefits and $484.34 in retirement for a total income of $3,649.34. By 2007, the facility was directly receiving the petitioner Social Security and retirement.

2. The first bill to the petitioner was on October 31, 2004. Medicare payment was made on the petitioner's bill in 2004. In 2005, payment was made by insurance, Medicaid and payment of patient responsibility by the power of attorney from the petitioner's income. In April 2006, the petitioner did not have an outstanding balance. From April 2006, payment for the petitioner stay at the

facility was to be paid by Medicaid and the petitioner's patient responsibility. The patient liability was $2,968.34. The entire amount of the Social Security and retirement was used to pay part of the patient responsibility. From April 2006, the patient responsibility was not paid in full each month, as the remainder due from the petitioner's power of attorney was not paid. The respondent sent the petitioner's power of attorney a bill each month. The respondent did not receive any communication from the power of attorney that she was no longer responsible for payment of the remainder of the patient liability. Since May 2006, each month the outstanding balance increased. The facility made every effort and contact with the family to have the bill paid. The petitioner was told by his family all bills were being paid. The respondent's attorney sent a letter and a copy of the debt collection letter to the petitioner on February 28, 2007. In 2007, the patient liability increased to $3,013.34. As of the May 31, 2007 billing, the outstanding amount due to the respondent was $24,257.46. The only payment in June 2007 was from the direct payment to the facility of the petitioner's Social Security and retirement in the amount of $1,859.34.

3. The respondent sent the petitioner notification on June 28, 2007 advising him of the facility's decision to discharge the petitioner on July 31, 2007. The basis of that discharge was that there had been lack of payment of her bill for services and after reasonable and appropriate notice the financial situation had not been resolved.

4. From June 2007 through October 9, 2007, the full patient responsibility was not paid. As of October 9, 2007, the outstanding balance was $20,511.46.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255 F.S. Matters that are considered at this type of hearing is the decision by the facility to discharge the patient. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that she would be discharged from facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a):

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

The facility has given the petitioner and his family reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial arrangement have not resulted. Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is in accordance with federal regulations. The respondent may proceed with the discharge to an appropriate location as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

DECISION

This appeal is denied. The respondent may proceed with the discharge, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of 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: [redacted] Petitioner
[redacted] Respondent
[redacted], Agency for Health Care Admin.
[redacted] and [redacted] Long Term Care Ombudsman

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DEPT. OF CHILDREN & FAMILIES

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
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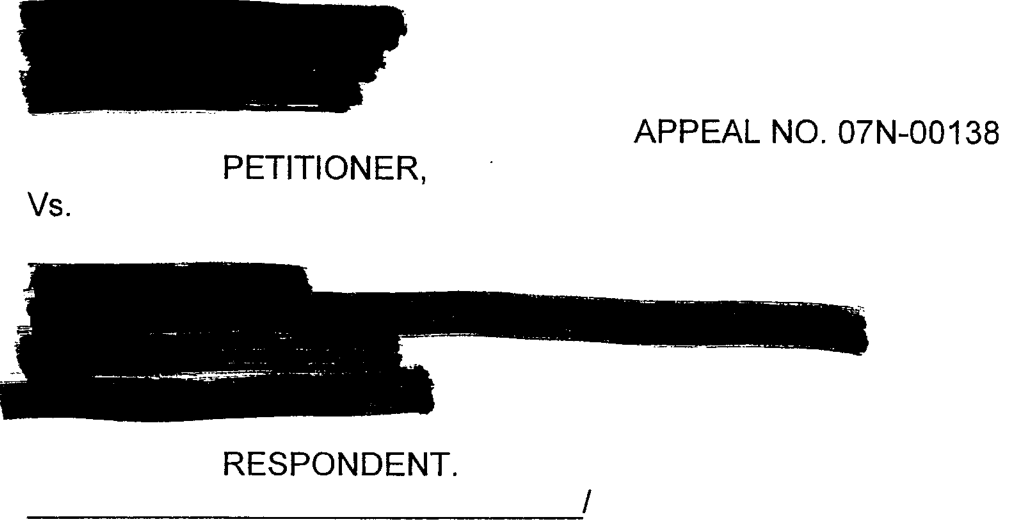

APPEAL NO. 07N-00138

PETITIONER,

Vs.

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 3, 2007, at 1:35 p.m., at the [redacted] in Sarasota, Florida. The petitioner was present. Present on behalf of the petitioner was [redacted] ombudsman. The respondent was represented by [redacted] executive director of the facility. Witnesses for the respondent were [redacted] assistant business office manager, and [redacted], business office manager.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of August 2, 2007 is in accordance with the requirements of 42 CFR § 483.12(a):

(2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

FINDINGS OF FACT

1. The petitioner has incurred expenses at the facility for his residence in the facility. The petitioner has an outstanding obligation to the nursing home in the amount of $898.22, as of August 2, 2007.

2. The petitioner was sent notification on August 2, 2007, advising him of the facility's decision to discharge the petitioner on August 31, 2007. The basis of that discharge was that there had been lack of payment of his bill for services and after reasonable and appropriate notice, the financial situation had not been resolved.

3. The facility requested an immediate payment arrangement of even the smallest amount. The petitioner agreed to pay $100 a month after he was discharged from the facility. The petitioner has an outstanding obligation to the nursing home in the amount of $1,195.77, as of October 3, 2007.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255. Matters that are considered at this type of hearing are the decisions by the facilities to discharge patients. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that she would be discharged from the facility in accordance with the Code of Federal Regulations at 42 CFR § 483.12(a):

(2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

The facility has given the petitioner reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial arrangement have not resulted. Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is in accordance with federal regulations. The respondent may proceed with the discharge to an appropriate location as determined by the petitioner's treating physician and in accordance with applicable Agency for Health Care Administration requirements.

DECISION

This appeal is denied. The respondent may proceed with the discharge, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of 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: [redacted] Petitioner
[redacted], Respondent
[redacted] Agency for Health Care Admin.
[redacted] ombudsman

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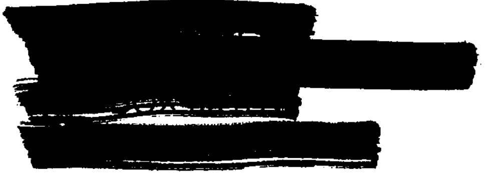
OCT 15 2007

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

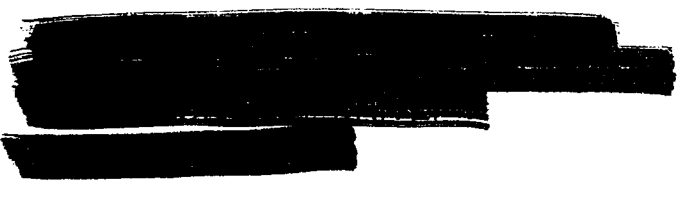
STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 07N-00128

PETITIONER,

Vs.



RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened at 2:50 p.m. on September 19, 2007 at the [redacted] The petitioner was not present but she was represented by her daughter, [redacted] The respondent was represented by [redacted], administrator, with testimony available from [redacted] business office manager. The record remained open an additional 10 days to accommodate submission of further information from both parties. Petitioner's Exhibit 2 was received and shared with the respondent as well. No further information was necessary or received.

ISSUE

At issue was whether or not intent to discharge was correct based upon failure to pay for services after reasonable and appropriate notice to pay. The respondent had the burden of proof.

FINDINGS OF FACT

1. In May 2007 the petitioner was admitted to the nursing facility because she needed daily skilled nursing service. Her need subsequently became more custodial in nature, rather than skilled. Need for custodial care service continues without dispute.

2. On behalf of the petitioner, to assist with cost of care, application for Medicaid was filed under the Institutional Care Program (ICP) with Department of Children and Families. That ICP application was denied during the summer of 2007.

3. While the petitioner received care at the facility, her family received statements of amounts due for services, as shown in Respondent's Exhibit 2. Statement of May 30, 2007 showed total due as $6270. The amount shown on the statements increased and by September 5, 2007, the statement reflected an amount due as $25,082.64.

4. Aware of ICP denial, but unaware of any challenge or appeal of the ICP denial, the respondent became concerned that adequate payment for service would be a problem. On July 19, 2007, the respondent issued to the petitioner a Nursing Home Transfer and Discharge Notice (Respondent's Exhibit 1) showing discharge would be effective August 18, 2007 because "bill for services at this facility has not been paid after reasonable and appropriate notice to pay." That notice corresponded to the statement dated July 3, 2007, reflecting balance owed as $13,329.82.

5. Notice of intended discharge was challenged as shown in Petitioner's Exhibit 1. Prior to date of the discharge hearing, the respondent had not seen the narrative hearing request. It described the petitioner's then-continuing pursuit of Medicaid.

6. The respondent testified that if the petitioner were pursuing Medicaid ICP through the fair hearing process of the Department, then the intent to discharge would

be forestalled until after the hearing process was completed. The respondent volunteered to retain the petitioner if her representative could verify pursuit of ICP eligibility through the hearing process.

7. The petitioner's representative testified that Medicaid ICP denial was under challenge through the Department's administrative hearing process, an appointment for hearing had been scheduled, the parties were trying to resolve the problem, the initial hearing had been postponed, and she was working toward attaining Medicaid ICP eligibility for her mother. She further testified she could prove such via submission of current correspondence from the hearing section. The record was left open for her to do that, and upon the respondent's receipt of such information, for the respondent to respond further if desired. The petitioner submitted documentary confirmation of her ICP hearing status as pending in Petitioner's Exhibit 2. Further information from the respondent was not necessary and was not received.

CONCLUSIONS OF LAW

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

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
> ...
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

...
(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
...
(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
(iii) The location to which the resident is transferred or discharged;
(iv) A statement that the resident has the right to appeal the action to the State....

Findings of fact indicated the facility appropriately issued billing statements and notified proper parties of charges. However, the findings also established that the respondent volunteered to retain the petitioner as a resident while her daughter actively pursued the Medicaid ICP hearing process, if the daughter could verify such status. The petitioner's daughter has completely confirmed the ICP Medicaid hearing status as current and pending. For that reason, and based upon the respondent's voluntary agreement to retain the petitioner rather than discharge her while the ICP administrative hearing process is pending, it is concluded that the July 19, 2007 discharge intent was premature.

DECISION

The appeal is granted and discharge intent is not upheld.

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 15th day of October, 2007, in Tallahassee, Florida.

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

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

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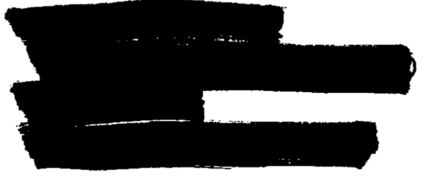
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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



PETITIONER,

APPEAL NO. 07N-00123

Vs.

CASE NO.

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 30, 2007, at 1:38 p.m., in Sarasota, Florida. The petitioner was present and represented himself. The facility was represented by their attorney, Present as a witness for the petitioner was a resident, Present as witnesses for the facility were the administrator, L.P.N; director of social services; R.N.; and , director of nursing. Also present was district ombudsman manager.

The record was left open for 10 days to allow the petitioner to return further information. No further information was received. The record was closed.

ISSUE

At issue is the July 13, 2007 action by the facility notifying the petitioner that he was to be discharged because the health and safety of other individuals in the facility were endangered.

FINDINGS OF FACT

1. On July 13, 2007, the facility gave notice to the petitioner that he would be discharged on August 16, 2007 because of actions that endangered the health and safety of other residents.
2. The facility cited an incident that occurred on July 11, 2007. Testimony by witnesses established that the petitioner became upset at the ranting of a resident roommate. When found, the petitioner had moved the residents' bed apparently intending to move it out of their room. The resident had a G-tube that was stretched to its limits from the wall and prevented the bed from moving any further. The witness responded when she heard loud cursing.
3. Staff reported an earlier incident with the resident that occurred on May 2, 2006 and is documented by a police report submitted at Facility Exhibit 6. He was accused of slapping a CNA in the face with an open hand. Witnesses including the CNA reported that the petitioner was in the wrong wing of the facility. When directed to return to his area by the CNA, he slapped the CNA in the face.
4. The facility submitted nursing notes and progress notes that reflected entries where the petitioner had verbal confrontations with staff, used

vulgar language with staff and residents, and was verbally abusive. The facility reported that he manipulates and intimidates other residents and staff. The police have been called to the facility on eleven different occasions due to the petitioner's threats and acts of aggression. The facility has the petitioner on a 1:1 staff ratio to avoid further incidents.

5. The petitioner filed multiple complaints on the facility with other agencies. The complaints were later determined to be unfounded.
6. Facility Exhibit 2 is a letter completed by [redacted] M.D. on August 10, 2007. He wrote "As the physician of record for [redacted] as well as the medical director for [redacted] [redacted] in my professional opinion, this resident is a threat to the other residents in the building due to his uncontrolled outbursts of anger towards the other residents in the facility. He has jeopardized the safety of one resident by trying to transfer the resident's bed, with the resident in the bed connected to a feeding pump and oxygen concentrator, to the hall. [redacted] continued stay at this facility does endanger the safety of other residents and staff."
7. The facility proposes to discharge the petitioner to an assisted living facility with home health services for wound care.

CONCLUSIONS OF LAW

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

§483.12 **Admission, transfer and discharge rights.**

(a) Transfer and discharge--

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

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

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

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

(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement that the resident has the right to appeal the action to the State;
(v) The name, address and telephone number of the State long term care ombudsman;
...
(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

The evidence establishes that the nursing facility issued a Nursing Home Transfer and Discharge Notice to the petitioner indicating that they intended to discharge him from the facility. The listed reasons for the discharge action were threats to the health and safety of other residents. The facility cited repeated incidences aggression, abusive language, and intimidation of staff and other residents.

The petitioner does not deny that the incidences occurred. However, he argues that the incidents have been exaggerated and magnified. He argues that the facility does not want him there because he is young, African American, intelligent, and able to criticize his care.

The facility argues that testimony from trained staff establishes that the petitioner has been abusive in the past and has two incidents where he endangered a resident and a staff member. The facility argues that the law does not require an act to establish the threshold regarding endangerment. The threat based on past acts should be sufficient.

After reviewing the evidence in the form of medical records and witness testimony, the hearing officer concludes that the evidence supports the facility's assertion that the petitioner has been a threat to staff and residents. For this reason, the health and safety of individuals in the facility is endangered. The law requires the facility to complete discharge planning and discharge the petitioner to a suitable location. The facility proposes to discharge the petitioner to an assisted living facility with wound care provided by a home health agency. Once discharge planning has been completed, the discharge is allowed.

DECISION

This appeal is denied. The facility may proceed with the discharge action.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17th day of October, 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
[redacted] Respondent
[redacted] Agency for Health Care Administration

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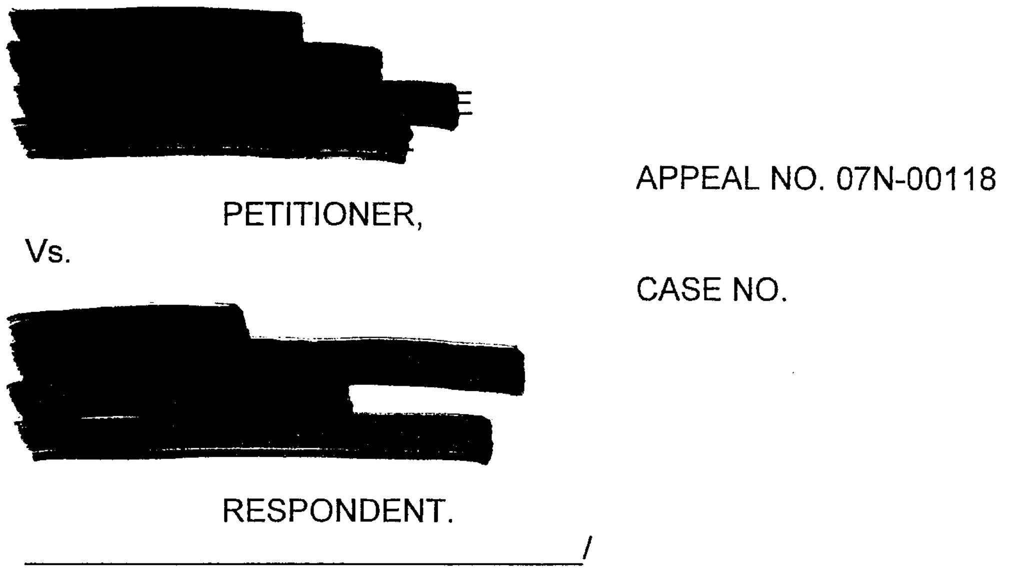
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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



PETITIONER,

Vs.

RESPONDENT.

APPEAL NO. 07N-00118

CASE NO.

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 13, 2007, at 10:40 p.m., in Port Charlotte, Florida. The petitioner was not present. He was represented by his son, [redacted] and his son's fiancé, [redacted] The facility was represented by [redacted] administrator. Present as witnesses for the facility were [redacted] social services director; [redacted] director of nursing; [redacted] regional business office consultant; and [redacted], business office manager. Also present were [redacted] and [redacted] ombudsmen.

ISSUE

At issue is the July 6, 2007 action by the facility proposing to discharge the petitioner for failure to pay for his services in the facility after reasonable notice to do so.

FINDINGS OF FACT

1. On July 6, 2007, the nursing facility notified the petitioner that they proposed discharging him in 30 days. The listed reason for the discharge was the failure of the petitioner or his representative to pay for his services.

2. The petitioner became a private pay resident of the facility in January 2007. His monthly room and board charges to the facility are $5,425. The admission packet specifies that room and board charges are to be paid in advance. The facility submitted copies of the monthly bills given to the petitioner outlining his charges. The petitioner's finances are managed by his son and future daughter-in-law.

3. The facility recorded the following payments from the petitioner:

February 20, 2007	$4,025
March 30, 2007	$2,000
June 6, 2007	$20,945.13
July 5, 2007	$8,676.25

4. As of the date of the proposed discharge notice, the facility listed the petitioner's unpaid charges as $16,708.51. As of July 31, 2007, the facility reflected the petitioner's unpaid charges as $15,609.31. The representative paid the room and board of $5,425 for August on August 2, 2007.

5. The monthly bills for the petitioner reflect charges other than room and board. He has additional charges for medical supplies and the rental of a

wound vacuum machine. The representative complained that they did not receive itemized statement until July 2007.

6. The representative questioned the charge for the wound vacuum machine after he independently obtained a quote for the daily rental of the machine that was lower than that charged by the facility ($80 per day versus $106.50 per day).
7. The representative questioned the waste in using part of a medical supply packets and throwing away the remainder. He questions the bandage charges alleging that they are being charged for bandages that are not used.
8. On October 1, 2007, the petitioner notified the hearing officer that he was recently hospitalized. His former nursing facility refused to take him back at the end of his hospitalization. He entered another nursing facility where he currently resides. The petitioner is very pleased with the new facility and no longer wishes to return to [redacted] nursing facility.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255. Matters that are considered at this type of hearing are the decisions by the facilities to discharge patients. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice

indicating that he would be discharged from the nursing facility in accordance with the Code of Federal Regulations at 42 CFR § 483.12(a):

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

The petitioner was aware that there is an outstanding debt through his representative. They have not paid the nursing home the money due because they disagree with some of the charges. In addition, the representative has complaints regarding the care his father has received at the facility.

The hearing officer reviewed the rules and regulations of the Program. Jurisdiction has been conveyed to the fair hearing process to determine if the facility may discharge a resident. This resident currently resides in another nursing facility and does not wish to return to this nursing facility. The sole action available to the hearing officer is to approve or deny the discharge action. Since the discharge has occurred and the resident does not wish to return, the facility's action is upheld.

DECISION

This appeal is denied. The petitioner no longer wishes to return to the facility.

NOTICE OF RIGHT TO APPEAL

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

district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The party must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 10 day of October, 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
[redacted] Respondent
[redacted] Agency for Health Care Administration

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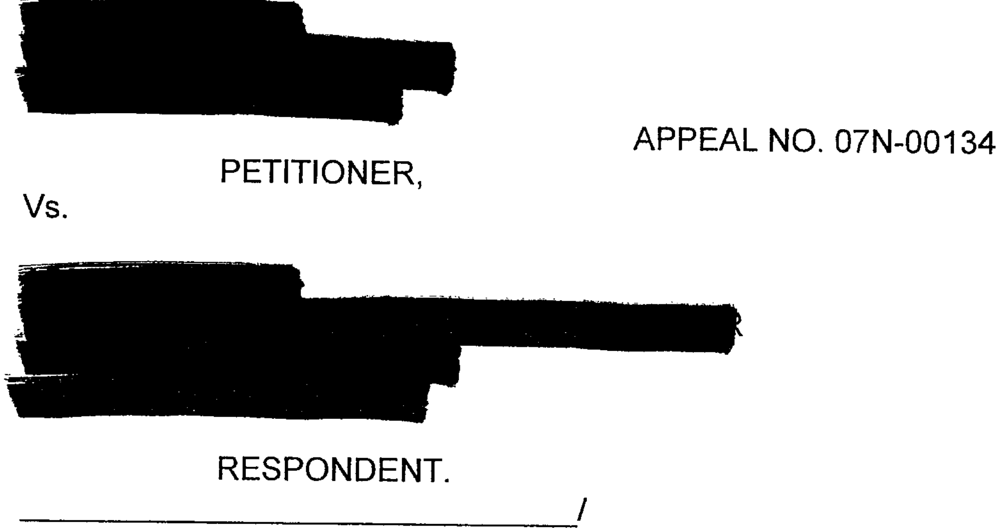
DEPT. OF CHILDREN & FAMILIES

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



PETITIONER,

APPEAL NO. 07N-00134

Vs.

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 25, 2007, at 1:44 p.m., at in Clearwater, Florida. The petitioner was present. The respondent was represented by Observing were , administrator, and social worker.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of July 23, 2007 is in accordance with the requirements of 42 C.F.R. § 483.12(a):

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

FINDINGS OF FACT

On July 23, 2007, the petitioner was given a Nursing Home Transfer and Discharge Notice. The reason listed in the discharge was: "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".

1. The petitioner was admitted to the facility in 2006. The expenses incurred by the petitioner were paid by Medicare for the first 100 days through December 24, 2007. In January 2007, petitioner did not receive her disability check of $560. The petitioner stated she did not pay her nursing home patient responsibility of $524 for January 2007. She does not remember receiving a bill every month. She received some monthly billing and received statements when she requested them. She found the billing to be very confusing with payment not always applied for the month in which the bill was paid. She is aware that the facility is seeking $1,515.26 in payment for services.

2. The patient responsibility is billed on the first of the month for the entire month. The respondent attested that a billing statement was hand-delivered to the petitioner every month, approximately five days after the end of the billing month. The first billing to the petitioner was on December 5, 2006 for November 2006. As of the June 2007 billing statement, the petitioner has an outstanding obligation to the nursing home in the amount of $902.26 for services through May 31, 2007.

3. The petitioner was sent notification on June 18, 2007, advising her of the facility's decision to discharge the petitioner on July 18, 2007. The basis of that discharge was that there had been lack of payment of her bill for services

and after reasonable and appropriate notice the financial situation had not been resolved.

4. The petitioner's services and payments are as follows based on services and payment entered on the billing statements:

Service Month	Patient Resp	Amount Paid	Date Paid	Balance remaining
Dec 2006	$114.26	$17	April 3, 2007	$97.26
Jan 2007	$524.00	$243.00	April 12, 2007	$281.00
Feb 2007	$524.00	$524.00	February 2, 2007	$0
March 2007	$524.00	$524.00	April 3, 2007	$0
April 2007	$524.00	no payment received		$524.00
May 2007	$524.00	$524.00	May 11, 2007	$0
June 2007	$524.00	$400.00	June 13, 2007	
		$35	Sept 13, 2007	$89.00
July 2007	$524.00	$524.00	August 13, 2007	$0
Aug 2007	$524.00	$524.00	Sept 13, 2007	$0
Sept 2007	$524.00	no payment as of September 24		$524.00
Total unpaid by petitioner				$1,515.26

As of September 24, 2007, the petitioner has an outstanding obligation to the nursing home in the amount of $1,515.26 for services through September 30, 2007.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at § 400.0255. Matters that are considered at this type of hearing is the decision by the facility to discharge the patient. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice

indicating that she would be discharged from facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a):

> (2)(v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

As of the billing received on or about June 5, 2007, the total amount due was $902.26. The unpaid balance as of June 5, 2007 of $902.26 plus the unpaid balance of June 2007 of $89 and the unpaid balance of September 2007 of $524 equals $1,515.26. The hearing officer recognizes that the billing statements may have been difficult for the petitioner to understand. On the billing, there were several credits and adjustments and the facility credited funds paid in April 2007 to December 2006 and January 2007. It is understandable how the petitioner thought she made payment for April 2007 in April 2007 and the billing for January 2007 remained unpaid. The fact is that the petitioner stated that she was aware of one month that she made no payment. Based on the amount of patient responsibility and amount paid by the petitioner from December 25, 2006 through September 24, 2007 there remains the amount of $1,515.26 that is unpaid by the petitioner and owed to the facility. The petitioner is aware that there is a debt to the facility. The facility has given the petitioner and her family reasonable and appropriate notice of the need to pay for the petitioner's stay at the facility and reasonable and adequate financial arrangement have not resulted. Based upon the above cited authorities, the hearing officer finds that the facility's action to discharge the petitioner is in accordance with federal regulations. The respondent may proceed with the discharge to an appropriate location as

determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

DECISION

This appeal is denied. The respondent may proceed with the discharge, as determined by the treating physician and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of 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: [redacted] Petitioner
[redacted] r, Respondent
[redacted], Agency for Health Care Admin