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

[redacted]

PETITIONER,

APPEAL NO. 07N-00119

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer at the [redacted] in Winter Garden, Florida, at 3:45 p.m. on August 22, 2007. The petitioner was not present but was duly represented by her daughter, [redacted] and her granddaughter, [redacted] Also present on behalf of the petitioner were [redacted] Hospice team manager, and [redacted] social worker. The respondent was represented by [redacted], administrator. Testimony on behalf of the respondent was also available from [redacted] social service director; [redacted] residential care coordinator; and [redacted] director of nursing.

ISSUE

At issue was whether or not discharge from the nursing facility was correct due to facility's inability to meet the needs of the petitioner. The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner entered the [redacted] nursing facility on May 12, 2007 from an assisted living facility. Health problems included dementia and memory impairment. Health problems of that nature are undisputed.

2. The [redacted] facility does not have a locked section to provide for security of individuals with disorientation or dementia - related wandering. The facility has recently been refurbished, but changes did not include provision of a locked area.

3. The petitioner is ambulatory and unrestrained. She has difficulty finding her own room and in avoiding entry to other residents' rooms. By May 14, 2007 she was found wandering into others' rooms and was easily redirected by staff (Respondent's Exhibit 2, nursing section). On May 30, 2007 progress notes reflected the wandering and "socially inappropriate behavior" (social service notes). In June 2007 those notes and care plan reflected her behavior of "rummaging through" belongings of others. In other words, without invitation, she enters the rooms of other residents.

4. Some other residents are not comfortable about that behavior and grievances have been registered (Respondent's Exhibit 2, grievance section). Provision of a landmark to help her identify her own area helped for a time, but not as an ongoing tool. By August 13, 2007 she continued to wander and "became agitated when redirected..." (nursing notes).

5. On July 3, 2007, with a determination that the facility could not meet her needs, and that she needed a more secure location, notice of discharge intent was issued (Respondent's Exhibit 1). That notice was accompanied by the attending physician's authorization for discharge to [redacted] That location is east of [redacted] and is in the same county. [redacted] has a locked unit to provide security for such residents. It is a licensed facility. This is undisputed, although the family did not prefer the area where [redacted]s located. The respondent planed to achieve relocation to the new location by August 2, 2007.

6. Her family is committed to visiting with the petitioner and involving her in their lives and vice versa. Location proximity is important to the family. The family wants the petitioner to be located close to them in an area where they feel safe visiting. Petitioner's Exhibit 1 reflected some of their concerns. Key family members work, have difficulty traveling and also face serious health problems. The family has participated in care planning.

7. The family wants additional time to handle the relocation problem, and is primarily able to address this matter on the weekends or outside of work hours. There is another facility in [redacted] that has a secure unit and another facility in another county just west of the area. Agreement to and placement for relocating had not been achieved by the family as of date of hearing.

8. When the hearing was registered, the undersigned directed that review be conducted by the Agency for Health Care Administration (AHCA). While such a review may have been conducted, it is not necessarily controlling for hearing purposes and was not available as of hearing. If results were received before the final order was

complete, the undersigned agreed to provide copies of the review to the parties and afford opportunity to respond. AHCA review results were received and were shared under separate order, with opportunity for and instructions for response. Response was not necessary nor received. The review did not change facts developed at hearing.

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, transfer and discharge is addressed at 42 C.F.R. § 483.12 stating in relevant part:

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (iii) The safety of individuals in the facility is endangered;
>
> (iv) The health of individuals in the facility would otherwise be endangered;
>
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
>
> (vi) The facility ceases to operate.
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

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

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

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

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

(5) Timing of the notice.

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

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

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

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

Based on all evidence and testimony presented, it is concluded the current facility cannot adequately meet the security or personal welfare needs of the petitioner, as described in the notice. Discharge to a more secure section of a facility such as [redacted], in a community not too far away would be appropriate, as also set forth in the notice under challenge. Due to wandering and behavior concerns, another location which would provide greater security is not only preferable, it is needed for the welfare of the petitioner.

While the family might prefer a close location, more time for research and visiting other facilities, and would prefer certain other aspects of favorable accommodations, such are not controlling factors under regulation. The regulations do not permit a longer period of time for research or planning and do not provide for individual preferences as

to sections of the community. To some extent, preparation time may be afforded by the thirty day advance time set forth in the notice.

Upon careful review of all facts and regulatory guidelines, if the location for intended discharge has a secure section and is appropriately licensed, such a location would be a permissible location for discharge. [redacted] meets standards for discharge. Therefore, it is concluded that discharge planning and orientation to the facility named in the notice may proceed.

DECISION

The appeal is denied and the discharge notice is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th day of September, 2007, in Tallahassee, Florida.

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

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

[redacted]

PETITIONER,

APPEAL NO. 07N-00106

Vs.

CASE NO. 1253702551

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 21, 2007, at 9:15 a.m., in Lauderhill, Florida. The petitioner was not present. He was represented by his daughter [redacted] The respondent was represented by [redacted] administrator of [redacted] Also present from the facility was [redacted] business office manager, and [redacted] social services director. Also present was [redacted] chairman of the Broward County Long Term Care Ombudsman Council.

ISSUE

At issue is the [redacted] Care Center's action of June 5, 2007, to discharge the petitioner for not paying the cost of care in the facility.

FINDINGS OF FACT

As of the time of the hearing, the petitioner resided at the [redacted] in Lauderhill, Florida. The petitioner was provided with a Nursing Facility Transfer and Discharge Notice, dated June 5, 2007, informing him that he would be discharged from the facility due to non-payment of care in the facility. At the hearing, the petitioner's representative asserted that she did not disagree with the discharge of the petitioner from the facility. She also agreed that the petitioner owes money to the facility.

Included in the evidence are copies of Notice Of Case Action forms from the Department dated March 15, 2007, to the petitioner informing him that he was approved for Institutional Care Program Medicaid benefits. He was informed that his patient responsibility to the facility is $2,373.86 monthly. Included in the evidence are copies of statements sent from the facility to the petitioner's representative informing her of the facility charges from April 2007 to August 2007. According to a statement dated August 1, 2007, the balance due as of that time was $12,136.79.

CONCLUSIONS OF LAW

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

In accordance with the Federal Regulations at 42 C.F.R. § 483.12 (a):

> (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.

At the hearing, the petitioner's representative asserted that she did not disagree with the discharge of the petitioner from the facility. She also agreed that the petitioner owes money to the facility, which was $12,136.79 as of August 1, 2007. It is determined that the facility's action to discharge the petitioner, is upheld.

DECISION

The appeal is denied, and the [redacted] action to discharge the petitioner is affirmed.

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 12th day of September, 2007,

in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished To: [redacted] Petitioner

[redacted] Respondent

Agency for Health Care Administration

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

[redacted]

APPEAL NO. 07N-00108

PETITIONER,

Vs.

CASE NO.

[redacted]

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 10, 2007 at 11:20 a.m., at the [redacted] in Jacksonville, Florida. The petitioner was not present. However, she was represented by her daughter, [redacted] at the hearing. The nursing facility was represented by [redacted] Administrator and [redacted] Director of Nursing.

ISSUE

The petitioner wishes to appeal the respondent's action for failing to readmit the petitioner to the facility after an emergency admission to a hospital.

FINDINGS OF FACT

The petitioner was admitted to the nursing home in 2004. On December 28, 2006, the petitioner was transferred to the [redacted] due to a

medical emergency. The petitioner remained in the hospital for 13 days. There was no evidence submitted that would show the transfer was not a medical emergency. The petitioner was provided with a Resident Transfer Form when she was transferred to the hospital. The petitioner was discharged from the hospital on January 9, 2007 and she is currently a patient at another nursing home facility. The petitioner would like to return to the [redacted] facility as soon as possible. The respondent stated that there have not been beds available for the petitioner. The petitioner believes that other beds have become available but not offered to the petitioner to allow her to return.

CONCLUSIONS OF LAW

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

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

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

> Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.

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

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

> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand...
> (5) Timing of the notice.
> (ii) Notice may be made as soon as practicable before transfer or discharge when--
> (A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;..
> (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a) (2)(i) of this section; or...

These regulations only provide for a hearing of actions to transfer or discharge a resident. The petitioner does not challenge the transfer to the hospital. The issue before this tribunal is whether the respondent is obligated to maintain a bed for more than eight days after an emergency transfer to a hospital. This is referred to as a bed-hold policy. The respondent's bed-hold policy states that the bed will not be paid by Medicaid for more than eight days. After that, the resident will be re-admitted to the first available Medicaid bed. The petitioner's stay in the hospital was longer than eight days.

The petitioner was properly noticed of the policy and given a transfer form. The issue of the transfer is not the issue that is being challenged. Rather is it the failure of the respondent to readmit the petitioner after her hospital stay. Therefore, this is not an issue of a transfer or a discharge. As such, there is no jurisdiction for this hearing officer to entertain this matter. Concerns relating to the respondent's bed-hold policy and admitting or readmitting a resident would more properly be addressed to the Agency for Health Care Administration (AHCA) for resolution.

The petitioner was transferred to a hospital based on a medical emergency. The regulations at 42 C.F.R. §483.12 requires the facility to issue a notice of transfer at the time of transfer, or as soon as possible thereafter. In this case, the nursing facility has complied with this policy. As such, the transfer was correct under the regulations.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 12th day of September, 2007, in Tallahassee, Florida.

James Abdur-Rahman
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

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

APPEAL NO. 07F-03858

PETITIONER,

Vs.

CASE NO. 1260149072

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 20, 2007, at 11:07 a.m. in Lakeland, Florida. The petitioner was not present. He was represented by his legal counsel Connie Durrance. The respondent was represented by Jerome Major, district counsel. Present as witnesses for the petitioner were his son and power of attorney, his daughter, ; his daughter and family friend, s. Present as witnesses for the respondent were Shirley Johnson, supervisor; and Clare Short, economic self-sufficiency specialist.

ISSUE

At issue is the June 11, 2007 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program due to his failure to follow through in establishing eligibility.

FINDINGS OF FACT

1. On April 4, 2007, the petitioner filed a Request for Assistance to apply for benefits through the Institutional Care Program. He was represented by his son and power of attorney, [redacted]. The petitioner resided in a nursing home. He has a spouse in the community. The couple does not have any mutual children.
2. The respondent issued a notice requesting information with a return deadline date of April 19, 2007. On May 10, 2007, the respondent denied the petitioner's application for failure to return requested information. One of the items he failed to return was verification of the income and assets of the community spouse. On May 16, 2007, the application was reopened following the recommendation of a program specialist with the Department.
3. On May 17, 2007, the respondent issued another request for information. The respondent requested information on the income and resources of the community spouse, proof of the balance in shared accounts, proof of the market value of the home, and proof of the health insurance premium. There was a question of the validity of the transfer of the couple's home to the community spouse's daughter in February 2007. The deadline date to return the information was May 19, 2007.
4. The validity of the transfer of the homestead was resolved. However, the petitioner failed to return verification of the community spouse's income and assets owned

singly or with the petitioner. On June 8, 2007, the respondent denied the petitioner's application for failure to return requested information.

5. The petitioner was diagnosed with early stage dementia over four years ago. He was hospitalized on February 28, 2007 due to swollen legs, extreme fluid build up on his feet, and fluid in one of his lungs. Prior to his hospitalization, family noticed his rapid deterioration in that he was disheveled, appeared heavily medicated, and could not carry on a sensible conversation.
6. During his hospitalization, his son and power of attorney noted his community spouse's lack of interest in the petitioner's care. She did not want to take responsibility for or discuss his long term care needs. On March 6, 2007, the petitioner was discharged from the hospital to a nursing facility,
7. During his nursing home stay, physicians determined that the petitioner was no longer capable of acting in his best interests and make decisions. His son was his health care surrogate and power of attorney. The nursing facility determined that he could be discharged home with services in the community. His community spouse would not agree to provide his care in their home. In addition, she was uncooperative in providing necessary information for his application for Medicaid. Attempts by the son to obtain information resulted in instructions to cease any contact with the community spouse by the community spouse's son-in-law who is a police officer.
8. The POA/son explained the status of his father's marriage to the respondent. It is not in dispute that he discussed his inability to obtain the cooperation of the community spouse in providing further information regarding any shared resources

with a program specialist and an eligibility specialist with the Department. The son provided copies of two separate emails from the community spouse documenting her refusal to cooperate in providing information.

9. According to the son, the couple experienced a bankruptcy and their only resource was their home where the community spouse currently resides. The son was able to provide a copy of a bank statement showing deposits reflecting the community spouse's income, but she has since removed the petitioner's name from the account.

10. The petitioner submitted an Assignment of Rights to Support form signed by the son (POA) and his two sisters. This assigns any interests he has to the state in exchange for Institutional Care Program benefits. An investigation into obtaining a divorce to separate the couple legally discovered that it is a lengthy procedure involving forming a guardianship.

CONCLUSIONS OF LAW

The Fla. Admin. Code at 65A-1.712 provides for resource limits in SSI-Related Medicaid eligibility and states in relevant part:

> (g) The institutionalized community spouse shall not be determined ineligible based on a community spouse's resources if all of the following conditions are found to exist:
>
> 1. The institutionalized individual is not eligible for Medicaid institutional services because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse; and
>
> 2. The institutional spouse assigns to the State any rights to support from the community spouse by submitting the Assignment of Support Rights form referenced in Rule 65A-1.400, F.A.C., signed by the institutionalized spouse or their representative; and

3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and

4. The institutionalized spouse has no other means to pay for the nursing home care.

The Integrated Public Assistance Policy Manual states in relevant part in the following passages:

1640.0314.01 Assets Available to Community spouse (MSSI)

The following policy applies to ICP, ICP-MEDS, and ICP-Hospice individuals admitted to institutions on or after September 30, 1989. This includes SSI recipients applying for institutional services. (If the client was institutionalized prior to September 30, 1989, refer to Chapter 2200). Although the assets of a Medicaid recipient's community spouse may not have been considered available to the client in the community (e.g., when the couple is separated), when the client applies for institutional services, the assets of both spouses must be considered in determining the client's eligibility for institutional services.

The portion of a couple's assets available to the institutional spouse is the amount remaining after the community spouse's asset allowance is subtracted from the couple's total included assets. If this figure is over the program's allowable asset limit, the individual is ineligible until the assets are reduced to within the program's standard.

If after declaring and verifying his assets, the community spouse refuses to make them available to the client, the institutionalized may assign his rights of support to the state and obtain institutional care benefits (refer to passages 1640.0314.03 and 1640.0314.04 for policy). Community spouses who refuse to make their assets available to the institutionalized spouse are not entitled to a community spouse income allowance...

1640.0314.03 Assignment of Support Rights (MSSI)

If the community spouse refuses to make available assets attributed to the institutionalized spouse, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits. This situation may arise when assets allocated to the client actually solely belong to the community spouse who, in turn, refuses to make them available to the client.

The institutionalized spouse may complete CF-ES Form 2504, Assignment of Support Rights, which allows the state to pursue recovery from the community spouse. Refer to CF Manual 165-24, Integrated

Public Assistance Forms Manual, for proper completion (including who can sign the form). The original copy of this form is to be sent to Economic Self-Sufficiency Services, Policy Bureau, in Tallahassee, Attention: SSI-Related Medicaid Program staff. This form is not an option that an ESS suggests to an ineligible couple, but rather a solution to an existing situation which is brought to the ESS' attention.
When all conditions in passage 1640.0314.04 are met, the allocated assets being withheld by the community spouse will no longer be considered available to the institutionalized community spouse.
If the institutionalized spouse does not assign the rights of support to the state, continue to consider the assets available to the institutionalized individual.

1640.0314.04 Undue Hardship (MSSI)

The institutionalized spouse will not be determined ineligible based on a community spouse's assets if all of the following conditions are found to exist:

1. The institutionalized individual is not eligible due to the community spouse's assets and the community spouse refuses to use the assets for the institutionalized community spouse; and
2. The Assignment of Support Rights form (CF-ES Form 2504) is signed; and
3. The institutionalized community spouse would be eligible if only those assets to which he has access were counted; and
4. The institutionalized community spouse has no other means to pay for the nursing home care.

1640.0321 Assets Unavailable: Circumstances Beyond Control (MSSI, SFP)

Assets unavailable due to circumstances beyond the individual's control are not considered in the determination of eligibility.
The individual must present convincing evidence to prove the asset is unavailable to him due to circumstances beyond his control. The ESS will make an independent assessment of the availability based on the evidence presented. Additional guidance can be requested from the District Program Office, District Legal Office, or central office through the District Program Office.

The evidence establishes that the petitioner's community spouse has not taken responsibility for his care. Moreover, the evidence establishes that she has not cooperated in any efforts to obtain Medicaid to pay for his care in the nursing facility.

The respondent does not dispute that the son reported the difficulties in obtaining the requested information from the community spouse and the fact that their marriage was estranged.

It is clear that the community spouse is resistant to the eligibility process for Medicaid and could even be considered separated from her community spouse. Any assets owned by the community spouse can be considered unavailable to the petitioner due to the failure of the community spouse to cooperate in establishing eligibility. The respondent did not offer the petitioner any exception to providing information on the community spouse or an opportunity to sign an Assignment to Rights to Support. Subsequently, the petitioner signed this form and offered it to the respondent. According to the above-cited rules, the respondent can disregard any assets owned by the petitioner but controlled by the community spouse.

DECISION

This appeal is granted. The respondent's action denying the petitioner's application is reversed. The respondent should reevaluate the petitioner's eligibility for benefits based the known income and assets available to the petitioner.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
14 DPOES: Ellen Schultz
Jerome Major, Esquire
Connie Durrance, Esquire

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

APPEAL NO. 07F-04226

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 01 Escambia
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 5, 2007, at 8:40 a.m., in Pensacola, Florida. The petitioner was not present but was represented by her mother, [redacted]. The Agency was represented by Cindy Henline, medical health care program analyst, Agency for Health Care Administration (AHCA). Testifying on behalf of the Agency, via speakerphone, was Dr. Rakesh Mittal, KePRO South. Observing the hearing was George Smith, review operations supervisor, KePRO and Mary Wheeler, review operations manager, KePRO.

The hearing record was held open for 14 days or until September 19, 2007 to allow the respondent to submit additional evidence which was received and entered as Respondent's Exhibit 3.

ISSUE

The petitioner is appealing AHCA's action of July 13, 2007 to reduce Private Duty Nursing (PDN) from a request of 1440 hours to 480 for the time period of July 10, 2007 through September 7, 2007 based on the contention that the intensity or level of medical care requested was not medically necessary.

FINDINGS OF FACT

1. The petitioner (date of birth [redacted]) is a Medicaid recipient. The petitioner has been receiving PDN services under Medicaid. A request for 1,440 hours of PDN was submitted by the provider, Maxim Healthcare Services, Inc., for the period of July 10, 2007 through September 7, 2007.

2. Prior to the action under appeal, the petitioner was authorized to receive 16 hours per day, seven days per week of PDN. The petitioner's mother is unemployed. The provider's request for PDN indicated that the child's biological father was in the home every day and night except one when nursing staff were present. In addition, both parents are trained caregivers. The petitioner's mother testified that the biological father does not reside in the home and "drops" in without notice.

3. Requests for PDN are reviewed with a contract provider who completes prior authorization for the requested service. That contract provider is KePRO. The request for services is submitted by the home health care provider, in this case, Maxim Healthcare Services, Inc. The requests are for 60 day time periods. All communication is sent between KePRO and the provider until a decision is reached. KePRO reviews

the written request for services to determine if the number of hours requested are medically necessary. If additional information is needed, KePRO contacts the provider. Once services, as in this case, were rejected or modified, a notice is sent to the recipient's family.

4. KePRO received the request for 1,440 hours of PDN submitted by the provider, Maxim Healthcare Services, Inc. A KePRO Registered Nurse Reviewer (RNR) completed a screening of the Plan of Care submitted on July 6, 2007 and suspended the case as the "Plan of Care (POC) was signed outside of the 21 day range from the start date of the certification period." On July 9, 2007, the provider submitted an updated POC signed by the attending physician, Dr. Julia Niebauer. The request was for night nursing only, from 11 p.m. to 7 a.m., seven days per week or 480 hours (Respondent's Composite Exhibit 2, Section C and Respondent's Exhibit 3).

5. At AHCA's direction, the RNR used modified InterQual Criteria and a Pediatric Home Care Guide for Private Duty Nursing (PDN) Hourly Utilization to review the request for PDN services. Using that documentation, a Utilization Form was developed. The Utilization Form assigns point values to physical conditions of the petitioner and level of care that is anticipated. KePRO concluded that based on the points the petitioner was scored, a physician's review was required.

6. The case was then referred to a Board Certified Pediatric Specialty Physician Consultant. A Board Certified Pediatrician reviewed the case and made the following determination: "1 y/0 with unspecified congenital anomalies, failure to thrive. Has trach,

on ventilator at bedtime; requires nebulizer treatment and sat checks...Lives with mother who does not work and question of whether Dad is living in the home/may or may not be working. Nurse Reviewer Recommendation---:approve 480 hours for 11 p.m. to 7 a.m. every day so Mom can sleep; deny 960 hours. Updated request is for 480 hours, 8 hours per day, 7 days per week." (Respondent's Composite Exhibit 2, Section C). The determination of the physician consultant was sent to Maxim Healthcare Services, Inc. on July 12, 2007 and July 13, 2007. Based on the documentation, the pediatric consultant denied 960 hours and approved 480 hours of the 1,440 requested hours of PDN.

7. The documentation indicated a request for the petitioner with congenital anomalies of the larynx, trachea, bronchus, and failure to thrive. The petitioner is developmentally intact. The petitioner has a tracheostomy and g-tube. In addition she is on a ventilator, especially at night when sleeping and during nap time. She requires suctioning of the tracheostomy as needed to clear secretions. She requires medication administration and tube feedings when she fails to take enough nutrition. The provider informed KePRO that the "patient has been stable for the past 60 days. She has had no hospitalization and no episodes of respiratory distress during this certification period. The Patient is off her ventilator for several hours at a time during the day but stays on continuous when sleeping. Patient has required no supplemental oxygen. Patient receives bottle feedings by mouth. If ordered amount is not taken in during the day

patient receives the remaining amount per g-tube continuous at night..." (Respondent's Composite Exhibit 2, Section C).

8. The provider accepted KePRO's decision and a reconsideration was not requested. The program is operated with the understanding that parents or caregivers will be able to participate in providing care as they are trained in providing for the child's care. In addition, PDN services must be ordered by the attending physician.

9. KePRO received an updated request for 480 hours of PDN and approved the request. The petitioner's mother did not agree with the decreased request and requested a fair hearing. As a result of the request for hearing, 960 hours of PDN (16 hours/day 7 days a week 7 a.m. to 3 p.m. and 11 p.m. to 7 a.m.) was administratively approved in subsequent certification periods pending the outcome of the appeal.

10. At the hearing, the mother stated that her daughter weighed approximately 22 pounds and is 28 ½ inches tall. The mother indicated that she needs help with the petitioner's care at least 16 hours per day for 7 days a week because the petitioner is more "active". In addition, the representative needs time to complete household duties such as shopping and bill paying.

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 Statutes § 409.919 Rules (2006) states:

> The agency shall adopt any rules necessary to comply with or administer ss. 409.901-409.920 and all rules necessary to comply with federal requirements. In addition, the Department of Children and Family Services shall adopt and accept transfer of any rules necessary to carry out its responsibilities for receiving and processing Medicaid applications and determining Medicaid eligibility, and for assuring compliance with and administering ss. 409.901-409.906, as they relate to these responsibilities, and any other provisions related to responsibility for the determination of Medicaid eligibility.

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

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

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

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

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

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

The Home Health Services Coverage and Limitations Handbook , Chapter 2, p.2-2, states in part:

> In order to be reimbursed, home health services must also be:
> - Ordered by and remain under the direction of the attending physician...licenses under Chapter 461, 458 or 459 F.S. or licensed in the state in which the attending physician practices;
> - Consistent with the individualized written physician-approved plan of care
> - Provided by qualified staff; and
> - Consistent with accepted standards of medical and nursing practice.

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

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

The Home Health Services Coverage and Limitations Handbook , Chapter 2, p.2-16, states in part:

> 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 that they can safely render. Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.

The Home Health Services Coverage and Limitations Handbook, Chapter 2, p.2-16, states in part:

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

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

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

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

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

AHCA's Home and Health Services Coverage and Limitations Handbook (October 2003) Plan of Care certification period, states in part;

> The attending physician must review the POC at least every 60 days. The attending physician is required to indicate his approval by signing each POC.
> The attending physician must countersign an ARNP or physician assistant signature on a POC.
> Each POC must incorporate or include as a separate document the physician order for home health services.
> If home health services require pre-certification or service authorization, the POC must be reviewed and signed by the attending physician before submitting the pre-certification or service authorization request.

Home Health Services Coverage and Limitations Handbook (October 2003), Appendix B states:

> Service authorization is the approval process required prior to providing certain services to recipients under 21 years of age. Medicaid will not reimburse for these services without service authorization when it is required.
> **Services Requiring Service Authorization**
> The following home health services require service authorization for reimbursement:
> - Private duty nursing; and
> - Personal care.

As a result of the reduction in PDN services paid for by Medicaid, the petitioner, through her representative, appeals this action, asserting that at least 16 hours per day, seven days per week of PDN services are necessary.

According to the above authorities, the agency is the final arbiter of medical necessity. In making the determination of medical necessity, the agency followed its procedure to have a professional registered nurse practitioner and the opinion of the attending physician and the reviewing physician. Such determination was based upon the information available at the time the goods or services were provided.

According to the above authorities, the request for prior authorization must be submitted by the provider who plans to furnish a service. The Findings of Fact show that the request for prior authorization and an updated Plan of Care was submitted by the provider who furnishes PDN service.

In weighing the evidence, the following conclusion is reached by the undersigned: the petitioner's treating physician signed the Plan of Care recommending the reduced hours deemed as medically necessary. There was no medical evidence presented by the petitioner to rebut the treating physician's Plan of Care and the medical necessary hours of PDN. Therefore, the hearing officer concludes that the reduction in the PDN hours due to no medical necessity, to match the number of hours submitted by the treating physician in the Plan of Care, is affirmed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL

32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 26th day of September, 2007,

in Tallahassee, Florida.

Linda Garton

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

Copies Furnished To: , Petitioner
Delphine Metarko, Area 1 Medicaid Adm.

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

APPEAL NO. 07F-03946

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 15, 2007, at 2:30 p.m., in Fort Lauderdale, Florida. The petitioner was not present. He was represented by his mother [illegible]. The Agency was represented by Steven Comeau, program operations administrator. Present from Children's Medical Services was Dr. William Bruno, medical director; Lillian Niedo, supervisor; Mary Hooshmand, nursing director; Rebecca Moniod, case manager; and Anita Eneida-Medina, social worker. Present from Memorial Healthcare Systems was Jessica Lerner, medical director; Amy Pont, clinical services director; and Barbara Williamson, case manager.

ISSUE

At issue is the Agency's June 21, 2007 action of cancelling the petitioner's Prescribed Pediatric Extended Care (PPEC) services through August 31, 2007, due to not meeting medical necessity. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner, date of birth [redacted], is 9 years old, and he has been receiving PPEC services through the Medicaid Program. Included in the evidence is a copy of a Children's Medical Services (CMS) Notice of Denial for Requested Services, dated June 21, 2007. It states that PPEC services were denied effective August 31, 2007, due to not meeting medical necessity. The recommendation, as listed on the form was to transfer the petitioner to regular aftercare, daycare, or a camp program.

According to information provided at the hearing, a Children's Medical Services CMAT staffing occurred, and the team determined that there is no longer medical necessity for PPEC, as the petitioner's condition no longer justifies such intense care. CMAT determined that the situation is not medically complex or fragile enough, or sufficient instability, to justify continuation of PPEC.

Included in the evidence is a copy of a Children's Medical Center Record Of Treatment report on the petitioner, dated July 13, 2007, from Dr. Ernesto Blanco. The petitioner has type 1 diabetes mellitus and hypothyroidism. The doctor did not make any changes at that time to the petitioner's dose of insulin injections. He prescribed to repeat a hemoglobin A1C, serum glucose, TSH, T4, and free T4 prior to his next clinical visit.

The petitioner's mother disagrees with removing him from PPEC, asserting that he needs the medical care provided to make sure that his blood sugar is regulated properly.

According to Dr. William Bruno, at the hearing, he asserted that this was the first time that he has seen a child attend PPEC due to diabetes, and the petitioner's condition is not severe enough to attend such a medical day care facility. He concurs with the CMAT team that the cancellation of PPEC services for the petitioner is correct, due to him not meeting the medical necessity criteria.

CONCLUSIONS OF LAW

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

Fla. Admin. Code 59G-1.010 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-4.260, addresses **Prescribed Pediatric Extended Care Services**. Subsection (2) informs as follows:

All Medicaid enrolled prescribed pediatric extended care service providers must be in compliance with the Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

The Florida Medicaid Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, October 2003, informs as follows:

Purpose
The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Program is to enable children with medically-complex conditions or the need for acute medical care to receive medical care at a non-residential pediatric center.

Description
A PPEC is a rehabilitative facility that serves three or more children under the age of 21 who require short or long-term continual medical care due to medically-complex conditions or the need for acute medical care. A PPEC offers services that meet the child's physiological, developmental, physical, nutritional, and social needs.
...
Who Can Receive Services
To receive PPEC services, a recipient must meet the following criteria:
- Be Medicaid eligible;
- Be medically fragile or technologically dependent;
- Be age 20 or under;
- Be medically stable; and
- Must require short or long-term health care supervision due to medically-complex condition or the need for acute care.

Definition of an Acute Medical Condition
An acute medical condition is a debilitating disease or condition of one or more physiological or organ systems that made the person dependent upon short or long-term medical care, nursing, health supervision, or intervention.

Medically Necessary
Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service...

Approval of Services
PPEC services must be: ...
- Recommended by the CMAT...
- Authorized by the area Medicaid service authorization (SA) nurse.

CMAT Referrals ...
An individual who is medically able to attend a PPEC, and whose needs can be met by the PPEC, should have PPEC services recommended by the CMAT. ...

Reauthorization of Services
The service authorization nurse must review the recipient's renewed plan of care every one to six months depending on the authorization period for which the services were approved. If the services continue to be medically necessary and appropriate, the service authorization nurse can reauthorize the services.

Under appropriate statute and administrative authorities, CMAT is charged with determining whether medical necessity has been adequately established and AHCA must assess whether the Medicaid reimbursement criteria have been met. The petitioner's PPEC services through the Medicaid Program were cancelled. His mother argued that it was difficult to locate a satisfactory community day care alternative. Substantive evidence did not support such a contention. A physician's support for the continuation of these services is not controlling without solid and substantive evidence to confirm such a position, and such was not available.

A non medical day care facility should be able to handle the petitioner's needs as they have been described. The physician that testified at the hearing agreed that cancellation of PPEC services for the petitioner is correct, due to him not meeting the medical necessity criteria. Evidence submitted supports the Agency's determination as to

the appropriateness of the transition to an equally effective, less restrictive and more conservative or less costly alternative. Based upon the evidence and the governing guidelines, it is concluded that the plan, to cease Medicaid authorization of PPEC, is a reasonable determination. After careful consideration, it is concluded that the Agency's action to cancel the petitioner's PPEC services, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of September, 2007,

in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished To: J, Petitioner
Gail Wilk, Area 10 Medicaid Adm.
Sally Hill, M.D.
William Roberts

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

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
DISTRICT: 12 Volusia
UNIT: 88211

RESPONDENT.
_____/

APPEAL NO. 07F-04170

CASE NO. 1117716058

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer at 1:30 p.m. in Daytona Beach, Florida on August 15, 2007. The petitioner was not present but was represented by ry, business office manager at . The respondent was represented by Ernestine Bethune, senior eligibility specialist with ACCESS, and testimony was available from Parrey Hardwick, eligibility specialist. Following a recess, Jackie Zachery, program specialist with ACCESS, also participated.

ISSUE

At issue was whether or not Institutional Care Program (ICP) and Medicaid denial was correct due to excess assets during January and March 2007. The petitioner had the burden of proof, as an applicant.

FINDINGS OF FACT

1. The petitioner applied for ICP benefits on April 2, 2007. Eligibility was approved for months of February 2007 and April 2007 as well as ongoing. Notices of approval were Respondent's Exhibit 1.

2. Benefits were denied for months of January and March 2007. The respondent issued no notices of denial, but it was understood that denial occurred because the respondent determined there were excess assets of approximately $164 or more for both months.

3. Monthly income of the petitioner was $777 Social Security and the respondent did not count income also as an asset during the same month.

4. The petitioner's representative (knowing the finances and having relevant information) had personally faxed the bank data and had the fax receipt to show such, in a timely response to the Department's request for bank information. She believed and the respondent's representative did not dispute, that the faxed information would reflect balance under $2000 for a later date in January 2007 and outstanding checks for March 2007, which reduced both months' assets below $2000. Petitioner's Exhibit 1 showed the January 2007 bank data and Petitioner's Exhibit 2 showed March 2007.

5. Upon additional case review of existing information, the respondent concurred that bank information had been timely faxed and favorable conclusion was a distinct possibility. However, it appeared that the back pages of the fax were not successfully transmitted and the respondent had not notified the petitioner of this problem. (In the days immediately before the hearing, the parties had been unsuccessful in contacting each other and attempting to resolve problems.)

6. The parties agreed that further efforts toward resolution should occur. That meant that the application of April 2007 was preserved, protected and review would proceed without prejudice. It also meant that retroactive eligibility for the three prior months (which would include January and March 2007) would be reviewed in depth using the additional information.

CONCLUSIONS OF LAW

Argument of the petitioner was that assets were within limits during January 2007 and March 2007 and that she could have submitted additional information to establish eligibility if she had known it was needed. The program specialist agreed with the petitioner to the extent that she believed the Department needed some time to evaluate materials that were submitted during the hearing and which would enable a better eligibility study. Additionally, and perhaps best described as a customer service concern, the petitioner wanted opportunity to speak with a knowledgeable employee actually within the service center. She did not believe that adequate communication was being achieved as related to the eligibility determination process.

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

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

20 C.F.R. § 416.1205 establishes the maximum asset limitation for the ICP category as $2,000 for an individual with income at the level of the petitioner's (greater than $749 per month in accord with regulation and Fla. Integrated Pub. Policy Manual

165-22, Appendix A-9). Fla. Admin. Code 65A-1.712 addresses **SSI-Related Medicaid Resource Eligibility Criteria**:

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

In accord with state and federal regulations, the Department's guidelines at **Fla. Integrated Pub. Policy Manual 165-22,** inform as follows:

> **1640.0408 Determining Asset Value (MSSI, SFP)**
> The countable value of an asset is the equity an individual or couple has in the asset. In some cases, the asset value counted toward the applicable asset limit is first reduced by an allowable excluded amount.
> Equity value is the amount that an asset can expect to sell for on the open market in the particular geographic area involved (that is the fair market value of the asset), less any legal debt on the asset.
> Debts are any form of legal indebtedness against the asset in question, such as:
> 1. mortgages,
> 2. liens,
> 3. loans,
> 4. purchase contracts, or
> 5. security interests.
>
> Only the amount of the principal owed and any prepayment penalty required by such a debt is deducted from the fair market value in establishing the equity value of the asset.
> Any future interest owed as a result of the asset is not considered in establishing equity value.
> Outstanding checks that have not cleared the bank yet are considered a form of legal indebtedness against the asset.

Therefore, based upon regulations and policies, it is proper to reduce the asset by the amount of checks outstanding on the account and written during a month, and it is also proper to use the lowest value existing during a month. Further, under Fla. Admin. Code **65A-1.702 Special Provisions** (2) "...The date of eligibility includes the three months immediately preceding the month of application (called the retroactive

period)." Also, the Fla. Admin. Code **65A-1.205** addresses the **Eligibility Determination Process** informing at (1)(d)

> If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required...the specialist must grant the assistance group 10 calendar days to furnish the required documentation....

Consequently, when the fax was submitted for the April 2007 application but crucial information was somewhat obviously omitted, it would have been appropriate for the respondent to inform the petitioner of the problem and afford further verification opportunity.

After careful review of all findings of fact and the relevant regulatory guidelines, in view of the problems inadvertently caused by both the petitioner and the respondent, and in keeping with their agreement toward resolution efforts, the following conclusion is reached. The application date of April 2, 2007 is preserved. Eligibility study shall proceed as agreed and consistent with requirements noted herein. If the respondent determines eligibility, then benefits shall be authorized for months in question and notice of such shall be issued. If the respondent denies eligibility, then the petitioner shall be advised in writing of the negative determination and appeal rights would exist in customary fashion of the Department.

DECISION

The appeal is granted in that the eligibility review shall be resumed. Notice of review results for each month shall be issued and shall be appealable under standard procedure of the Department.

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 7th day of September, 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
12 DPOES: Theola Henderson

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

APPEAL NO. 07F-03911

PETITIONER,

Vs.

CASE NO. 1243177896

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Escambia
UNIT: 88638

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 13, 2007, at 3:00 p.m., in Pensacola, Florida. The petitioner was not present but was represented by his wife, . Present at the hearing was his sister-in-law, . The Department was represented by Franzaro Dudley, Access Florida supervisor. Present for the Department was Kendra Parker, Access Florida case processor.

ISSUE

The petitioner is appealing the Department's action of June 28, 2007 to terminate Institutional Care Program (ICP) benefits effective August 1, 2007 based on the contention that income is more than allowed for the ICP program. The Department bears the burden of proof.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner resided in A Place Assisted Living Facility (ALF) and was receiving Home and Community Based Services (HCBS) Medicaid since at least December 2006. The petitioner had income from Social Security of $1,111 (2006) and a pension of $827.52. It was necessary for an income trust to be established and funded, as the petitioner had gross income which exceeded the HCBS/ICP income standard of $1,809 effective April 2006. The petitioner established an income trust on May 23, 2006 and the Irrevocable Medicaid Income Trust account was opened and funded on May 30, 2006.

2. The petitioner was admitted to a nursing home in late March 2007 and an application for Institutional Care Program (ICP) benefits was submitted to the Department on April 3, 2007. The Department completed a determination of eligibility and approved the petitioner for ICP benefits on May 17, 2007 effective April 2007 (Petitioner's Composite Exhibit 1).

3. The trustee of the qualified income trust, in this case, the petitioner's community spouse, must provide quarterly statements identifying the deposits made to the trust for each month. On June 19, 2007 the Department received copies of bank statements for the months of February 2007 through May 2007 indicating that no deposits had been made to the Qualified Medicaid Income Trust Account (Respondent's Composite Exhibit 2).

4. Effective January 2007, the petitioner's income consisted of Social Security of $1,147 and his pension of $827.52. The total income beginning January 2007 was $1,974.52. The ICP income standard was $1,809 effective January 2007 and increased to $1,869 beginning April 2007. The petitioner's total countable income outside the trust exceeded the income standard of $1,809 from February through March 2007 and $1,869 from April through at least May 2007. Therefore, he was not eligible to receive ICP benefits unless he funded the trust each month. On June 28, 2007, the Department terminated ICP benefits effective August 2007 because the petitioner did not deposit sufficient income into the income trust account for the months of February 2007 through May 2007 and because his income exceeded the ICP income standard.

5. The petitioner's representative believes that she was never advised that deposits to the Income Trust had to be made monthly to qualify for Medicaid Institutional Care services or HCBS. In addition, the representative stated that she paid the ALF directly from another account for February and March 2007 rather than through the Income Trust account because the petitioner's income is directly deposited to their checking account and drafts are deducted each month. She acknowledged that she knew there was to be an income trust and that she understood that money was to be deposited to the income trust when there was a bill for services. It was her belief that she would deposit income to the trust when the petitioner was billed for services. She argued that she did not know the amount of patient responsibility to pay to the nursing home because he entered the nursing home in March 2007 under Medicare. The

nursing home could not tell her what was owed and therefore she did not make deposits to the Irrevocable Medicaid Income Trust account. The representative testified that when she was advised of the amount to pay the nursing facility, she transferred funds to the income trust and paid the nursing home from the income trust account (Petitioner's Exhibit 1).

6. A copy of the transaction history for the Income Trust account dated February 16, 2007 showed that deposits were made on November 16, 2006 of $1,800, on December 19, 2006 of $1,600 and January 22, 2007 of $1,818 (Petitioner's Exhibit 1). Bank Statements submitted to the Department dated February 2007 through May 25, 2007 and statements submitted at the hearing dated May 26, 2007 through June 26, 2007 showed no deposits to the Income Trust. The statement dated June 27, 2007 through July 25, 2007 indicated a deposit was made on June 28, 2007 of $325, July 5, 2007 of $1,900 and July 23, 2007 of $700 (Petitioner's Exhibit 1). The petitioner began funding the trust in June 2007 on the same day that the Notice of Case Action was mailed advising the representative that ICP benefits would terminate in August 2007. In addition, the statements indicate the income trust was funded for July 2007.

7. The Department reinstated the ICP coverage group effective August 2007 pending the outcome of the hearing.

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in relevant part:

> (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(14)(a), F.A.C.

The Department's published Transmittal Number I-06-03-0006 on March 10, 2006 which sets forth the ICP income limit, effective April 2006 and states in relevant part:

> Federal Poverty Level Changes ICP/HCBS/Hospice Individual (3 X FBR) INCOME LIMIT $1,809...

The Department's published Transmittal Number I-06-02-0002 on February 26, 2007 which sets forth the ICP income limit, effective April 2007 and states in relevant part:

> Federal Poverty Level Changes ICP/HCBS/Hospice Individual (3 X FBR) INCOME LIMIT $1,869

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

> To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate... If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust...
>
> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.**

> The Economic Self-Sufficiency Specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received. (This may require the individual to begin funding an executed income trust account prior to its official approval by the District Legal Counsel.)
>
> The trustee of the qualified income trust must provide quarterly statements identifying the deposits made to the trust each month...

The Findings of Fact show that the petitioner's gross monthly income exceeded the income limit for ICP Medicaid established for April 2006 and April 2007. The findings show that the petitioner executed an Irrevocable Income Trust, funded it in May 2006 and continued to fund the Income Trust from at least November 2006 through January 2007. The findings also show that the petitioner stopped depositing income into the Income Trust from February 2007 through May 2007. Finally, the Findings of Fact show that the petitioner began funding the income trust in June and July 2007.

The petitioner's representative argued that she was not advised of the need to fund the Income Trust each month and that she stopped funding the trust because she did not know how much the patient responsibility would be. The petitioner's argument is rejected as it is apparent that she had been funding the trust up until February 2007 and had done so on a monthly basis. It is apparent that there was some confusion regarding the amount of patient responsibility because the petitioner entered the nursing facility under Medicare in March 2007. Evidence shows that the Department advised the petitioner of his patient responsibility on May 17, 2007.

According to the above authorities, individuals with income over the limit may qualify for ICP Medicaid by establishing an income trust and depositing sufficient income into the trust to reduce the countable income, outside of the trust, to within the Program income standard. According to the above authorities, the deposit must be made for each month that eligibility is requested and the income is received. The petitioner's position was considered and researched, however, no authorities could be found to allow ICP approval for the vendor payment in a month that the Irrevocable Income Trust Fund was not funded. The hearing officer concludes that the Department's action to terminate ICP Medicaid was correct at the time the action was taken. However, new evidence can be considered through the administrative hearing process.

Florida Administrative Code 65-2.056, Basis of Hearings, states in part:

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

According to the above authorities, the hearing is a de novo process in that new evidence not previously considered by the Department may be accepted and considered in the hearing officer's decision. Evidence was provided by the petitioner showing that the income trust was adequately funded for July and August 2007. Therefore, the undersigned authority concludes that the Department's action to terminate ICP benefits effective August 2007 was premature.

DECISION

The appeal is granted. The Department's action to terminate ICP Medicaid benefits effective August 2007 is reversed.

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 7th day of September, 2007, in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
1 DPOES: Jan Blauvelt
[redacted]

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

[redacted]
PETITIONER,

APPEAL NO. 07F-03923

Vs.
AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
DISTRICT: 12 Volusia
RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 1:45 p.m. on July 31, 2007. The petitioner represented herself and the respondent was represented by DeWeece Ogden, Agency for Health Care Administration (AHCA) program analyst, with telephone testimony presented by George Smith, KePRO review operation supervisor, and Maureen Levy, M.D., KePRO Medical Director.

ISSUE

At issue was whether or not the agency correctly denied authorization for inpatient hospital care for a total abdominal hysterectomy. The petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner is an adult Medicaid recipient who sought inpatient hospital care during June 2007 for a total abdominal hysterectomy. She was born in 1966, is a nurse and has children.

2. She was not seeking a hysterectomy for purpose of sterilization. She was seeking the hysterectomy under recommendation of her doctor due to repeated episodes of severe pain and bleeding. Emergency room treatment occurred three times in recent past.

3. Medical records confirmed bilateral ovarian cysts. Medical records and evidence did not confirm uterine involvement. Petitioner's Exhibit 2 and Respondent's Exhibit 2 section C reflected medical information about the problem. There is no dispute as to polycystic ovaries with pain and bleeding.

4. The white blood count was high on June 4, 2007 and there may have been an infection. Evidence from the attending physician and medical data did not reflect recent antibiotic treatment or medical recommendation for a less extensive treatment than total abdominal hysterectomy.

5. As related to the hysterectomy request, the medical information was submitted to KePRO and reviewed.

6. On June 22, 2007, a KePRO physician consultant, who was board certified in obstetrics and gynecology, denied request for two days hospital care, with a determination "cannot approve for hyst as does not meet criteria for hyst. The cyst is ovarian, and no uterine pathology presented. The pain is probably related to the cyst, and cannot meet AHCA/Medicaid criteria for medical necessity for hysterectomy for just an ovarian cyst." Notice of denial was issued, page 1 of Respondent's Exhibit 1.

7. On June 27, 2007 a reconsideration review occurred by a similarly credentialed physician consultant, and the denial was upheld: "Denied based on the information provided where the surgery required for this patient appears to be a

cystectomy or oophorectomy (removal of ovaries) addressing the medical condition in question." Notice of the additional denial was page 2 of Respondent's Exhibit 1.

8. The petitioner challenged the denial(s) as shown in Petitioner's Exhibit 1.

9. AHCA denial was predicated on InterQual Care Planning Criteria submitted in Respondent's Exhibit 2, section F. This review process was conducted under standard operating procedure of AHCA. These criteria identified circumstances corroborating approval of total abdominal hysterectomy. Ovarian cysts were not shown as justification for hysterectomy.

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 Administrative Code 59G-1.010(166) defines medical necessity as:

> (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.

Florida Statute 409.905, **Mandatory Medicaid services,** states in part:

(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. ...
(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 nonemergency hospital inpatient admissions for individuals 21 years of age and older. ...The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of cost and potential for unnecessary hospitalizations represented by certain diagnoses. ...

Additional statute 409.913 addresses **Oversight of the integrity of the Medicaid program** and subsection (1) informs as follows:

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

The June 2005 AHCA Hospital Services Coverage and Limitations Handbook, in keeping with statute and regulations, addresses **Hysterectomies** at page 2-9. It informs as follows: "Some hysterectomy procedures must meet specific requirements

before payment can be made." Thus, while surgery may be recommended by an attending physician, surgery is not automatically approved under AHCA procedures. The InterQual Care Planning Criteria was the system used by AHCA for review and it was appropriately utilized.

After careful review, and based upon evidence submitted along with guidelines cited herein, it cannot be concluded that a total abdominal hysterectomy would be the medically necessary treatment for the situation documented at the time of review. Thus, it is concluded Medicaid denial of inpatient payment for authorization of a total abdominal hysterectomy was justified.

DECISION

The appeal is denied and the agency action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the 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 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 18th day of September, 2007, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Lisa Broward, Area 4 Medicaid Adm.

FILED

SEP 26 2007

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

[redacted]

APPEAL NO. 07F-3344

PETITIONER,

Vs.

CASE NO. 1151821497

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 11, 2007, at 1:48 p.m., in [redacted] Florida. The petitioner, [redacted] was not present however present on his behalf was his mother, [redacted] The respondent was represented telephonically by [redacted] from the Florida Department of Health, Brain and Spinal Cord Injury Program (BSCIP) administrator. Present was [redacted] case manager from the Department of Health served as translator. The hearing was previously scheduled for July 24, 2007 and August 14, 2007, but was rescheduled at the request of both parties.

ISSUE

The petitioner is appealing the respondent's action of May 22, 2007, to place him on the Brain and Spinal Cord Injury Waiver waiting list. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner (age 26) is a Medicaid recipient residing in [redacted] County along with his mother. He has been on the BSCI Waiver waiting list since February 2004. The petitioner requires assistance or total help with activities of daily living, due to his spinal cord injury and other medical conditions.

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

According to an April 2006 promulgated rule, everyone on the Brain and Spinal Cord Injury Program Medicaid Waiver waiting list had to be screened, using a screening tool. This process was initiated in December 2006 and continues. Persons would be screened, receive a score according to their situation and placed on the waiting list according to the screening score received. The highest obtainable score is 170.

On May 16, 2007, a Prioritization Screening Instrument was completed on the petitioner. The instrument requested information from the petitioner such as, his medical condition; living situation; assistance required with activities of daily living (ADL) and instrumental ADL; nutrition; information on caregiver; and other support mechanisms. The score obtained from the instrument totaled 63 according to the information obtained. The BSCIP did not have any openings (slots) at the time and the petitioner was placed on the waiting list.

On May 22, 2007, the petitioner was issued a Notice of Decision informing him, that he has been placed on the BISCI Waiver waiting list and that he obtained a prioritization score of 63. The petitioner requested the hearing on June 1, 2007.

CONCLUSIONS OF LAW

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

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

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

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

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

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

The respondent stated that in part, the petitioner's score was not high because the family was receiving daily services at the time of the assessment (May 2007). That impacted the prioritization score he received and must place him according to that score he received. The respondent stated that they can re-evaluate his situation and will from time to time. The respondent was unable to inform the petitioner with his exact placement on the waiting list.

The petitioner's representative states that her son is bedridden and has lost the daily services in July 2007 and his condition has worsened.

The respondent agreed to re-evaluate the petitioner and conduct another screening, using the current information. The respondent agreed to initiate the process within seven days and inform the petitioner of his new score. The petitioner's representative agreed to have her son's situation re-evaluated by the respondent.

As the Findings of Fact shows, the petitioner had been on the waiting list and was re-evaluated in May 2007, scoring 63 out of a possible 170. Testimony received from the Program's administrator was that the petitioner was placed on the waiting list, as there were no openings at the time due to funds.

According to the screening instrument and the petitioner's representative there had been daily services being received by the petitioner, which are no longer available to him. Therefore, the respondent will re-evaluate the petitioner's current situation completing a new prioritization screening instrument and inform the petitioner of their decision.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th day of September, 2007,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted], Petitioner
Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Kristen Russell, Administrator, HCBS
Florida Department of Health

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 02 Jefferson
UNIT: 88511

RESPONDENT.
_____/

APPEAL NO. 07F-02831

CASE NO. 1250657024

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 28, 2007, at 9:30 a.m., in Tallahassee, Florida. The petitioner was not present but was represented by Jana McConnaughhay, Esq., of McConnaughhay, Duffey, Coonrod, Pope & Weaver. The Department was represented by Ace Pedrosa, managing attorney, District 2. Testifying on behalf of the Department was Robyn Gordon, economic self-sufficiency specialist supervisor.

The hearing was reconvened on August 17, 2007 at 10:30 a.m., in Tallahassee, Florida. Appearing and testifying on behalf of the petitioner was her son [redacted], her daughter-in-law, [redacted], and [redacted], LPN, Director of Wellness, [redacted]. The Department was represented by Michael Lee, attorney, District 2. Tommie Hudson, economic self-sufficiency specialist supervisor, appeared as a witness.

The record was held open an additional seven days or until August 24, 2007 to allow the petitioner to submit additional evidence which was received and entered as Petitioner's Exhibit 8.

ISSUE

The petitioner is seeking an increase in the community spouse diversion amount under the Medicaid Institutional Care Program (ICP) from the Department's approval action of May 4, 2007. The petitioner bears the burden of proof.

FINDINGS OF FACT

Prior to the action under appeal, the petitioner (institutional spouse) and his wife (community spouse) who is age 85, resided in an assisted living facility. The petitioner and his wife entered a Florida nursing facility as private pay patients on February 8, 2006. The petitioner remains at the nursing home. His wife was discharged to an Assisted Living Facility (ALF) on August 24, 2006 after receiving physical therapy and because her medical condition had improved.

The community spouse is blind in the right eye since birth and has a corneal transplant in the left eye making it difficult for her to see. She has corrected vision in her right eye of 20/400 and her best corrected vision in the left eye was the ability to count fingers at one foot distance. Her ophthalmologist, [redacted] indicates she is considered legally blind (Petitioner's Exhibit 8). The community spouse has had small transient ischemic attacks resulting in frequent falls and the tendency to drag her right foot at times. In addition, she is diagnosed with depression, osteoporosis, dementia,

hypertension, hyperlipidemia, and hypothyroidism. Her physician indicated that her needs could be met in an ALF. The community spouse needs help taking her medications because she is unable to see the labels and because she is forgetful. Her medications are Actone, aspirin, docusate sodium, paxil, plavix, senna tablets, aricept, zocar, calcium 600 mg, tramadol HCL, and synthroid 100 mcg.

At the time the community spouse was admitted to the ALF in August 2006, she was able to independently ambulate, dress herself, complete her personal hygiene and eat independently. She currently needs assistance with bathing, grooming and with dispensing and taking her medication. In addition, the community spouse is becoming more forgetful and needs reminders to come down to meals. She is also using a walker to assist with ambulation due to the tendency to drag her right foot.

An ICP application was filed on January 31, 2007 for the retroactive month of December 2006 and ongoing months from January 2007. The Department approved the request and the patient responsibility assigned for December 2006 was $916.75 and the community spouse allowance was $1,511. Beginning January 2007, the patient responsibility assigned was $972.79 and the community spouse allowance was $1,509.

The Department determines the community spouse allowance by a budgeting procedure that considers the community spouse's shelter costs and income. At the time of the application, the community spouse resided in an ALF. Her monthly shelter obligation including room and board was $2,795. The monthly shelter obligation including room and board increased to $2,935 effective September 1, 2007 (Petitioner's

Exhibit 8). The ALF was unable to provide a breakdown of the room and board expenses or separate the monthly cost of food from the monthly cost for room and board (rent). In its calculation, the Department relied on an internal clearance dated August 18, 2003 clarifying policy regarding the shelter allowance for community spouses living in an ALF. The clearance indicated that if a facility is unwilling or unable to identify the portion of the room and board attributable to the rent only, no credit could be given toward a shelter expense. Because the Department could not determine how much of the room and board represented the cost of rent, none of the community spouse's cost for shelter was used.

The standard Minimum Monthly Maintenance Income Allowance used to determine all ICP community spouse income allowances was $1650 at the time of this action. In this case, the community spouse's gross income of $139 for December 2006 and $141 beginning January 2007 was subtracted from $1650 to determine the community spouse income allowance (Respondent's Exhibit 5). Petitioner's Exhibit 3 shows the community spouse's income for January 2007 at $140.50.

To determine the patient responsibility, the Department subtracted a personal need allowance amount of $35 from the institutional spouse's gross monthly income, which was $2,462.75 for December 2006 and $2,516.79 effective January 2007. For December 2006, the institutional spouse's income consisted of a pension from the City of St. Petersburg of $2,101.75 and Social Security of $361. Effective January 2007, his income consisted of a pension of $2,143.79 and Social Security of $373. The

Department acknowledged that it did not subtract the cost of health insurance when calculating the patient responsibility for the institutional spouse because verification was not provided. The community spouse allowance was then subtracted, leaving the patient responsibility amount of $916.75 for December 2006 and $972.79 beginning January 2007.

The community spouse is concerned that she will be unable to meet her expenses in the community if the Department does not allow any of the cost of the ALF toward the shelter in its computation of excess shelter cost. Because the Department did not use any of the cost of room and board toward the community spouse's shelter cost, her total income is not enough to cover her cost of care.

The community spouse is responsible for paying an additional $300 for the cost of personal care indicated as support Level of Care (Tier 1), a Medicare premium of $70.50 and third party medical insurance from Cigna of $99.35. The support Level of Care includes assistance with medications, bathing and personal grooming. The above expenses are in addition to the basic monthly rental expense of $2795. (Petitioner's Exhibit 4) The petitioner submitted information from the Benefits Division of the City of [redacted] that states, "The petitioner and his spouse are enrolled in the City of [redacted] retiree group insurance program. Eligible dependents may be enrolled only in insurance plans in which the retiree is enrolled. The City of [redacted] group insurance plan contracts are effective April 1 through March 31 of each year, therefore insurance premiums are subject to change annually. Upon the death of [redacted]

his spouse will be allowed to continue the group health insurance plan up to 12 months at the retiree's rate at that time. After 12 months, [redacted] will be offered a continuation of group health insurance through COBRA up to an additional 24 months." The medical insurance covers the couple and the monthly premium is withheld from the institutional spouse's retirement pension. The above expenses are in addition to the basic monthly rental expense of $2795 (Petitioner's Exhibit 4).

The community spouse pays a monthly rent or basic services to the ALF. Basic services are dependent upon the room accommodations provided to the resident and include room accommodations, weekly laundry services for linens and towels and one load of personal laundry, weekly housekeeping, scheduling of transportation and appointments, observation of the resident's physical and mental condition, basic utilities with the exception of personal telephone service or long distance telephone service. The basic services vary in cost from $1650 for semi-private accommodations to $4995 for a two-room suite. The community spouse is living in the Madison I studio apartment costing $2795 per month. Fees are subject to be amended periodically by the ALF after a 30 day advance written notice. This accommodation was the only vacancy available at the ALF at the time of admission. She is currently on a wait list for less expensive accommodations.

The community spouse is concerned that her resources will be rapidly depleted in order to pay for her living expenses in the community The representative presented a list of the monthly expenses including $3235 for assisted living consisting of $2935

basic rent (recently increased effective September 2007) and $300 Tier 1 level of care, $32.45 telephone, co-payments for prescription drugs of $221.90, $100 daily living expenses (outings to mall and for meals), $33.50 clothing and personal expenses, and $70.50 Medicare premium (Petitioner's Exhibit 6).

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.7141 states in part:

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the **individual's patient responsibility (emphasis added)**. This process is called 'post eligibility treatment of income'.
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance...
> (d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses...
> (g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.
> 1. The medical/remedial care service or item must meet all the following criteria:
> a. Be recognized under state law;
> b. Be medically necessary;
> c. Not be a Medicaid compensable expense; and
> d. Not be covered by the facility or provider per diem.
> 2. For services or items not covered by the Medicaid State Plan, the amount of the deduction will be the actual amount for services or items incurred not to exceed the highest of a payment or fee recognized by

Medicare, commercial payers, or any other contractually liable third party payer for the same or similar service or item.
3. Expenses for services or items received prior to the first month of Medicaid eligibility can only be used in the initial projection of medical expenses if the service or item was provided during the three month period prior to the month of application and it is anticipated that the expense for the service or item will recur in the initial projection period.
4. For the initial projection period, the department will allow a deduction for the anticipated amount of uncovered medical expenses incurred during the three month period prior to the date of application, and that are recurring (reasonably anticipated to occur) expenses in the initial projection period.
5. Actual incurred and recognized expenses will be deducted in each of the three months prior to the Medicaid application month when an applicant requests three months prior Medicaid coverage and is eligible in the prior month(s).
6. The initial projection period is the first day of the first month of Medicaid eligibility beginning no earlier than the application month through the last day of the sixth month following the month of approval. A semi-annual review is scheduled for the fifth month after the month approved to evaluate the recipient's actual incurred medical expenses for the prior six months.

Fla. Admin. Code 65A-1712, **SSI-Related Medicaid Resource Eligibility Criteria,** states in part:

(4) Spousal impoverishment. The department follows 42 U.S.C §1396r-5 resource allocation and income attribution and protection when an institutionalized individual including a hospice recipient residing in a nursing facility, has a community spouse...(f) Either spouse may appeal the amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist.

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

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...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 incurrment 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...

The Department's Integrated Policy Manual, 165-22, section 2640.0122, Minimum Monthly Maintenance Income Allowance (MSSI), explains in part:

The following policy applies to ICP...
This income allowance is the basic monthly allowance the state recognizes for a community spouse whose spouse was institutionalized on or after 9/30/89. The state's minimum monthly maintenance income allowance (MMMIA), is based on 150% of the poverty level for two individuals.

The Department's published transmittal I-07-06-0009 dated June 8, 2007 provides the spousal impoverishment standards effective July 1 used to compute income allowance for community spouses of institutionalized individuals under the Institutional Care Program. It states in relevant part:

Spousal Impoverishment Income Standards

Minimum Monthly Maintenance Needs Allowance (MMMIA):

July 1, 2006	July 1, 2007
$1,650	$ 1,712

Excess Shelter Standard:

July 1, 2006	July 1, 2007
$ 495	$ 514

The maximum monthly community spouse income allowance (MMMIA plus excess shelter costs) remains $2,541. This cap (maximum) standard changes annually in January.

The Department's Integrated Policy Manual, 165-22, section 1840.0904 instructs that the cents are dropped from Social Security income for SSI-Related Programs, which would include the ICP Program.

The Department's published transmittal P-04-06-0007 dated June 8, 2004, Uncovered Medical Expense Deductions, states in part:

> Certain incurred medical expenses not covered by Medicaid or another third party are deductible from an individual's income when calculating patient responsibility. The expenses are deducted only after allowing for the individual's own personal needs (including deduction for therapeutic wages) and the maintenance needs of the individual's spouse, family, or dependent, if applicable.

The petitioner's position is that the community spouse income allowance is not enough to cover the expenses she is responsible for. Her rent, including room and board is more than her income, including the community spouse income allowance. She has room and board expenses, an additional expense for personal care and other

personal expenditures.

The Department's budgeting methodology, as outlined in the Findings of Fact, correctly reflects the budgeting methodology set forth in the above authorities in calculating the community spouse allowance. However, Florida Administrative Code permits possible adjustment to this methodology and the resulting community spouse allowance, if proof is presented of exceptional circumstances that result in financial duress.

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

The Findings of Fact reflect that the basic rent at the ALF where the community spouse resides is $1650. In addition, the Findings of Fact reflect an additional expense for personal care, Tier 1 level of care of $300, a Medicare premium of $70.50 and a premium for third party medical insurance. The community spouse income was $139 for December 2006 and $140 beginning January 2007. The Findings show that the institutionalized spouse had income of $2,462.75 (December 2006) and $2,516.79 beginning January 2007.

According to the above authorities, 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. Guidance in the State Medicaid Manual explains that circumstances other than those taken into account in establishing maintenance standards for spouses are reasonable in defining an exceptional circumstance. The undersigned authority has determined that there is an exceptional circumstance based on the blindness and medical condition of the community spouse that results in significant financial duress. An incurred expense by community spouses for medical, remedial and other support services which contributes 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 may be considered. Therefore, the undersigned authority concludes that the personal care, cost of supervision of $300 per month is to be considered as a medical or remedial support service not already recognized for the community spouse's maintenance needs. In addition, the cost of Medicare currently $70.50 and cost of third party medical coverage for the community spouse, currently $99.35, is to be considered.

The hearing officer concludes that the community spouse could not live alone in the community and therefore, the basic room and board of at least $1650 is related to the community spouse's exceptional circumstances and is also to be considered as the

shelter cost for the community spouse, as the facility cannot determine which portion is for rent only.

To determine the amount of the community spouse income allowance the hearing officer subtracted 30% of the MMMIA or $495 from the basic $1650 shelter cost to arrive at excess shelter of $1155. The MMMIA of $1650 was added to the excess shelter of $1155 to total $2805. After subtracting the community spouse gross income of $139 the result is $2666 and after subtracting the 2007 income of $140, the result is $2665. Therefore, the community spouse income allowance could be up to the maximum of $2541. The institutional spouse's gross income for 2007 is $2462.75 minus the $35 personal need allowance results in $2427.75, therefore, the undersigned authority has determined the community spouse income allowance is the institutional spouse's remaining income, causing the patient responsibility to be $0. The same calculation was completed beginning July 2007 with the higher spousal impoverishment income standards cited above. The result is the same in that the community spouse income allowance would be the remaining income of the institutional spouse's income after the $35 personal need allowance, not to exceed the maximum monthly community spouse income allowance of $2541, also cited above.

The medical allowances referenced above for the community spouse are not needed in this calculation since her excess shelter cost alone causes her to retain all of the institutional spouse's income, after the $35 personal need allowance is deducted. According to the above authorities, the institutionalized individual's insurance premium

is considered only after determining the community spouse's maintenance need allowance. Therefore no additional allowance for his insurance premium is allowed, as all of his income, with the exception of the $35 personal need allowance, is to be diverted to his community spouse.

DECISION

The appeal is granted. The Department is to adjust the patient responsibility to zero and the community spouse income allowance to the remainder of the institutional spouse's income, not to exceed the maximum community spouse income allowance, beginning with the January 2007 application, retroactive to December 2006.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 4th day of September, 2007,

in Tallahassee, Florida.

Linda Garton

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

Copies Furnished To [redacted] Petitioner
2 DPOES: Denise Parker
Nolene Roberts
Jana McConnaughhay, Esq.
Michael Lee, Esq.

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

[redacted]

APPEAL NO. 07F-03789

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 August 22, 2007, at 8:18 a.m., in St. Petersburg, Florida. The petitioner was not present. He was represented by his grandmother, [redacted]. Witness for the petitioner was the petitioner's father, [redacted]. The respondent was represented by [redacted] registered nurse specialist.

ISSUE

The petitioner is appealing the notice of June 22, 2007 for the Agency's action to reduce private duty nursing hours from 24 hours a day to 13 hours a day and replace with up to 11 hours of Prescribed Pediatric Extended Care (PPEC) as ordered by the treating physician. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner's step-mother was sent a notice on June 22, 2007 informing her that the petitioner's private duty nursing would be reduced from 24 hours a day to 13 hours a day and replace with up to 11 hours of PPEC as ordered by the treating physician.

1. The petitioner care is medically complex. He was receiving private duty nursing 24 hours a day. The petitioner's services are reevaluated every 60 days. The petitioner's services were reevaluated for the 60 day period beginning July 2, 2007.

2. On June 12, 2007, the petitioner treating physician ordered a PPEC evaluation. On June 19, 2007, the treating physician notified the respondent by Physician Orders that the evaluation had been completed. The treating physician ordered that the petitioner met medical eligibility and admission criteria for PPEC. He indicated the admission process with PPEC as per his order should be continued.

3. The respondent's primary goal is to provide services for medically necessary long term care services for medically complex children. The treating physician determined that the petitioner was medically eligible for admission to PPEC. Based on this written order from the treating physician, the respondent notified the petitioner's grandmother that the petitioner's private duty nursing would be reduced from 24 hours a day to 13 hours a day and replace with up to 11 hours of PPEC.

4. The petitioner's grandmother and father do not agree with placement in PPEC. There were no physician's orders that rescinded the order by the treating physician that the petitioner was medically eligible for admission to PPEC.

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.

Recommendation for PPEC is set forth in the Home Health Services Coverage and Limitations Handbook on page 2-15:

> A recipient who is medically able to attend a PPEC and whose needs can be met by the PPEC, should have PPEC services recommended...
> The Medicaid physician consultant's signed recommendation will suffice as an order for reimbursement purposes in the event that attending physician refuses a PPEC service without medical justification...

Recommendation for PPEC services is set forth in the Prescribed Pediatric Extended Services Coverage and Limitations Handbook on page 2-3:

> An attending physician must order PPEC services before the services begin. The order must be written on letterhead or printed prescription...

Neither rule of handbook gives authority to the respondent to disapprove PPEC service when PPEC is ordered by the treating physician. As set forth in the handbook, the Medicaid physician consultant's signed recommendation will suffice as an order for reimbursement purposes in the event that attending physician refuses a PPEC service without medical justification. The treating physician did not refuse PPEC and did order that the petitioner was medically eligible and the petitioner met the admission criteria for PPEC. The recommendation for the reduction of private duty nursing hours from 24 hours a day to 13 hours a day and replace with up to 11 hours of Prescribed Pediatric

Extended Care (PPEC) for the 60 day period beginning July 2, 2007 meets the definition of medical necessity. The respondent's action to reduce private duty nursing hours from 24 hours a day to 13 hours a day and replace with up to 11 hours of Prescribed Pediatric Extended Care (PPEC) as ordered by the treating physician is consistent with rule and the handbook.

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 7th day of September, 2007,

in Tallahassee, Florida.

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

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

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

[redacted]

APPEAL NO. 07F-04679

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 7, 2007, at 10:47 a.m., at the West Dade Service Center, in Miami, Florida. The petitioner was present and represented himself at the hearing. Present on behalf of the petitioner was his wife, [redacted] Rey, internist, was present as a witness. The Agency was represented by Oscar Quintero, senior specialist, Agency For Health Care Administration (AHCA). Present as witnesses for the Agency, by speakerphone, were [redacted] medical director at KēPRO South, [redacted] education specialist with KēPRO, George Smith, review operations supervisor with KēPRO and Diane Weller, registered nursing consultant for the KēPRO contract, AHCA.

ISSUE

At issue is the Agency's action of July 11, 2007, to deny the petitioner's request for inpatient services for a lumbar laminotomy/laminectomy/fusion procedure. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who is currently about 37 years of age, has been diagnosed with Lumbar Spondylosis. The petitioner's present signs and symptoms/treatment plan are outlined in Respondent Composite Exhibit 1.

2. On July 10, 2007, the petitioner's physician requested prior authorization for a pending lumbar laminotomy/laminectomy/fusion procedure on July 13, 2007, with subsequent hospitalization through July 14, 2007.

3. Keystone Peer Review Organization (KēPRO South) is the Peer Review Organization (PRO) contracted by the AHCA to perform medical review for the Medicaid Prior Authorization for Inpatient Hospital Medical Services Program for Medicaid beneficiaries of the Florida Medicaid Program. KēPRO performs a prior authorization to determine medical necessity as defined in Fla. Admin. Code 59G-1.010(166).

4. The Prior Authorization Process was completed for the petitioner by KēPRO. KēPRO determined on July 11, 2007, that the clinical information received from the petitioner's physician office did not meet medical necessity for acute inpatient care. KēPRO needed more pre-operative data.

5. On July 20, 2007, KēPRO notified the petitioner that the authorization request for impatient services has been denied.

6. At the hearing, Dr. Rey, petitioner's treating physician, explained why in his professional opinion the petitioner needed corrective surgery in his lumbar area. Dr. Rey noted that he has been treating the petitioner with potent narcotic medication for his severe low back pain. Dr. Rey concluded that without surgery the petitioner's condition will continue to deteriorate neurologically.

7. The petitioner submitted additional medical records to support his need for surgery. Included in the evidence was a CT of lumbar spine and CT myelogram of spine results. (Petitioner Composite Exhibit 2)

8. After listening to testimony from the petitioner's attending physician and information provided by the petitioner at the hearing, KePRO stipulated that the medical care as described to them appears to require inpatient services and that the denial has been overturned.

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. Stat. ch. 409.905, Mandatory Medicaid services, states in relevant part:

(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.

The Agency determined the petitioner is eligible for inpatient services for a lumbar laminotomy/laminectomy/fusion procedure.

DECISION

This appeal is granted as the inpatient denial has been reversed.

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 28th day of September, 2007,

in Tallahassee, Florida.

Alfredo Fernandez

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

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

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

[redacted]

APPEAL NO. 07F-03846

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 15, 2007, at 10:05 a.m., in Fort Lauderdale, Florida. The hearing was rescheduled from July 17, 2007, at the respondent's request. The petitioner was present with his mother [redacted] and his father [redacted] Also present was his nurse [redacted] The Agency was represented by Loraine Wasserman, registered nurse specialist. Present on the telephone from Kepro was Dr. Ratesh Mical, and George Smith, review operations supervisor.

ISSUE

At issue is the Agency's June 19, 2007 action of reducing the petitioner's skilled home nursing services from 21 hours daily to 14 hours daily. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner, date of birth [redacted] is 15 years old. He has been receiving skilled home nursing services of 21 hours daily for 7 days per week. A hearing was held on November 17, 2005, (appeal number 05F-5218) concerning the respondent's action to cancel the petitioner's skilled home nursing services. The decision of the appeal was in the petitioner's favor.

Included in the evidence is a copy of a Recipient Denial Letter, dated June 7, 2007, stating that 488 hours of skilled home nursing services were denied, and 480 hours were approved for him for May 15, 2007 to July 13, 2007. Included in the evidence is a copy of a Recipient Reconsideration Denial Overturned notice, dated June 19, 2007. This notice informs the petitioner that upon reconsideration the total hours approved for him was 840, which is 14 hours daily 7 days per week from May 15, 2007 to July 13, 2007.

The notice explains that it was determined by Kepro that the medical care of the skilled home nursing services of 840 hours was determined to be medically necessary. Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner, dated May 15, 2007, stating that he was diagnosed with disorders of mitochondrial metabolism and other convulsions.

Included in the evidence is a copy of a Kepro Synopsis of Case report, concerning the reconsideration, dated June 19, 2007. It supports 14 hours of the daily services Monday through Friday, but there is no supporting clinical or social information to support 22 hours per day on Saturday and Sunday. On June 28, 2007, there was a clarification of this determination. It states that the services should cover 14 hours daily 5:00 p.m. to

7:00 a.m. Monday through Friday, and deny 8 hours daily Saturday and Sunday, and approve service coverage from 5:00 p.m. to 7:00 a.m. Saturday and Sunday.

Included in the evidence from the petitioner is a copy of a medical neurology evaluation, dated December 16, 2006, from [redacted] from the Children's Hospital of Pittsburgh, Division of Child Neurology. He was positive for failure to thrive, he had G-tube feeds, and he was positive for dystonia and myoclonus. Included in the evidence from the petitioner is a copy of a statement, dated July 10, 2007, from Dr. [redacted], from the [redacted] According to the doctor, the petitioner is, "in clear need of proper nurse supervision".

According to information provided at the hearing, the petitioner attends school during the day, and in the summer he attended a special program. His mother does not work, and his father works as a teacher. Included in the evidence is a copy of a statement, dated July 12, 2007, from [redacted] stating that the petitioner should receive nursing care 24 hours daily 7 days per week. According to Dr. Ratesh Mical at the hearing, from the information that he has at the time of the hearing, he agrees that 840 hours, which is 14 hours daily of skilled home nursing services from May 15, 2007 to July 13, 2007, is medically necessary for the petitioner.

CONCLUSIONS OF LAW

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

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

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

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. The petitioner is receiving skilled home nursing services of 21 hours daily for 7 days per week, and it was determined these services would be reduced to 14 hours daily 7 days per week, which is 840 hours from May 15, 2007 to July 13, 2007.

The Agency's determination takes into account what is medically necessary for the petitioner, and his parent's availability to help care for him. The physician that testified at the hearing agrees that the petitioner needs skilled home nursing care, and the determination of reducing the skilled home nursing services from 21 hours daily to 14 hours daily. According to information from the petitioner, a doctor requested 24 hours daily nursing care for him. After careful consideration of the proper authorities and evidence, including the petitioner's diagnosis and condition, and his gastrostomy tube feedings, it is determined that the Agency's action to reduce the skilled home nursing services, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of September, 2007,

in Tallahassee, Florida.

Stuart Imberman II

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

Copies Furnished To: [redacted] Petitioner
Gail Wilk, Area 10 Medicaid Adm.
Karen Kinser, Nursing Consultant
Mary Wheeler

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

[redacted]

APPEAL NO. 07F-04374

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in [redacted] Florida, at 2:00 p.m. on September 5, 2007. The petitioner represented herself with assistance of her husband, [redacted] The respondent was represented by [redacted], AHCA program analyst, with telephone testimony from [redacted], KePRO review operation supervisor under contract with AHCA; [redacted], KePRO review operation manager; [redacted], M.D. and medical director of KePRO; and [redacted] contract manager with AHCA.

ISSUE

At issue was whether or not the agency correctly denied authorization for inpatient hospital care for a total abdominal hysterectomy. The petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner is age 46, has children and has had serious gynecological problems since at least May 2007. Medicaid eligibility is undisputed and prior authorization for inpatient surgical care was requested through her doctor. The request was denied by the respondent on July 20, 2007 (Respondent's Exhibit 1) and was promptly challenged by the petitioner (Petitioner's Exhibit 1).

2. To treat her health problems during summer 2007, her doctor recommended total abdominal hysterectomy including bilateral salpingo oophorectomy, planned for a three day inpatient hospital stay. The request was denied following initial KePRO review.

3. There was no indication the hysterectomy was sought for purpose of sterilization. The petitioner suffered chronic pelvic pain, menorrhagia, rectocele and passed large clots. Health problems are undisputed.

4. The doctor's office submitted information to KePRO as reflected in Respondent's Exhibit 2, section C. Such information did not include endometrial sampling results, pregnancy was not ruled out, and method to accomplish rectocele correction via abdominal entry was not evident, nor did the information establish how the severe rectocele would be remedied.

5. The medical information submitted by the attending doctor's office was reviewed by a KePRO physician consultant (board certified in gynecology) during July 2007. The July 19, 2007 KePRO physician consultant rationale, shown in section C of Respondent's Exhibit 2, informed:

> Cannot approve. Close to meeting criteria, but at 46 with abnormal bleeding need endometrial sampling results. Also a 3rd degree rectocele noted yet no procedure listed to treat, and the route of the hyst (hysterectomy) is abdominal. Need endometrial sampling and clarification. All days denied...

6. KePRO staff also requested additional medical information from the attending doctor's office on July 27, 2007 but the requested clarification was not received by KePRO. The inpatient request remained unauthorized following the initial KePRO review. Without additional information from the medical office, further reconsideration by KePRO did not occur.

7. KePRO review included use of InterQual Care Planning Criteria as submitted in Respondent's Exhibit 2, section F. These criteria identified circumstances that would justify approval of total abdominal hysterectomy. Rectocele repair was not shown as justification for abdominal hysterectomy. Standard operating procedure of AHCA was followed.

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 Administrative Code 59G-1.010(166) defines medical necessity as:

> (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.

Florida Statute 409.905, **Mandatory Medicaid services,** states in part:

(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. ...
(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 nonemergency hospital inpatient admissions for individuals 21 years of age and older. ...The agency may limit prior authorization for hospital inpatient services to selected diagnosis-related groups, based on an analysis of cost and potential for unnecessary hospitalizations represented by certain diagnoses. ...

Additional statute 409.913 addresses **Oversight of the integrity of the Medicaid program** and subsection (1) informs as follows:

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of

> medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

The June 2005 AHCA Hospital Services Coverage and Limitations Handbook, in keeping with statute and regulations, addresses **Hysterectomies** at page 2-9. It informs as follows: "Some hysterectomy procedures must meet specific requirements before payment can be made." Thus, while surgery may be recommended by an attending physician, surgery is not automatically approved under AHCA procedures. The InterQual Care Planning Criteria was the system used by AHCA for review and it was appropriate.

After careful review, and based upon evidence submitted along with guidelines cited herein, it cannot be concluded that a total abdominal hysterectomy would be the medically necessary treatment for the situation(s) and supporting materials set forth by the physician's office at the time of July 2007 review. Thus, it is concluded Medicaid denial of inpatient hospital care authorization for total abdominal hysterectomy was justified. It is possible that additional medical information, if submitted, could create a different review result and the parties may continue their efforts toward resolving the problem. If an additional denial were to be issued, it would also be appealable within customary agency practices.

DECISION

The appeal is denied and the agency action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th day of September, 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
Lisa Broward, Area 4 Medicaid Adm.