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

APPEAL NO. 08N-00136

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 3, 2008 at 11:05 a.m., at the respondent nursing facility. The respondent was represented by the facility administrator, and the facility risk manager, . The petitioner was represented by her daughter, . The petitioner was present to testify. Present as witnesses for the petitioner were , fiancé of the petitioner's daughter, facility social services director, , facility physical therapy assistants, and . The facility treating physician Dr. appeared telephonically as a witness for the petitioner.

The record was held open until September 10, 2008 for both parties to submit additional evidence. The facility submitted evidence which has been entered as Respondent's Exhibit 5.

ISSUE

At issue is whether the petitioner can be discharged from the respondent facility because the petitioner's health has improved sufficiently so that facility services are no longer needed. The respondent has the burden of proof at a clear and convincing level.

FINDINGS OF FACT

1. The petitioner has been residing at the facility since June 23, 2008. The petitioner's date of birth is December 4, 1935, the petitioner is age 72.
2. The petitioner has been diagnosed with diabetes, angina, hypertension, obesity, depression and left mastectomy. In addition, the petitioner's right leg has been amputated below the knee.
3. On July 15, 2008, the petitioner was given written notice that she was being discharged effective August 14, 2008 because her health had improved so that she no longer needed facility services. The undersigned hearing officer received a request for hearing form from the petitioner's authorized representative (and daughter, on July 28, 2008. A copy of the discharge notice was included with the written hearing request form. The discharge notice was not signed by a physician or designee nor was the notice accompanied by a discharge order from a physician or physician's assistant. August 6, 2008, the undersigned hearing officer spoke with the facility administrator who stated the required paperwork would be faxed to the Office of Appeals hearing the following day. On August 7, 2008, the

undersigned hearing officer received a Physical Therapy Evaluation form for the petitioner dated June 24, 2008. The form detailed a skilled physical therapy plan for the petitioner for the period June 24, 2008 through July 24, 2008. The evaluation form contained space for the proposed discharge location which read, "to home of daughter." The form contained a physician's signature (illegible to the undersigned hearing officer). Included with the evaluation form was a note from the facility administrator which states in part "See attached Physical Therapy Evaluation which was signed by the physician which reflects the accepted discharge plan to home with the daughter...we would contend that the physician has agreed to the discharge by acknowledgement of the plan for discharge to home."

4. During the hearing, the facility asserted its belief that the petitioner should be discharged because she no longer needs the facility's services. The petitioner's daughter disputed the facility's assertions and requested that the facility's treating physician, Dr. appear telephonically as a witness. Dr. believes that the petitioner needs 24 hour a day skilled care. He does not agree with discharging the petitioner to the daughter's home unless someone can be there 24 hours a day to take care of the petitioner's needs. When questioned about the Physical Therapy Evaluation form, the facility's risk manager asserted that Dr. signed the form. The doctor

had no recollection of signing the form and reiterated that in his professional opinion the petitioner needs 24 hour a day skilled care.

5. The facility stipulated that the discharge notice did not contain the required physician signature nor is there a separate discharge order for the petitioner. However, the respondent maintains the belief that the petitioner no longer needs skilled nursing care and asserts that Dr. previously gave verbal authorization for discharge. The facility believes the petitioner is no longer in need of facility services in part because she can transfer from her bed to her wheelchair, to a bedside toilet and back again without help. The petitioner's daughter and the daughter's fiancé disputed this assertion and requested facility physical therapy assistants and appear as witnesses. believes that the petitioner has made some progress during her stay at the facility, she can dress herself if the clothes are brought to her, she can intermittently, with help of a sideboard, transport herself from the bed to her wheelchair and back, however, the petitioner is very fearful of independent transferring from one location to another, independent standing, independent showering and independent toileting and has yet to consistently master these activities on a daily basis. She requires at least two people be in the room with her while she attempts these activities.

6. The petitioner's daughter also believes that the petitioner's weight (327 lbs) necessitates facility care, that at least two people are needed to assist moving the petitioner. The petitioner's daughter asserted this type of care on a 24 hour a day basis is not possible in her home. She is afraid the petitioner would be unable to get out of her home in an emergency situation like a fire or may fall while attempting activities of daily living. The facility believes the possibility of falling while attempting activities of daily living is true for everyone as is the possibility of not being able to exit a burning building. The petitioner believes she could go down the steps at her daughter's home in her wheelchair without assistance, but could not go up the stairs and she would need assistance leaving the home in an emergency situation which required a rapid exist. The petitioner's main concern is not being a burden to her daughter. The petitioner believes her daughter's small stature would make it impossible for her daughter to move her. The petitioner has a strong fear of falling due to her size and amputated leg. The petitioner believes it is necessary for someone to be with her while she attempts activities of daily living. The facility suggested home health services could be of assistance to the petitioner and her daughter.
7. The record was held open until September 10, 2008 for both parties to submit additional evidence. On September 9, 2008, the undersigned hearing officer received from the facility a letter (Respondent's Exhibit

5) which states in part "We wanted to provide a listing of services in the area which might be of benefit to the family and the resident...At the facility level the assessments from the physical and occupational therapies, nursing and nursing administration and now a home health agency all saying her supervision needs can me *[sic]* meet *[sic]* at home."

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42C.F.R. §431.200.

The Code of Federal Regulations at §483.12 Admission, transfer and discharge rights states in relevant part:

(a)Transfer and discharge-

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

(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.

Further, Florida Statutes 400.0255 (7) (3) states in part:

Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.

The petitioner's treating physician's opinion is that the petitioner needs 24 hour skilled care and he is not in agreement with the discharge action. The undersigned has relied on this expert opinion in reaching a conclusion that the facility has not met its burden to prove that the proposed discharge action is in accordance with the above controlling authorities.

DECISION

The appeal is granted. The respondent facility is not permitted to discharge the petitioner.

NOTICE OF RIGHT TO APPEAL

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

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

DONE AND ORDERED this 18th day of September, 2008,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
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850-488-1429

Copies Furnished

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

APPEAL NO. 08N-00120

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 11, 2008, at 8:30 a.m., in Tallahassee, Florida. The petitioner was present. He was represented by , district ombudsman manager, Florida Long Term Care Ombudsman Committee (LTCOC). The respondent was represented by , executive director, . Testifying on behalf of the respondent was , director of social services, assistance director of nursing, and , LPN, unit manager A wing.

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of Federal Regulation at 42 C.F.R. §483.12(a).

FINDINGS OF FACT

1. The petitioner is a resident of . He is 44 years old and has unspecified heart problems and a depressive disorder.
2. The respondent entered into evidence records of incidents of verbally abusive behavior to staff members of the facility. He curses at the staff and uses racial epithets. On occasions, the petitioner refuses to take his medication and becomes verbally abusive. In addition, the respondent presented records and testimony regarding an altercation with another resident of the nursing facility that occurred on May 27, 2008 and May 28, 2008 (Respondent's Exhibits 2, 3, and 4). The petitioner engaged in a verbal altercation which escalated to physical contact. The petitioner, who is ambulatory, spun the resident's wheelchair around. In retaliation, the other resident threw a soda can at the petitioner striking him on his arm. The facility notified the Department of Children and Families' Adult Protective Services (APS) of the incident. No further action was taken by APS. The petitioner and other resident were jointly interviewed regarding the incident. The respondent's clinical record, dated May 28, 2008, indicates that a review of the resident and staff rights was conducted. The petitioner and the other resident mutually agreed to "stay apart one on one supervised if necessary and abiding by facility smoking policy." The petitioner was moved to another room. Further, the petitioner was advised that Social Services would try to find a more

independent setting for him. A discharge plan was discussed with ARNP as the petitioner "is functional (ambulatory/AOL)" (Respondent's Exhibit 2).

3. There was no evidence presented to show that further incidents of physical or verbal abuse have occurred.

4. On May 29, 2008, the facility Interdisciplinary Team members along with the executive director met and determined the petitioner would be issued a Nursing Home Transfer and Discharge Notice giving him 30 day notice of its plan to discharge him from the facility. The discharge notice was discussed with the petitioner but he refused to sign it. The petitioner acknowledged that he did sign the notice at a later date.

5. The respondent, by Nursing Home Transfer and Discharge Notice dated May 29, 2008, notified the petitioner of its intent to discharge him, effective June 28, 2008, because the safety of other individuals in the facility was endangered. On June 19, 2008, the petitioner filed a request for hearing. The notice bears the signature of the treating physician and is dated May 29, 2008. There was no evidence presented offering the opinion of the treating physician to show his recommendations for discharge or discharge planning.

6. On June 7, 2008, a psychiatric evaluation/consultation was conducted by Dr. The record shows no evidence of psychosis, hallucinations or delusions. His assessment indicated the petitioner has

dysthymia and anxiety. It was recommended he continue current treatment as is. A re-assessment would be conducted if there were continued conflicts with other residents.

7. At the time the Notice of Transfer and Discharge was issued to the petitioner, the facility indicated that he was to be discharged to his grandmother's address in the community. The petitioner's grandmother is deceased. The address given on the discharge notice does not exist. The respondent acknowledged that an incorrect address was entered on the notice. In addition, due to a change in staff, the respondent was unsure what discharge planning was conducted. Further, action to complete discharge planning was not completed because the respondent anticipated an appeal of its proposed action to discharge.

8. The petitioner argued that the Notice of Transfer and Discharge was inadequate because it did not show that the facility provided sufficient preparation and orientation to the petitioner to ensure safe and orderly transfer or discharge from the facility. In addition, the notice appeared to have been altered. The copy of the notice faxed to the LTCOC on June 19, 2008 was missing a brief explanation to support the action. In addition, it was not signed or dated by the petitioner (Petitioner's Exhibit 1). Petitioner's Exhibit 2 is a copy of the Nursing Home Discharge Notice with an entry dated May 30, 2008 that does not appear on the Petitioner's Exhibit 1. The

petitioner acknowledged that he did sign the notice of discharge. The date of his signature was at issue. The respondent also acknowledged that he was advised of the respondent's intent to discharge him.

CONCLUSIONS OF LAW

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

Federal regulations at 42 C.F.R. §483.12 states in 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.

(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;...

In this case, the notice of discharge specifies the reasons for discharge that appear in 42 C.F.R. §483.12(a)(2)(iii), which states, in part:

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--...(iii) The safety of individuals in the facility is endangered....(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

42 C.F.R.§483.10 Resident rights, states in part:

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:...

> (b)(4) The resident has the right to refuse treatment, or refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section...

42 C.F.R.§483.15(b) states in relevant part:

> (b) Self-determination and participation. The resident has the right to (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;...(3) Make choices about aspects of his or her life in the facility that are significant to the resident...

Florida Statutes 400.0255, Resident transfer or discharge; requirements and procedures; hearings, states in relevant part:

> 15)(a) The department's Office of Appeals Hearings shall conduct hearings under this section. The office shall notify the facility of a resident's request for a hearing.
> (b) The department shall, by rule, establish procedures to be used for fair hearings requested by residents. These procedures shall be equivalent to the procedures used for fair hearings for other Medicaid cases, chapter 10-2, part VI, Florida Administrative Code. The burden of proof must be clear and convincing evidence...

The Findings of Fact show that the discharge reason is "The safety of other individuals in this facility is endangered." The petitioner's behavior includes verbal abuse, refusal to take medication and a physical altercation involving another resident. The facility has counseled with the petitioner, completed medication reviews, and made changes to his room assignment to meet his needs and modify his behavior. The evidence shows no further incidents involving verbal or physical confrontations.

The undersigned authority has reviewed all of the evidence and testimony. According to the above authorities, the facility's burden of proof must be clear and

convincing evidence. The only medical evidence presented by a physician was from a psychiatrist, completed after the May 28, 2008 incident, which indicates no prior history of inpatient or outpatient psychiatric care and recommends the petitioner continue current treatment with reassessment, should he continue to have conflicts with other residents. There was no evidence presented that showed that he no longer required nursing care. Based on the psychiatric evaluation, this facility should be able to meet his continued care needs. Based on all evidence and testimony presented, the hearing officer concludes that the facility's action to discharge the resident is not justified according to the controlling authorities. The petitioner is to be allowed to remain at the nursing facility.

DECISION

The appeal is granted. The respondent did not meet the burden of proof to show that the safety of other individuals in the facility is endangered. The facility may not proceed with the proposed discharge.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of September, 2008,

in Tallahassee, Florida.

Linda Garton
Hearing Officer
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 08N-00109

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 22, 2008, at 9:10 a.m., in Plantation, Florida. The petitioner was present with her daughter, Also present was from the Broward County Long Term Care Ombudsman Council. The respondent was represented by director of the facility. Also present from the facility was director of social services , activities director, and unit manager.

ISSUE

At issue is the Manorcare of Plantation's May 29, 2008 action to discharge the petitioner from the facility, because her needs cannot be met, and the safety of individuals is endangered. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner resides at the [redacted], in Plantation, Florida. Included in the evidence is a copy of a Nursing Facility Transfer and Discharge Notice, dated May 29, 2008, stating that the petitioner was being discharged from the facility because her needs cannot be met there.

2. The petitioner smokes cigarettes, and included in the evidence is a copy of a Smoking Evaluation form from the facility dated November 6, 2007. completed the form because the petitioner started a fire when she threw her cigarette in the trash.

3. According to the November 6, 2007 Smoking Evaluation form, the petitioner is not able to make decisions regarding tasks of daily life, she cannot demonstrate safe smoking techniques with holding a cigarette, lighting a cigarette, extinguishing matches after use and disposal of ashes. She does not remain alert during the course of smoking, she has burn marks on her clothing, and she is not able to communicate the safety risks associated with smoking.

4. Included in the evidence are copies of the facility's Smoking Guidelines and Smoking Policy. The petitioner was determined to be an at risk smoker, and according to the Smoking Guidelines, she is required to wear a protective smoking vest, and she refuses to wear one.

5. According to the facility's Smoking Policy, all of the petitioner's smoking accessories, including cigarettes, lighters, and matches, are to be kept under control of the nursing staff, when not in use.

6. Included in the evidence is a copy of Nurse's Notes, dated May 14, 2008, which was completed by . It states that he informed the petitioner's daughter, ., that the petitioner is not following the facility's smoking policy. The petitioner had cigarettes and a lighter when the nursing staff should have been in possession of her cigarettes and the lighter.

7. Included in the evidence is a copy of a letter from to the petitioner's daughter, stating that the petitioner does not follow the smoking policy, and that she smokes when staff members are not present. This was after it was determined that she cannot smoke alone due to safety reasons.

8. Included in the evidence is a copy of Nurse's Notes, dated August 13, 2008, completed by . It states that the petitioner had a cigarette and three lighters in her pocket. She was reminded that the she can only smoke when supervised.

9. The respondent's representative explained at the hearing that the petitioner was being discharged from the facility because her needs cannot be met, and for safety reasons. The safety of individuals is endangered, because she does not follow the smoking policy and guidelines.

10. The petitioner has a right to smoke, however she was offered a smoking patch to help her stop smoking, and she refused it.

11. According to and at the hearing, they observed the petitioner dozing off while smoking, and being uncooperative with staff when they tried to take the cigarette from her mouth. They also observed that the petitioner has cigarettes and lighters, and smokes unsupervised by the staff. According to them, the petitioner has burn marks on her clothing.

12. According to the petitioner's daughter, the petitioner should not be discharged from the facility, and the staff should supervise her more when she smokes.

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 a 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-
> (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.

The petitioner, a resident of the , was being discharged from the facility because her needs could no longer be met, and the safety of individuals is endangered. The petitioner smokes cigarettes. She is non compliant with the facility's smoking policy and guidelines. According to the evidence and testimony at the hearing, the staff at the facility has made an effort to accommodate the petitioner when she

smokes cigarettes. Even at the hearing, the petitioner or her daughter did not assert that the petitioner will follow the smoking policy and guidelines.

The petitioner is an at risk smoker who started a fire when she threw her cigarette in the trash. According to the Smoking Guidelines, she is required to wear a protective smoking vest, and she refuses to wear one. The petitioner had cigarettes and lighters when the nursing staff should have been in possession of her cigarettes and lighters. The petitioner and her daughter have been previously informed about her non compliance with the smoking policy and guidelines, and that if she continues to be non compliant, she would be discharged from the facility. After careful consideration, it is determined that the action to discharge the petitioner from the facility is upheld.

DECISION

The appeal is denied, and the action to discharge the petitioner from the facility 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 5th day of September, 2008,

in Tallahassee, Florida.

Stuart Imberman

Stuart Imberman
Hearing Officer
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Copies Furnished

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

APPEAL NO. 08N-00125

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 4, 2008, at 9:00 a.m., in Palm Beach Gardens, Florida. The petitioner was not present. Representing the petitioner was her son, Representing the respondent was administrator, Appearing as a witness was business manager.

ISSUE

At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to transfer the petitioner because the "bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The nursing home has the burden of

proof to establish that the transfer and discharge action is consistent with the federal regulations.

FINDINGS OF FACT

1. The petitioner is presently a resident of the [redacted]. She has been a resident since January 2008.
2. On June 27, 2008, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner with an effective transfer date of July 31, 2008. The Notice indicated the reason for transfer as "your bill for services has not been paid after reasonable and appropriate notice to pay".
3. Presently there is approximately $4,000 in unpaid bills. Debt is accumulating at approximately $4,900 per month. The last payment to the facility was $1,000, April 2008.
4. The representative applied for Institutional Care Program (ICP) Medicaid with the Department of Children and Families February 2008. This application was denied March 2008 when it was determined that the assets exceeded Program limits. The respondent has reapplied for ICP August 2008 with that application pending verifications.
5. The respondent explains that the petitioner no longer requires skilled care and that her insurance will only cover that type of care.

6. The representative explains that his brother had been managing his mother's affairs and that he was not aware that even the mother's monthly Social Security of $600 had not been forwarded to the facility. He was willing to at least give that amount now and then attempt to resolve the outstanding balance.

7. Finally, the respondent has explained that the brother has assigned the Social Security to the facility but that does not take affect until another three months.

CONCLUSIONS OF LAW

42 C.F.R. § 283.12 **Admission, transfer, and discharge rights** states in part:

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

Pursuant to federal guidelines, the nursing facility issued a Nursing Home Transfer and Discharge notice (AHCA Form 3120-0002) to the petitioner (and/or representative) on June 27, 2008. administrator, signed this Notice.

The Notice, as required, indicated the reason for transfer as the petitioner's "bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The effective date of discharge was given as July 31, 2008. The location to which the petitioner was to be discharged was given as the home.

All requirements have been met by the nursing facility. No payments have been made since April 2008 and no attempt to make payments prior to this hearing has been made. The family failed to cooperate by providing verifications

to Children and Families and the family assets may have exceeded ICP Program limits.

It is noted that there is no guarantee that the petitioner would be or will be eligible for ICP benefits.

DECISION

The appeal is denied. Pursuant to 42 C.F.R. § 483.12(7), the "facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility".

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the 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 9th day of September, 2008,

in Tallahassee, Florida.

Melvyn Littman

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

Copies Furnished To

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

APPEAL NO. 08N-00138

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on August 25, 2008, at 9:04 a.m., at the Florida. The petitioner was present and represented himself at the hearing. Also present on behalf of the petitioner was ombudsman. The respondent was represented at the hearing by , owner, and , administrator, . Testifying on behalf of the facility was medical records; nurse; and , nurse supervisor.

ISSUE

The respondent notified the petitioner that he was to be discharged for the following reason: "The safety of other individuals in the facility is endangered..." The respondent will have the burden of proof to establish by clear and convincing evidence that the

discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and Fla. Stat. ch. 400.0255.

FINDINGS OF FACT

1. The facility notified the petitioner on or about July 14, 2008 that he was to be discharged by August 14, 2008. The discharge location was indicated as "Another facility TBD." At the hearing, the respondent provided a location of discharge as the [redacted] which is located in [redacted], Florida. Currently the petitioner resides at [redacted]

2. The discharge notice was not signed by the petitioner's treating physician. The respondent submitted as part of Respondent Exhibit 1, a copy of the physician's notes and Orders indicating the need for discharge, signed by the petitioner's physician.

3. Respondent Exhibit 1, also contains copies of nurses' notes; social services notes and psychological evaluations and numerous letters from staff at the facility. It also contains a police report on an incident involving the petitioner and another resident.

4. The petitioner and the other resident were involved in a physical altercation. The other resident; a women, had marks on her arm caused by the petitioner, according to the police report and staff at the facility. The petitioner apparently had no marks on his person from the incident, according to the police report and staff at the facility.

5. The witnesses for the respondent had written letters concerning problems with the petitioner. The witnesses testified that they were threatened by the petitioner. Some of the letters that are part of the Respondent's Exhibit indicate the petitioner had threatened the staff at the facility.

CONCLUSIONS OF LAW

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

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

This regulation continues and states in part:

> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.
>
> (4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident... (6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following: ...(iii) The location to which the resident is transferred or discharged...

As shown in the Findings of Fact, the facility notified the petitioner on or about July 14, 2008 that he was to be discharged by August 14, 2008, based on: "The safety of other individuals in the facility is endangered...". The respondent provided testimony from the staff at the facility concerning the petitioner's verbal attacks against the facility's staff and physical attack against a resident. The respondent also provided a discharge location at the hearing.

The petitioner argued that he has not threatened anyone at the facility. He argued that the resident involved in the incident with him; attacked him first and caused him some

bodily harm. He also argued that he is the president of the resident's board, in which he was voted into office; which shows he is popular with the other residents.

The respondent argued the petitioner has a history of threatening staff at the facility and he has proven that he also is a threat to the residents at the facility. The respondent argued that they are afraid the petitioner; will harm some of the less able; dementia suffering residents at the facility. They argued that the facility of discharge has a younger patient population than and should be more suitable for the petitioner.

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

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of Sept., 2008,

in Tallahassee, Florida.

Robert Akel

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

Copies Furnished T

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

APPEAL NO. 08F-3836

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 July 15, 2008, at 9:20 a.m., in Miami, Florida. The petitioner was present at the hearing and represented herself. Present as a witness for the petitioner was . The respondent was represented by Mara Perez, program specialist with the Agency for Health Care Administration (AHCA). Phillys Bentil, program specialist was present as an observer. Present as witnesses for the respondent, via the telephone, were: Dr. Stuart B. Chesky, medical director and Gary Erickson, RN, fair hearing specialist, both with Keystone Peer Review Organization (KēPRO) South. Margaret Warner, program specialist was also present. The hearing was previously scheduled for August 27, 2008, but was continued upon agreement by both parties.

ISSUE

At issue is the respondent's action of May 28, 2008 in denying the petitioner's request for daily Home Health Aide (HHA) visits. The service requested was for the certification period of April 26, 2008 through June 24, 2008. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is fifty six years old and a Medicaid beneficiary in the state of Florida. The petitioner's diagnosis as reported to the respondent, "Other Emphysema; Shortness of breath; Unspecified essential hypertension; Reflux esophagitis."
2. On May 7, 2008, the provider (Ace Home Health Services) requested on behalf of the petitioner, daily personal care services of a home health aide. The provider submitted medical and social information on the petitioner.
3. The respondent has contracted KēPRO South to perform medical reviews of Private Duty Nursing and Personal Care Prior Authorization Program for Medicaid beneficiaries. This prior authorization review determines medical necessity of the hours and services that are requested, under the terms of the Florida Medicaid Program.
4. The request for service is only submitted by the provider, along with all information required, in order for KēPRO to make a determination on medical necessity for the level of service being requested. This review process is performed prospectively for a certification period.

5. On May 9, 2008, a physician consultant, board certified in family practice documented the following, "PC review for medical necessity for daily HHA [home health aide] visits denied as information submitted fails to show the medical necessity for this level of care. Rational: This is a 55 y/o with emphysema, HTN [hypertension] and reflux. Reported to live alone, has a daughter who checks on her daily. She is oriented, independent with medications, up is tolerated, holds onto walls/furniture to ambulate, is independent with transfers, and not incontinent. The above information indicates to me that patient and/or caregiver can participate in patient care."
6. On May 12, 2008, the provider was notified (electronically) that the request was denied, stating the above mentioned reasons.
7. On May 21, 2008, the provider submitted a reconsideration request along with the following additional information, "...PT is OZ [oxygen] dependent due to her emphysema, daughter not available to assist PT during the day PT unable to independently perform ADLs due to SOB. PT will benefit from HHA services to promote personal hygiene. PT needs assistance with bathing, getting in and OT of the shower, dressing, light housekeeping, laundry, services."
8. The reconsideration request was denied by a second physician consultant who documented, "Deny all reconsidered HHA. Updated data does not support the requested services. Patient is documented oriented, independent with meds, ambulatory and continent. Updated information does not demonstrate medical dx or limits based on the dx [diagnosis] that would prevent patient from

managing own adls [activities of daily living] as documented. Appears as the patient should be able to participate in own care, though slowly."

9. On May 28, 2008, the provider was notified of the reconsideration denial and the reasons for the denial as mentioned above.

10. On May 28, 2008, a Beneficiary Notification of Denial was issued to the petitioner informing her, "...the services have been Denied because documentation submitted by the agency (Provider) does not support the medical necessity for the visit frequency of the services requested." The petitioner appealed the decision on June 3, 2008.

CONCLUSIONS OF LAW

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

Fla. Stat. 409.905 addresses Mandatory Medicaid services and states in part:

> The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided *only* when medically necessary and in accordance with state and federal law. ... Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.
>
> (4) HOME HEALTH CARE SERVICES.--The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. ... (a) In providing

home health care services, the agency may require prior authorization of care based on diagnosis.

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

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

(2) All home health agency providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Home Health Services Coverage and Limitations Handbook, July 2007, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated in Rule 59G-4.001, F.A.C. ...

The Home Health Services Coverage and Limitations Handbook (July 2007), page 2-21 states in part:

Personal Care Services Definition
Person care services are to provide medically necessary assistance with activities of daily living that support a recipient's medical care needs.

Personal Care Services Requirements
Personal care services must be:

- Documented as medically necessary;
- Prescribed by the attending physician;
- Supervised by a registered nurse;
- Provided by a home health aide;
- Consistent with the physician approved plan of care; and
- Prior authorized prior to providing services.

Pursuant to the Florida Administrative Code at 59G-1.010 Definitions, states in part:

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

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and

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

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

The petitioner's friend stated that she would help the petitioner with the preparation of her meals, since she looses her breath.

The petitioner stated that she has shortness of breath, cannot clean with the oxygen, she takes a quick shower as she can only be without the oxygen for five to ten minutes at a time. She states that her daughter works and has children. The petitioner provided a statement from an internist stating in part, "...has moderately advanced Emphysema Oxygen Saturation of less than 89% requiring home oxygen and multiple inhalers to be minimally functional... She will require assistance with ADL daily."

The consultant physician responded by stating that the same information in the letter was considered in their decision. The petitioner can go for short periods of time

without the use of the oxygen and the medical information does not indicate that she is prevented from slowly managing her own activities of daily living. Additionally, the daughter visits daily and can assist.

The hearing officer agrees with the physician consultant's opinion and their denial of daily home health aide services. The evidence presented does not support the medical necessity for the visit frequency (daily) of the service. The respondent's denial is affirmed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25th day of September, 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

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

APPEAL NO. 08F-05303

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 September 17, 2008, at 8:35 a.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by her mother,

The respondent was represented by Lorraine Wasserman, registered nurse specialist. Present on the telephone from Kepro was Dr. Robert Buzzeo, and Gary Erickson, registered nurse reviewer.

ISSUE

At issue is the Agency's June 17, 2008 action of approving the petitioner's skilled home nursing services for 2,472 hours, and denying 948 hours for the time period of April 25, 2008 to October 21, 2008. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is 18 years old. She is a Medicaid benefits recipient in Broward County, Florida.

2. Included in the evidence is a copy of a Recipient Denial Letter, dated May 9, 2008, stating that 2,700 hours of skilled home nursing services were approved, and 0 hours were denied for the petitioner for the time period of April 25, 2008 to October 21, 2008.

3. Included in the evidence is copy of another Recipient Denial Letter, dated May 14, 2008, stating that 2,700 hours of skilled home nursing services were approved, and 720 hours were denied for the petitioner for April 25, 2008 to October 21, 2008. Mr. Erickson explained that there was an error in the calculation of the nursing hours in the May 9, 2008 notice, and then it was corrected in the May 14, 2008 denial notice.

4. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld notice, dated June 17, 2008, stating that upon reconsideration 2,472 hours of skilled home nursing services were approved, and 948 hours were denied for the petitioner for April 25, 2008 to October 21, 2008.

5. Included in the evidence is a copy of an Internal Focus Review Findings form from Kepro, dated July 14, 2008, stating that the petitioner requested skilled home nursing services of 19 hours daily on 7 days per week from 9:00 a.m. to 7:00 p.m., and 10:00 p.m. to 7:00 a. m.

6. Included in the evidence is a copy of a Synopsis Of Case from Kepro explaining the denial of skilled home nursing services for the petitioner, and the approval of the nursing hours of 3:00 p.m. to 7:00 p.m. on Mondays through Fridays, and 9:00 a.m. to 7:00 p.m., and 11:00 p.m. to 7:00 a.m. on Saturdays and Sundays.

7. According to the Kepro Internal Focus Review Findings report, the petitioner was diagnosed with Infantile Cerebral Palsy, and essential hypertension convulsions.

8. According to the Synopsis Of Case form from Kepro, the petitioner's mother does not work due to a cardiac condition, and in the household are the petitioner's siblings, ages 18, 13, and 11. It was determined that the petitioner's mother, and her grandmother can take care of her when she is not receiving the nursing care.

9. According to the petitioner at the hearing, there are actually five of her children in her household. She asserted that due to the petitioner's grandmother's medical condition, she cannot help in caring for the petitioner when she is not receiving nursing care.

CONCLUSIONS OF LAW

By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 F.S. Fla. Admin. Code 59G-1.010 states 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. Physicians at Kepro for the Agency, approved the petitioner for skilled home nursing services of 2,472 hours, and denied 948 hours for the time period of April 25, 2008 to October 21, 2008.

In the Agency's determination of the number of hours of nursing care for the petitioner, what is medically necessary is taken into account, and her mother's availability to take care of her. The physician that testified at the hearing agrees that the petitioner needs nursing care, and the denial of the 948 hours from April 25, 2008 to October 21, 2008. After careful consideration of the proper authorities and evidence, including the petitioner's diagnosis and condition, it is determined that the Agency's action of the denial of the 948 hours of 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 25th day of September, 2008,

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

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

APPEAL NO. 08F-04001

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on September 11, 2008, at 2:33 p.m., in Sarasota, Florida. The minor petitioner was not present. The petitioner was represented by her mother, who also testified. Pat Brooks, program operations administrator with AHCA, represented the respondent and testified. Karen Smith, registered nurse specialist with AHCA, appeared as a witness for the petitioner. Jessica Bruno, registered nurse specialist, observed.

ISSUE

At issue is the respondent's decision of April 11, 2008 to terminate Prescribed Pediatric Extended Care (PPEC) services based on the assertion that the petitioner's condition no longer requires this type of care.

FINDINGS OF FACT

1. The petitioner is seven years old with a birth date of November 9, 2000. The petitioner lives with her mother. The petitioner is in the second grade, attends regular school classes, and can do normal physical and intellectual activities. On non-school days, she attends a PPEC.
2. The petitioner has a diagnosis of short bowel or short gut syndrome. The petitioner has a G-tube placement. The petitioner's condition has improved to the point where she has not required any IV or G-tube hydration while in PPEC since February 2008. The PPEC provider has used her g-tube only for medication administration of flagyl. Additional fluids may be given in the evening by mouth.
3. Dr. ' is the petitioner's pediatric gastroenterologist. On May 7, 2008, Dr. opined the petitioner to need continued PPEC services to monitor her risk of dehydration due to frequent episodes of diarrhea. On September 5, 2008, Dr. determined the petitioner's health status to be stable and therefore, has no need to attend PPEC. Dr. opined that the petitioner may need to re-enroll for PPEC if her status changed.
4. Dr. ' is the petitioner's pediatrician. On May 27, 2008, Dr. opined the petitioner to need care in a setting with medical personnel capable of supplying her needs, such as PPEC. On August

1, 2008, Dr. also opined the petitioner to be medically stable and capable of attending a regular childcare center.

5. The respondent reviewing AHCA nurse opines that the petitioner no longer requires skilled nursing intervention for her conditions. On April 11, 2008, the respondent sent notice to the petitioner that PPEC services were to terminate effective August 8, 2008.
6. The petitioner's mother believes the petitioner needs to be monitored by an experienced daycare such as PPEC. The petitioner's mother works at night as a certified nursing assistant (CNA). Nursing services are provided at night. There is no other child in the home. The petitioner's father is in the home, but is sick and in bed. The petitioner's mother has not been able to find a regular daycare that would accept the petitioner with her conditions.

CONCLUSIONS OF LAW

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

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

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

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. The petitioner's treating pediatrician and gastroenterologist have both opined that the petitioner no longer has a medical need for PPEC services.

The language of the Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, Chapter 2, page 1 sets forth the requirements to receive PPEC services. This handbook shows that an individual must be diagnosed as medically complex or medically fragile per definitions on page 2-2, and:

> Require short, long-term, or intermittent continuous therapeutic interventions or skilled nursing supervision due to a medically complex condition.

Page 2-3 of the same handbook shows that PPEC services must also be ordered by an attending physician or the Medicaid physician consultant. Findings show that the petitioner no longer needs continuous therapeutic interventions or skilled nursing supervision, based on the opinion of treating medical providers. Therefore, the continued provision

of PPEC services is not defined as medically necessary, and would be in excess of the petitioner's needs.

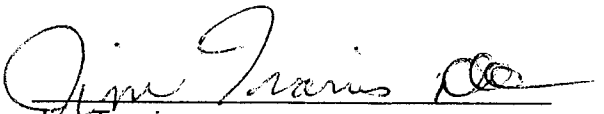
DECISION

This appeal is denied. The respondent has met its burden to prove that defined PPEC services are no longer medically necessary. Thus, the respondent decision to terminate the PPEC services at issue is upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, 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 25th day of September, 2008, in Tallahassee, Florida.



Jim Travis
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Tallahassee, FL 32399-0700
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

PETITIONER,

APPEAL NO. 08F-04414

Vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
DISTRICT: 07 Seminole
RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on July 25, 2008 at 1:35 p.m. in Sanford, Florida. The petitioner was present with her parents, and Also present on her behalf were: wheelchair representative, Healthcare seating specialist; , exceptional student educational assistant; , observer; and , Seminole County Public School system physical therapist. Present in person on behalf of AHCA were Lissette Knott, human service program specialist and Benjamin Czeslowski, registered nurse specialist; and by telephone, Jody Winter, physical therapy consultant. Post hearing submissions were arranged and Petitioner's Exhibit 5 with Respondent's Exhibit 5 as responsive .

ISSUE

At issue was whether or not authorization denial of model C400 Stander Jr. power wheelchair was correct. Burden of proof is on the petitioner.

FINDINGS OF FACT

1. The petitioner was born on November 14, 1992 and has special strengths as well as special challenges. She lives at home, attends public high school with excellent grades, and plans to attend college under prepaid tuition package. She has friendships and school activities, with family, community, and recreational activities as well.

2. Medicaid eligibility is undisputed and a C400 stander junior wheelchair was recently requested and denied by AHCA. (This was also described as K0014 Powered Standing Wheelchair request.) Respondent's Exhibit 1, denial of May 30, 2008, says, "it is not the least costly alternative that can provide powered mobility."

3. Denial clarification in Respondent's Exhibit 3 informed "...a separate standing device for home use could be approved...appropriate power wheelchair and a standing device can be provided for less than $20,000.00..." The desirability of the equipment was explained as insufficient to equate with medical necessity.

4. AHCA reviewed medical, physical therapist and equipment information as submitted in Respondent's Exhibits 2 and 3 along with state guidelines. The high school physical therapist submitted an eight page "Letter of Medical Necessity" detailing many aspects of the school, medical and social life of the petitioner as related to the equipment. Following submission of additional medical data (Petitioner's Exhibit 5) after the hearing, AHCA continued to deny authorization (Respondent's Exhibit 5).

5. The petitioner is not independently mobile, and has "periventricular leukomalacia with cerebral palsy manifested by spastic quadriparesis" described by her pediatrician in Petitioner's Exhibit 5. He previously prescribed "power wheelchair" (Respondent's Exhibit 3, page 9) and in Petitioner's Exhibit 5, recommended:

> Permobil C400 stander junior wheelchair...facilitate standing options...minimize the development of pressure ulcers and allow the freedom of greater mobility...increasing sense of self worth and providing greater independence...approve this durable medical equipment for the health and well being of your insured.

6. The petitioner has skeletal pain that can be alleviated by position changes, and surgery has also occurred. Since 2002, she has used a power-operated wheelchair. At school and at home she also uses a stander. The stander at home is not readily transportable. She visits friends and family and settings where a stander is unavailable. She cannot transfer herself from wheelchair to stander without assistance. There are only five people capable to reposition her from up to down postures safely and effectively without adverse consequences. Under current circumstances, need for assistance in repositioning is undisputed.

7. Her long-term (since 1999) orthopedist noted several surgeries since 2002, also saying in part, in Respondent's Exhibit 5:

> (The petitioner) is not able to ambulate independently. She does some physiologic (exercise) ambulation and is minimally able to assist with transfers despite her multiple surgical procedures. Numerous studies have demonstrated the physiologic value associated with increased mobilization and upright positioning. Pulmonary capacity, GI and bladder function, cardiac functions have well documented benefits associated with standing upright. In addition, the musculoskeletal system only remains strong by exercise and weight bearing activities. All of (the petitioner's) surgical procedures have been attempts at helping maintain proper seating and standing posture in an attempt to promote good health and decrease the future need for more extensive, and more expensive surgical procedures.
> For many patients with quadriplegic cerebral palsy, the Permobil C400 Stander Jr. would be inappropriate ... (the petitioner)...is the perfect candidate to derive maximum benefit... She is able to make intelligent decisions regarding seating and standing. Unfortunately, (the petitioner) does not have the physical capacity to transfer herself and is therefore dependant *{sic}* on others for her exercise and positioning. ...

> Allowing (the petitioner) the ability to sit and stand in an "independent" manner, such as this chairs *{sic}* allows, will serve not only to protect her physiologically, but mentally and academically as well. At this stage (the petitioner) needs physiologic independence where ever possible. ... In a time when the technology is available, and an appropriate patient can be matched with and benefit from the technology to assist in becoming a contributing member of society, please reconsider the impact that this equipment would have on her life. I feel that use of this equipment could decrease potential future long bone fractures and muscle contracture. Over time, I believe the use of the Permobil C400 Stander Jr. chair could save financial resources.

8. The petitioner has tried and practiced with the C400 and has used it under close observation of professionals. The school physical therapist observed (Respondent's Exhibit 2, page 14) as follows: "....within a few minutes of demonstration and instruction, was able to manage the variety of controls and safely operate the wheelchair in standing. She was a very quick study ... " The therapist had also noted value of the equipment, saying, "greater functional abilities while fishing, attending movies, shopping...allow her to mature and take more responsibility for herself with all interactions rather than relying on an adult..."

CONCLUSIONS OF LAW

For reviewing equipment requests such as this one, federal guideline at 42 C.F.R. § 440.130 addresses **Diagnostic, screening, preventive and rehabilitative services** and informs in relevant part:

> (c) ``Preventive services'' means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to—
> (1) Prevent disease, disability, and other health conditions or their progression;
> (2) Prolong life; and
> (3) Promote physical and mental health and efficiency.
> (d) ``Rehabilitative services,'' except as otherwise provided under this subpart, includes any medical or remedial services recommended by a

> physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

Additional guidance is at § 440.230 addressing **Sufficiency of amount, duration, and scope** and informing:

> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. ...
> (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Consistent with regulation, the agency may evaluate medical necessity before authorizing special equipment. In setting the standard, Florida Administrative Code 59G-1.010(166) defines "medically necessary" care, goods or services. As related to wheelchair durable medical equipment authorization, state rule informs that medically necessary service 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.

AHCA determined the requested wheelchair was excessive for the petitioner's needs and was not the least costly alternative to accommodate medical need in the

situation. An excerpt from the DME/Medical Supply Services Coverage and Limitations Handbook on page 2-57 states in pertinent part:

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

Evidence has established that the petitioner could independently use the requested C400 wheelchair with the powered stander to facilitate medical need of standing in various settings. However, evidence also shows she cannot transfer on her own to a separate stander. Therefore, the less expensive wheelchair and accessories with the separate stander at home would not meet her medical need for standing. Further, since the powered stander function of the requested C400 wheelchair facilitates more independence in the performance of activities of daily living (ADLs), it is not evident the requested wheelchair exceeds the petitioner's needs.

The agency asserted the requested wheelchair is not the least costly alternative. However, an alternative wheelchair with separate stander is not equally effective to the requested C400 wheelchair with powered stander. The rule informs that a requested service under Medicaid must be "furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." Findings show that the requested C400 wheelchair would likely be more convenient for the petitioner and helpers for mobility and standing purposes. However, it is not concluded that the requested wheelchair is *primarily* intended for convenience of the petitioner or anyone else. There is significant medical benefit of frequent standing and repositioning without

need for assistance to transfer. Moreover, greater independence is important and is feasible in this circumstance.

In summary, evidence shows that C400 Stander Junior power wheelchair meets the defined medical necessity criteria. The petitioner's treating physicians strongly support need for this type of powered wheelchair, giving clear supportive explanations for their opinions. Statutory and regulatory guidelines provide for approval in situations such as these. Therefore, denial of the medical equipment has not been justified.

DECISION

The appeal is granted and the agency action is not upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 5th day of Sept, 2008, in Tallahassee, Florida.

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

Copies Furnished Tc

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

APPEAL NO. 08F-01630

PETITIONER,

Vs.

CASE NO. 1172011079

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 28, 2008 at 11:08 a.m., in Lakeland, Florida. The petitioner was not present. She was represented by Medicaid specialist with the . The respondent was represented by Gail Crews, Access supervisor.

The respondent was allowed an extension of time to reconsider the petitioner's eligibility based on disability. Her case was resubmitted to the District Medical Review Team. Evidence was received from the respondent on August 28, 2008. It was accepted as Respondent's Exhibit 2.

On September 3, 2008, the petitioner was notified that the respondent approved the requested benefits. The petitioner was allowed 7 days to offer any objection to the dismissal of the appeal. No further response or objection was received.

ISSUE

At issue is the February 19, 2008 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program and Medicaid for failure to meet the disability criteria.

FINDINGS OF FACT

1. On November 27, 2008, the petitioner filed a Request for Assistance to apply for benefits through the SSI-Related Institutional Care Program. No retroactive months were requested. Since she was 57 years old, she did not meet the aged criteria and a disability decision was required. The petitioner resided in a nursing facility so the request for a disability assessment was forwarded to the District Medical Review Team (DMRT).
2. On January 30, 2008, DMRT determined that the petitioner did not meet the disability criteria. However, the team did not give a reason code to explain why the petitioner did not meet the disability criteria. On February 6, 2008, the respondent notified the petitioner that her application was denied for failure to meet the disability criteria.
3. On August 28, 2008, the respondent notified the hearing officer that DMRT reconsidered the previous denial of disability. DMRT determined that the petitioner met the disability criteria. Subsequently, the respondent approved the petitioner for Institutional Care Program benefits back to November 1, 2007.

CONCLUSIONS OF LAW

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

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

The evidence establishes that the respondent requested benefits through the Institutional Care Program and Medicaid. The application was denied for failure to meet the disability criteria. Subsequently, the respondent reversed their position and approved the requested benefits. Therefore, a determination of the correctness of the respondent's action is now moot.

DECISION

This appeal is dismissed.

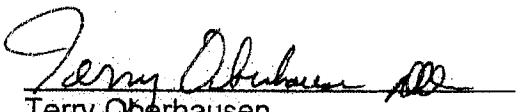
NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 17th day of Sept., 2008,

in Tallahassee, Florida.



Terry Oberhausen
Hearing Officer
Building 5, Room 203
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Tallahassee, FL 32399-0700
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 08F-04922

PETITIONER,

Vs.

CASE NO. 1279952059

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 01 Escambia
UNIT: 88637

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 5, 2008, at 9:00 a.m., in Pensacola, Florida. The petitioner was not present but was represented, via speakerphone, by her daughter, The Department was represented by Franzaro Dudley, ACCESS Florida supervisor. Testifying on behalf of the petitioner was Tracey Alexander, economic self-sufficiency specialist I.

The hearing was originally scheduled to be held on August 20, 2008 but was continued at the request of the petitioner's representative.

ISSUE

The petitioner is appealing the Department's action of July 10, 2008, to deny Institutional Care Program (ICP) benefits for the months of November 2008 through

June 2008 due to an alleged improper transfer of assets. The petitioner had the burden of proof.

FINDINGS OF FACT

1. On February 15, 2008, the petitioner filed an application for Institutional Care Program (ICP) benefits to include the retroactive months of November 2007, December 2007 and January 2008. Prior to the application, the petitioner was living independently in the community. She lived for a time with her daughter in Tennessee. She moved to Pensacola to be near her siblings after the death of her husband in April 2002. The petitioner's representative took care of her financial affairs and was a joint owner on her mother's savings account. The representative moved from Tennessee to Greenville, South Carolina and intended to move the petitioner in with her. On August 31, 2007, the representative paid $100 to reserve a lot for a three bedroom townhome (Petitioner's Exhibit 1). On September 12, 2007 she signed a purchase agreement for the townhome. However, on September 25, 2007, the petitioner had a fall which resulted in a pelvic fracture. She was admitted into a skilled nursing facility for rehabilitation therapy on September 28, 2007.

2. The petitioner was born on December 17, 1921 and was 86 years old at the time of the application. At the time of the accident, the petitioner was 86 years old. Subsequent to the accident, the petitioner underwent several months of rehabilitation in a skilled nursing facility. The representative believed the admission to the skilled rehabilitation unit would be for a few months until the petitioner was completely healed.

It was the petitioner's intent to be discharged home with the representative. On November 18, 2007, a care plan meeting was conducted at the skilled nursing facility. The representative believes the petitioner's progress was slow but steady and that the plan was to discharge the petitioner when therapy services were completed. The representative closed on the townhome property on November 30, 2007 based on her belief that the petitioner would be discharged upon completion of therapy. The property was listed solely in the name of the petitioner's representative. In December 2007, the petitioner reached a plateau in therapy and was not meeting her therapy goals. There was also a decline in her cognitive status. It was determined that the petitioner would not be able to return to her home without 24 hour supervision. In December 2007, a final decision was made regarding discharge. Due to a decline in the petitioner's physical ability and mental status, it was determined that the petitioner would remain in the nursing facility under long term care.

3. At the time of the application, the petitioner had a joint savings account with a balance of $46,268.09. The representative acknowledged the funds in the account belonged to the petitioner. The representative's name was on the account so that she could assist her mother with her financial affairs. On November 30, 2007, the representative withdrew $40,000 to be applied toward the purchase of the townhome in South Carolina. The representative, who has power of attorney, argued that the funds were spent for the petitioner's needs and was used to provide the petitioner with a home in anticipation of her discharge.

4. The Department presumed that the above transfers of funds were made to become Medicaid eligible. On May 29, 2008, the Department mailed the petitioner a Notice of Determination of Resource/Income Transfer which gave the petitioner the opportunity to rebut the presumption that the transfers of the funds were made to obtain Medicaid eligibility. In response to the above notice, the petitioner's daughter and power of attorney in a letter dated June 12, 2008 (Respondent's Exhibit 7) stated that she had been planning to move her mother to live with her in South Carolina since April 2002. The funds were used to pay for a townhouse suitable to accommodate the petitioner. The representative had no reason to believe that the petitioner would injure herself and that she would need long term nursing care. The Department determined that the petitioner had not successfully rebutted the presumption that the transfer was made to obtain Medicaid eligibility and determined that the petitioner was not eligible to receive ICP benefits for eight months from the date of the transfer (November 2007 through June 2008). The ineligibility period was determined by dividing the total amount transferred of $40,000 by $5,000 which was the average private nursing home rate.

5. On July 10, 2008, the Department denied ICP benefits for the months of November 2007 through June 2008 as it was determined that the petitioner improperly transferred funds to become eligible for ICP benefits and to obtain Medicaid eligibility. ICP benefits were approved effective July 2008.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.712 "SSI-Related Medicaid Resource Eligibility Criteria"

in part states:

> (3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing facility care services, institutional hospice or HCBS waiver services. The department will mail a notice to individuals who report a transfer for less than fair market value (Form CF-ES 2264, Feb 2007, Notice of Determination of Assets (Or Income) Transfer, incorporated herein by reference), advising of the opportunity to rebut the presumption and of the opportunity to request and support a claim of undue hardship per subparagraph (c)5. below. If the department determines the individual is eligible for Medicaid on all other factors of eligibility except the transfer, the individual will be approved for general Medicaid services (not long-term care services) and advised of their penalty period (Form 2358, Feb 2007, Medicaid Transfer Disposition Notice, incorporated herein by reference.) The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.
> (a) The department follows the policy for transfer of assets mandated by 42 U.S.C. § § 1396p and 1396r-5. Transfer policies apply to the transfer of income and resources....(d) Except for allowable transfers described in 42 U.S.C. § 1396p(c)(2), in all other instances the department must presume the transfer occurred to become Medicaid eligible unless the individual can prove otherwise.
> 1. An individual who disposes of a resource for less than fair market value or reduces the value of a resource prior to incurring a medical or other health care related expense which was reasonably capable of being anticipated within the applicable transfer look back period shall be deemed to have made the transfer, in whole or part, in order to qualify for, or continue to qualify for, medical assistance.... (g) For transfers made on or after November 1, 2007, periods of ineligibility begin with the later of the following dates: (1) the day the individual is eligible for medical assistance under the state plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period; or (2) the first day of the month in which the individual transfers the asset; or (3) the first day following the end of an existing penalty period. The department shall not round down, or otherwise disregard, any fractional period of ineligibility of the penalty

period but will calculate the period down to the day. There is no limit on the period of ineligibility. Once the penalty period is imposed, it will continue although the individual may no longer meet all factors of eligibility and may no longer qualify for Medicaid long-term care benefits.

1. Monthly periods of ineligibility due to transferred resources or income are determined by dividing the total cumulative uncompensated value of all transferred resources or income computed in accordance with paragraph 65A-1.712(3)(f), F.A.C., by the average monthly private pay nursing facility rate at the time of application as determined by the department (refer to paragraph 65A-1.716(5)(d), F.A.C.)... 3. Individuals who are ineligible due solely to the uncompensated value of a transferred resource or income are ineligible for nursing home, institutional hospice or HCBS waiver services payment, but are eligible for other Medicaid benefits.

The United State Code at 42 U.S.C. § 1396p(c)(2) states in pertinent part:

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that -
(A) the assets transferred were a home
(B) the assets
(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,
(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,
(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or
(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);
(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual;...

The Department's Policy Manual 165-22 section 1640.0618 in part states:

Period of Ineligibility (MSSI)
When the presumption is not successfully rebutted, the Economic Self-Sufficiency Specialist must determine the period of ineligibility.
The penalty period depends on:
1. the amount of the total UV,
2. when the transfer occurred, and
3. the average private nursing home cost at the time of application or discovery of the transfer.
The following basic formula is used to determine the period of ineligibility on all applicable cases:
Total UV (divided by) the average private nursing home rate = Number of months of ineligibility (rounded down to the nearest whole number).
Where assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, the values of all assets transferred are added together and divided by the average cost of private nursing home care.
Where multiple transfers are made in such a way that the penalty periods for each would not overlap, each transfer is treated as a separate event with its own penalty period.
If an institutionalized individual is ineligible for assistance due to a transfer of assets or income by the community spouse and the community spouse becomes eligible for ICP, HCBS, or PACE, any remaining period of ineligibility must be apportioned between spouses. This will be done by dividing any new or remaining penalty periods by two and attributing to each spouse. Any odd months may be attributed to the spouse that caused the penalty or attributed according to the couple's (or their representative's) wishes.
The current average private nursing home rate ($5,000) is used for all transfers, regardless of when the transfer occurred. There is no limit on the number of months of ineligibility.

The petitioner's daughter and representative, in rebutting the presumption that the transfers were made to become Medicaid eligible, argued that the transfers of the funds from the savings account was made because it was her intent to move the petitioner into a townhome suitable for her needs and to live with her in South Carolina.

She argues that at the time of the transfer, she had no reason to believe that the petitioner would need long-term care in a nursing facility.

The evidence presented showed that on September 25, 2007, the petitioner, who was 86 years old, fell and broke her pelvic bone. The petitioner was living independently in the community until the date of her accident. She was admitted to a skilled nursing facility on September 28, 2007 for rehabilitation.

According to the above authorities, an individual who disposes of a resource for less than fair market value or reduces the value of a resource prior to incurring a medical or other health care related expense which was reasonably capable of being anticipated, within the applicable transfer look back period, shall be deemed to have made the transfer, in whole or part, in order to qualify for medical assistance. As the petitioner was in a skilled nursing facility from at least September 25, 2007, it was reasonable to anticipate that a medical or other health care related expense would be incurred. Even if it was believed that the nursing facility stay would be for a short term, given the petitioner's age and injury, the petitioner and/or her daughter should have anticipated the need for continued medical care and therefore, the need for the funds from her savings to pay for the cost of her medical care. The representative's argument is not persuasive.

The Florida Administrative Code Rule 65A-1.712(3) states if a transfer is not specifically excluded, then the Department must presume the transfer occurred to become Medicaid eligible, unless the individual can provide sufficient evidence to prove

otherwise. The transfer in this case is not specifically excluded as set forth in the above authorities. Additionally, it is determined that the petitioner's argument is not sufficient to rebut the presumption that the transfer was made to become Medicaid eligible. Therefore, the Department correctly determined that the petitioner was not eligible to receive ICP benefits due to the transfer of assets.

The Department imposed a penalty for eight months from the date of transfer (November 2007 through June 2008). The amount of the transfer was $40,000. When this amount is divided by $5,000, the result is eight months. According to the above authorities, for transfers made on or after November 1, 2007, the penalty begins with the latter of the following: the first day the individual would have been eligible for ICP if a penalty period did not apply or the first day of the month of transfer. Because September 25, 2007 is the first day she would have been eligible (and was before the effective date of the amended code) and the transfer did not occur until November 2007, the Department was correct to use the latter date of November 2007 to begin the penalty period. Therefore, the penalty period assigned was correct.

DECISION

The appeal is denied. The Department's action to deny the petitioner ICP benefits for November 2007 through June 2008 is affirmed.

NOTICE OF RIGHT TO APPEAL

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

FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 25th day of September, 2008,

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

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

APPEAL NO. 08F-04956

PETITIONER,

Vs.

CASE NO. 1249020565

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on September 4, 2008, at 11:10 a.m., in Fort Lauderdale, Florida. The petitioner was not present. She was represented by her husband

The respondent was represented by Liliane Clerie, Florida Access specialist. The hearing was held open for four days from the date of the hearing, which was through September 8, 2008, to allow the parties an opportunity to submit information into evidence. Both parties submitted information into evidence within the deadline.

ISSUE

At issue is the Department's determination of the petitioner's patient responsibility of $759.84 in the Institutional Care Program. The petitioner has the burden of proof.

FINDINGS OF FACT

1. As of the time of the hearing, the petitioner was a resident of the , in Pembroke Pines, Florida, and her husband, lives in the community.

2. As of the time of the hearing, the petitioner's patient responsibility in the Institutional Care Program was $759.84. This is the monthly amount that she is expected to pay the nursing home.

3. Included in the evidence is a copy of a FLORIDA computer Monthly Unearned Income screen showing the petitioner's income of $956.00 and $230.00. The respondent's representative explained that the $956.00 is the petitioner's monthly gross Social Security benefits, and the $230.00 is her Veteran's Administration benefits. The petitioner's total monthly gross income is $1,186.00.

4. Included in the community spouse's Maintenance Need Allowance Budget are shelter costs of $1,348.56 minus $525.00, which is 30% of the MMIA, for an excess shelter cost of $823.56. Added to this is a MMIA amount of $1,750.00, for a total of $2,573.56, which is the allowable shelter deduction.

5. works for the , and his monthly gross earned income is $2,182.40. In the community spouse's Maintenance Need Allowance budget, the earned income is subtracted from the allowable shelter deduction of $2,573.56, for a community spouse income allowance of $391.16. This is the maintenance need allowance in the Patient Responsibility Budget.

6. Included in the Patient Responsibility Budget is the petitioner's total monthly gross unearned income of $1,186.00, minus a personal need allowance of $35.00, and a maintenance need allowance of $391.16, for a patient responsibility of $759.84.

CONCLUSIONS OF LAW

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

> (c) Spousal Impoverishment Standards
> 1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. § 1396r-5.
> 2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
> 3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMIA × 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.
> 4. Food Stamp Standard Utility Allowance: $198.
> 5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. § 1396r-5. This standard changes January 1 of each year.

The Department determined a patient responsibility of $759.84 for the petitioner in the Institutional Care Program. Included in the Patient Responsibility Budget is the petitioner's monthly gross Social Security income of $956.00, plus her Veteran's Administration income of $230.00, for a total gross income amount of $1,186.00. Subtracted from this is a personal need allowance of $35.00, and a maintenance need allowance of $391.16, for a patient responsibility of $759.84. After careful consideration, it is concluded that the Department's determination of a $759.84 patient responsibility is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16th day of Sept., 2008,

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

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

APPEAL NO. 08F-03827

PETITIONER,

Vs.

CASE NO. 1117893782

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 17, 2008, at 10:01 a.m., in Jacksonville, Florida. The petitioner was present and represented herself. The petitioner's daughter, [redacted] was present as a witness. The Department was represented by Rycha Redden, ACCESS supervisor and Michael Paul, economic self sufficiency specialist.

ISSUE

The petitioner is appealing the Department's action of May 28, 2008 to deny Medicaid benefits for April 2008, through the Institutional Care Program (ICP) Medicaid on the basis that she did not meet the disability criteria.

FINDINGS OF FACT

1. Prior to the action under appeal the petitioner was enrolled in the Family-related Medically Needy program with a share of cost. The petitioner's household consists of the petitioner and her two children / ll (21) and ll (15). The petitioner met the share of cost in this program for April 1, 2008 through April 30, 2008.
2. The petitioner had a heart attack on March 29, 2008. The petitioner was hospitalized from March 29, 2008 through April 16, 2008. The petitioner was transferred from the hospital on April 16, 2008 to receive skilled nursing care and rehabilitation therapy. The petitioner was discharged home from the nursing facility on April 29, 2008.
3. The petitioner applied for ICP Medicaid on April 21, 2008. The petitioner's date of birth is J . At the time of application the petitioner was age 60. Since the petitioner was under 65, she did not meet the aged criteria. To be eligible for ICP Medicaid, an individual must be age 65 or disabled.
4. The petitioner applied for disability through the Social Security Administration on May 4, 2008. The application is still pending.
5. A level of care determination was completed by the Comprehensive Assessment and Review from Long Term Care Services (CARES) Unit on April 16, 2008. The CARES unit recommended that the petitioner receive skilled nursing care for two to three weeks and certified that the

petitioner is in need of Medicaid Waiver Services in lieu of institutional placement.

6. The Department collected and submitted a medical packet to the District Medical Review Team (DMRT) on May 15, 2008. It was determined by DMRT on May 20, 2008 that the petitioner's condition was not severe enough to be considered disabling.
7. The Department denied the ICP Medicaid request on May 28, 2008 as the petitioner did not meet the disability requirement.
8. The petitioner's medical records show the petitioner suffered a myocardial infarction (heart attack) on March 29, 2008. She had an emergent coronary artery bypass grafting done and also a left common femoral artery repair with bovine patch. The petitioner subsequently underwent implementation of a pacemaker. The petitioner's medical records show past medical history of hyperlipidemia, hypothyroidism and gastroesophagel reflux disease.
9. The petitioner was employed part time as a cashier at [redacted] in Jacksonville when she had the heart attack in March 2008. The petitioner has not worked since the heart attack.
10. The petitioner asserted that when she entered the nursing facility she was unable to walk, she was unable to feed herself or take care of her own personal hygiene. The petitioner stated during her two week stay in the facility (April 16, 2008 – April 29, 2008), she regained use of her limbs and the ability to take care of all her personal hygiene needs. The

petitioner can walk for short periods of time and climb stairs with assistance of a railing. The petitioner stated her stamina has not returned to the level prior to the heart attack. The petitioner asserted the incision from her surgery has not completely healed and at times oozes blood.

11. The petitioner and her daughter believe she was disabled during her stay in the facility. They believe that her condition has significantly improved and that she may be able to return to work in three to five months. They credit the facility for the petitioner's improved medical condition and would like to see that the facility is paid for its services. The petitioner asked why the Medically Needy Program in which she is currently enrolled will not pay the facility bill. The Department explained that only ICP Medicaid can pay the vendor payment for a nursing facility.
12. The petitioner is also concerned about the cost of her heart medication which is approximately $200 per month. The petitioner stated that she can only afford half of the prescription and doesn't understand why the Medically Needy Program in which she is enrolled does not pay for her prescriptions. The Department explained that because the petitioner is enrolled with a share of cost, she is not Medicaid eligible for a given month until her submitted medical bills meet the share of cost. The share of cost must be met each month. Once the share of cost is met, the petitioner's Medicaid is activated from the date the share of cost is met

until the end of the month. The Department gave the petitioner a brochure which explained the Medically Needy Program.

CONCLUSIONS OF LAW

The Florida Administrative Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals who have income of less than the federal poverty level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. §416.905. The regulations state, in part:

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

The Department's Policy Manual, 165-22, Section 1440.1200, AGED, BLIND, OR DISABLED (MSSI, SFP), explains:

> An individual must be aged, blind, or disabled to be eligible for SSI-Related Medicaid. Exceptions to these criteria are individuals who qualify for QMB and SLMB benefits.

Federal Regulations at 20 C.F.R. §416.909, How long the impairment must last, states:

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

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

The second step is to determine whether or not an individual has a severe impairment. Severe impairment is defined in the federal regulations at 20 C.F.R. §416.920(c) and §416.921 (b) states in part:

> *You must have a severe impairment.* If you have an impairment(s) or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled... *(b) Basic work activities.* When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include – (1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (2) Capacities for seeing, hearing, and speaking; (3) Understanding, carrying out, and remembering simple instructions; (4) Use of judgment; (5) Responding appropriately to supervision, co-workers and usual work situations; and (6) Dealing with changes in a routine work setting.

The undersigned hearing officer concludes that there is a slight burden at step two as the court has determined that an impairment is not severe only if the abnormality is so slight and its effects so minimal that it would clearly not be expected to interfere with the individual's ability to work. The undersigned concludes that the petitioner's impairments have limited her ability to do basic work activities. However, there is also a 12-month durational requirement that must be met preventing the individual from engaging in Substantial Gainful Activity. Because the findings show that the petitioner expects to improve and

return to work in three to five months, along with the medical evidence showing a five month durational period, the undersigned was unable to conclude that the impairment(s) meets the disability durational requirement.

Based on the evidence provided and the controlling legal authorities, the undersigned hearing officer concludes that the petitioner does not meet the disability requirement for ICP Medicaid and the ICP denial is affirmed.

Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook, October 2003, explains on pages 2-2 and 2-3:

> Medicaid Institutional Care Program (ICP) - Medicaid reimburses nursing facilities for services provided to residents who have been determined to meet Medicaid ICP eligibility. In all cases, in order to receive reimbursement from Medicaid for nursing facility care, the facility must have received written notification from the Department of Children and Families approving the individuals for institutional care benefits. ... Eligibility Determination - Department of Children and Families (DCF) district staff determines eligibility for ICP. ICP eligibility must be approved for all individuals whose care will be paid for by Medicaid, including SSI recipients and individuals who were eligible for Medicaid in the community before entering a nursing facility. The possession of a Medicaid card is not proof that the individual is eligible for institutional care benefits. Eligibility determination is still required and must be done prior to billing Medicaid for services. DCF must determine and notify the facility in writing regarding the correct amount of the patient responsibility prior to the first billing. (See below for patient responsibility deductions.) A nursing facility must not bill Medicaid until it has written confirmation from DCF that all eligibility determination requirements are met including the patient responsibility determination. All notices of eligibility must be kept on file and must be readily accessible by facility staff. Medicaid reimbursement made to nursing facilities for residents not approved for ICP is subject to recoupment. ... Eligibility for ICP is determined using program-specific technical, financial and medical eligibility criteria.

The above authority explains that the Florida Medicaid Institutional Care Program reimburses nursing facilities for services provided to residents who have

been determined to meet Medicaid ICP eligibility. This authority also explains that the possession of a Medicaid card is not proof that the individual is eligible for institutional care benefits. The petitioner was enrolled in the Family-related Medically Needy Program for the month at issue. She has met the share of cost and although she is Medicaid eligible for April 2008, she was not approved for the ICP Program and therefore, the vendor payment to the facility is not covered. Any other medical bills for April 2008 can be billed to Medicaid if the provider is a Medicaid provider.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 2nd day of September, 2008,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
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Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished

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

PETITIONER,

Vs.

APPEAL NO. 08F-02181

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

CASE NO. 1267089849

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 8, 2008, at 10:30 a.m., in Fernandina Beach, Florida. The petitioner was not present. The petitioner was represented by her nephew, and authorized representative is the assistant business office manager of the nursing facility in which the petitioner resides, The Department was represented by Euzera Foster, ACCESS economic self-sufficiency specialist who appeared by phone. Daina Davis, ACCESS supervisor was present as proxy for Ms. Foster. A continuance was granted for both parties to obtain additional evidence.

A second hearing was scheduled for June 13, 2008. The petitioner's representatives had a scheduling conflict and could not appear. Another continuance was granted by the undersigned hearing officer. Pursuant to notice the hearing was reconvened on August 7, 2008 at 10:40 a.m. in Fernandina Beach, Florida. The

petitioner was not present. The petitioner was represented by her nephew, and her authorized representative . The Department was represented by Pam Jackson and Sara Malone, ACCESS economic self-sufficiency specialists who appeared by phone. Daina Davis, ACCESS supervisor was present as proxy.

ISSUE

The petitioner's representatives are appealing denial of Institutional Care Program benefits for the months of May 2007 through December 2007. The petitioner had the burden of proof.

FINDINGS OF FACT

1. On July 26, 2007, an application for Institutional Care Program (ICP) benefits for the petitioner was submitted by attorney . The attorney was hired by the petitioner's nephew. The application lists the nephew as the petitioner's authorized representative. On August 2, 2007, the Department sent a pending notice to the petitioner at the facility. The pending notice requested verification of the petitioner's last three months banking statements, a letter from the petitioner's treating physician regarding her medical condition, verification of the petitioner's Social Security benefits and explanation of the four asset transfers (totaling $27,000+) shown on the application. The requested verification was to be submitted to the Department by August 13, 2007. Having not received any of the requested verification, the Department denied the ICP application on August 24, 2007.

2. On September 13, 2007 another ICP application was submitted for the petitioner. The assistant business office manager of the nursing home in which the

petitioner resides, _ was listed as the petitioner's new authorized representative on the application and acted on the petitioner's behalf during the application process. On September 14, 2007 the Department issued a pending notice to the authorized representative requesting verification of the petitioner's last three months bank statements including verification of balances before and after transfers, a letter from the petitioner's treating physician documenting her medical condition and completion of forms enclosed with the pending notice. The Department received only one bank statement for the month of July 2007. No verification was received regarding balance transfers. On October 10, 2007, the Department sent another pending notice to the authorized representative requesting August 2007 and September 2007 bank statements for the petitioner be submitted no later than October 29, 2007. The requested verification was not received, the Department denied the September 13, 2007 ICP application on November 11, 2007.

3. On November 13, 2007 another ICP application was submitted for petitioner by the authorized representative. On November 19, 2007, the Department pended the application for verification of all pages of all bank statement for the petitioner for the months of August 2007 through October 2007, current letter from the petitioner's treating physician documenting her medical condition and completion of the financial medical release form enclosed with the pending notice. The petitioner has two banking accounts, one checking and one money market, with the same financial institution. The petitioner is issued individual monthly transaction statements for each account and a separate consolidated monthly statement which shows beginning and ending balances only for both accounts. The Department received consolidated statements for August

2007 through October 2007 and the monthly transaction statements for August 2007 through October 2007 for only the checking account; no individual account transaction verification was received for the money market account. The Department used the consolidated statements which show the petitioner's combined bank balances for both accounts for July 2007 through October 2007 exceeded the $2000 ICP asset limit for the petitioner each month. The November 13, 2007 application was denied due to excess assets on December 27, 2007.

4. On January 2008 another ICP application was submitted for the petitioner by the authorized representative. The application was subsequently approved effective January 2008 ongoing. $689.34 monthly Social Security benefits were budgeted as the petitioner's only income. The Department determined the petitioner's patient responsibility to be $548 monthly.

5. The petitioner's nephew asserted that he never received any communication from the Department in response to the July 2007 application. He is listed on the application as the authorized representative. The Department could only document pending and denial notices were sent to the petitioner at the facility. There is no evidence the notices were sent to the authorized representative. The petitioner is not alert or oriented and is incapable of handling her own affairs. The facility's business office representative did not recall any notices related to the July 2007 application being received for the petitioner. She testified it is the facility's procedure to forward mail for residents who are not alert and oriented to the resident's legal guardian or next of kin.

6. The authorized representative admitted receiving the September 14, 2007 and October 10, 2007 pending notices. She also admitted providing only the July 2007

bank statement to the Department. She asserted that she relayed the verification requests verbally to the petitioner's nephew and submitted to the Department the documentation he provided to her. The petitioner's nephew stated he was working in North Carolina at the time and verbally relayed the verification requests to his wife in Florida and it was his wife who submitted the documentation to the facility. He wasn't aware the verification was not sufficient.

7. Regarding the November 2007 application, the authorized representative acknowledged receiving the November 19, 2007 pending notice and relaying the request verbally to the petitioner's nephew. The petitioner's nephew stipulated to the facts as presented by the authorized representative. He believed he had given the authorized representative the verification that was needed by the Department. He explained that because the bank issues individual statements for each of the two accounts and then issues a consolidated balance statement, he was confused by the multiple statements and did not realize what he submitted was insufficient. The petitioner's nephew does not dispute the balance transfers totaling $27,000(+) shown on the July 2007 application. He explained that the transfers were from the petitioner to her son _____, he was once a joint holder on both accounts. The balances were transferred to the son when he was removed from the accounts. The petitioner's son subsequently died, the nephew could not remember the exact month or year of his death and no documentation was provided to support the nephew's testimony. The authorized representative and the petitioner's nephew acknowledge the combined bank accounts balances exceeded the $2000 asset limit. The nephew explained that he was unaware he should have been paying the petitioner's $548 monthly patient

responsibility to the facility. He believed his lawyer was directly paying the facility or that the expense was being automatically deducted from the petitioner's accounts by the facility. The funds for the patient responsibility accumulated in the petitioner's banking accounts causing the combined balance to exceed the $2000 limit ICP program limit. On January 18, 2008, the petitioner's nephew paid the facility $8000 from the petitioner's bank accounts. After the payment to the facility, the petitioner's remaining combined bank account balance was less than $2,000. The petitioner was subsequently approved for ICP benefits effective January 2008 forward, but denied ICP coverage for May 2007 through December 2007 for the aforementioned reasons.

8. The petitioner's representatives stipulate the first and only hearing request was made on March 26, 2008.

9. During the hearing, it was discovered that in addition to Social Security benefits, the petitioner also receives a monthly civil service pension. The petitioner has been receiving both incomes since prior to the July 2007 initial ICP application. The pension amount in 2007 was $487 monthly and increased to $681.85 monthly effective January 2008. The income was not reported on any of the ICP applications. The Department discovered the pension income while reviewing the evidence submitted by the petitioner's representatives during the hearing. The petitioner's representatives explained that the income was accidentally omitted from the applications. The Department explained that the pension income would be added the petitioner's ICP budget and the petitioner would be notified in writing regarding the resulting change in benefit eligibility.

CONCLUSIONS OF LAW

Fla. Admin. Code 65-2.060, Evidence, states:

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

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

1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
(a) The date on the written notification of the decision on an application.

Fla. Admin. Code 65-2.066, Final Orders, states in part:

(2) The Final Order shall be based exclusively on evidence and other materials introduced at the Hearing or material submitted after the Hearing upon agreement of all parties.

The Findings of Fact show the July 26, 2007 application was denied on August 24, 2007; the hearing request was submitted March 26, 2008 (215 days between notice date and hearing request date). Both parties stipulate to the correctness of this time line. The above legal authorities document that a hearing request must be received within 90 days from the date of notice. The undersigned hearing officer does not have jurisdiction over the denial of the July 2007 application as the appeal was not filed in a timely manner.

The Findings of Facts show the September 13, 2007 application was denied November 11, 2007; the hearing request was submitted March 26, 2008 (136 days between notice date and hearing request date). Both parties stipulate to the correctness of this time line. The above legal authorities document a hearing request must be received within 90 days from the date of the notice. The undersigned hearing officer does not have jurisdiction over the denial of the September 2007 application denial as the appeal was not filed in a timely manner.

Fla. Admin. Code 65A-1.716 (5)(a), Income and Resource Criteria, sets forth the SSI-Related Program Standards to include the asset limit at $2000 per individual.

The Department's manual, 165-22, section 1640.0205, Asset Limits (MSSI, SFP), clarifies that the ICP asset limit is either $2000 or $5000 depending on the income amount. Appendix A-9 of the manual (in effect beginning April 2007) sets forth the $2000 asset limit for ICP when the income is over $749.

The Findings of Facts show the November 13, 2007 ICP application was denied on December 27, 2007; the hearing request was submitted on March 26, 2008. Both parties stipulate to the correctness of this time line. As the request for hearing was filed within 90 days of the notice, the undersigned hearing officer does have jurisdiction over the December 2007 denial. According to the above authorities, the applicable asset limit was $2000. The findings show that the petitioner's asset value exceeded the $2000 ICP program limit. Therefore, the undersigned concludes the Department's denial was in compliance with its policy.

DECISION

The appeal is denied for the reasons detailed in the above conclusions.

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

DONE and ORDERED this 8th day of September, 2008,

in Tallahassee, Florida.

Leslie Green

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

Copies Furnished

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

APPEAL NO. 08F-05148

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 04 Duval
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 28, 2008, at 1:06 p.m., in Jacksonville, Florida. The petitioner was present. The hearing was continued because it was determined that the respondent for this issue, The Agency for Health Care Administration (AHCA), had not been noticed. The hearing was scheduled to reconvene on August 22, 2008, but was continued due to tropical storm Fay. The hearing was reconvened on September 9, 2008 at 2:40 p.m. in Jacksonville, Florida. The petitioner was present and represented herself. The respondent was represented by Celeste Cook, AHCA human service program specialist and Jill Hricz, AHCA senior human service program specialist. Also present was Thomas Gunderson, ACCESS supervisor.

The record was held open until September 22, 2008 for the respondent to submit additional evidence which was received on September 15, 2008 and entered as Respondent's Composite Exhibit 10.

ISSUE

The petitioner is appealing the respondent's decision to deny payment of medical services for October 2007 under Medicaid.

FINDINGS OF FACT

1. The agency declined to pay a medical bill submitted by the petitioner in the amount of $214.70 for the month of October 2007. The agency declined payment in part because the petitioner's medical provider does not accept the type of Medicaid in which the petitioner was enrolled during the service month. The service provider only accepts Medicaid Health Maintenance Organization (HMO) Healthease; the petitioner was enrolled in Medicaid fee-for-service during October 2007.

2. The petitioner was enrolled in Medicaid HMO HealthEase until approximately July 2007. The petitioner's loss of Medicaid coverage was due to imposition of a child support sanction by the Department of Children and Families. The petitioner testified that she was unaware that she was sanctioned. The Department subsequently lifted the sanction and restored Medicaid eligibility for the petitioner for October 2007, but could not re-enroll the petitioner in Medicaid HMO HealthEase as this function is under the jurisdiction of AHCA.

3. The agency explained that September 18, 2007 was the deadline date to enroll in Medicaid HMO HealthEase for the month of October 2007. The petitioner's October 2007 Medicaid eligibility was retroactively reinstated in March 2008 by the

Department of Children and Families. The Agency asserted that retroactive enrollment in Medicaid HMO HealthEase was not possible. The petitioner argued that she has an outstanding debt of $214.70 to the provider that she cannot afford to pay. The petitioner is single, unemployed, the mother of five minor children, attending college--working towards a law degree. The petitioner requested the agency reconsider its denial to retroactively enroll her in Medicaid HMO HealthEase for the month of October 2007 and pay the bill at issue. The agency agreed to contact its Bureau of Managed Health Care for reconsideration of the petitioner's request.

4. The record was left open until September 22, 2008 for the reconsideration decision. On September 15, 2008, the undersigned hearing officer received a letter from the Agency which states in part "Regarding ..She is being segmented retroactively into Medicaid HMO HealthEase for the month of October 2007...I contacted earlier this morning to advise her."

CONCLUSIONS OF LAW

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

Fla. Stat 409.903 Mandatory Payments for Eligible Persons states in part:

> The agency shall make payments for medical assistance and related services on behalf of the following persons who the department, or the Social Security Administration by contract with the Department of Children and Family Services, determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the

availability of moneys and any limitations established by the General Appropriations Act or chapter 216.
(1) Low-income families with children are eligible for Medicaid provided they meet the following requirements:
(a) The family includes a dependent child who is living with a caretaker relative.
(b) The family's income does not exceed the gross income test limit.
(c) The family's countable income and resources do not exceed the applicable Aid to Families with Dependent Children (AFDC) income and resource standards under the AFDC state plan in effect in July 1996, except as amended in the Medicaid state plan to conform as closely as possible to the requirements of the welfare transition program, to the extent permitted by federal law.
(2) A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program (SSI). This category includes a low-income person age 65 or over and a low-income person under age 65 considered to be permanently and totally disabled.

Medicaid Summary of Services Handbook states in part:

Most Medicaid recipients are required to obtain services through managed care.
Recipients who are not required to enroll in managed care obtain services through the Medicaid providers of their choice on a "fee-for-service" basis. Once approved for Medicaid, recipients are sent information on managed care plans in their area.
Medicaid contracts with a private company, ACS, who operates a toll-free Medicaid Options HelpLine, to help recipients enroll or disenroll in Medicaid managed care programs:
-MediPass (Medicaid Provider Access System);
-MPNs (Minority Physician Networks);
-Pediatric Emergency Room Diversion Program;
-HMOs; and
-PSNs.
Florida Choice Counseling also assists children with special health care needs in contacting and enrolling in the Children's Medical Services PSN. Recipients who enroll with a managed care plan are enrolled for a 12-month period beginning on the date of enrollment. They have 90 days, from the date of enrollment, to try the plan and request a change. After the initial 90 days, they must remain with their plan for the next nine months. Only plan changes for "good cause" will be allowed during these nine months. Each 12 months thereafter, recipients will receive notification of

their open enrollment period, which is when they may change plans for the following year.
Recipients may change primary care providers within their current plans at any time. To change their primary care provider, recipients should contact the plan in which they are enrolled (the MediPass Area Medicaid Office or the managed care plans (HMOs, PSNs, MPNs, and Pediatric Emergency Room Diversion Programs) member services office.

While the record was open, the Agency reversed the denial of the petitioner's request for payment of October 2007 medical services. The Agency's reconsideration decision was to retroactively enroll the petitioner in Medicaid HMO HealthEase and pay the bill at issue.

DECISION

The appeal is granted. If action has not already been taken, the Agency is ordered to begin the payment process for the bill at issue within 10 days from the date of this order.

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 30th day of September, 2008,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To:

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

APPEAL NO. 08F-03274

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 August 27, 2008, at 11:32 a.m., in Miami, Florida. The petitioner was not present but was represented by her mother, . program operations administrator, Agency for Health Care Administration (AHCA), represented the respondent. Witnesses for the respondent from Keystone Peer Review Organization (KePRO) were Dr. Rakesh Mittel, consulting physician, and Gary Erickson, registered nurse, KePRO. Carlos Rodriguez interpreted for the petitioner. This hearing was originally scheduled for July 2, 2008, but was continued at the request of the petitioner.

ISSUE

At issue is the respondent's action of April 16, 2008, to deny the petitioner 1,234 hours of private duty nursing (PDN) services for the certification period April 13, 2008 to October 9, 2008. The petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner is a two-year old recipient of Medicaid benefits who suffers from a variety of health problems, including primary pulmonary hypertension, respiratory distress syndrome in newborn, infantile cerebral palsy, primary apnea of newborn and failure to thrive.

2. KePRO is the Peer Review Organization contracted by AHCA to perform medical review for the private nursing and personal care prior authorization program for Medicaid beneficiaries in the state of Florida.

3. On April 16, 2008, Maxim Healthcare Services Inc, as the provider, submitted a request on behalf of the petitioner for 1,234 hours of private duty nursing for the period of April 13, 2008 through October 9, 2008.

4. The request was reviewed by a KePRO physician consultant Board-Certified in Pediatric who determined that there was no medical necessity supporting the request for PDN. On April 16, 2008, the initial denial letter was sent to the petitioner.

5. A request for Reconsideration was submitted and reviewed. A notice was sent to the petitioner on April 24, 2008. The notice upheld the decision to deny the PDN requested hours.

6. The respondent's witness explained that information provided by the petitioner's nursing service provider indicates that the child is now ambulatory, eats by himself and respiratory medications are given only twice daily. The information also reflects that the petitioner's mother does not work and has no medical issues.

7. The respondent's representative acknowledged that the petitioner's mother needs help, but a home registered nurse is not necessary for this help. He suggested that the petitioner's mother could receive assistance from a home health aid (HHA).

8. At the hearing, the petitioner's representative challenged the respondent's assertion that she was not working. The petitioner's representative claims that she works six days a week, Monday through Saturday, from 11:00 a.m. to 6:00 p.m. She also claims that her son does not eat by himself and that he needs constant Oxygen therapy.

9. The respondent's representative noted that this information was not received from the provider and explained that the provider needs to send them clinical and social information that supports the medical necessity for the service.

CONCLUSIONS OF LAW

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

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

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

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

The Home Health Services Coverage and Limitations Handbook (July 2007), page 2-17 states in part:

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

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

Fla. Admin. Code 65-2.056, **Basis for 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.

Testimony provided by the petitioner's mother shows that KePRO received incorrect information from the provider, specifically that she was not working, that he was able to feed himself and that he only needed intermittent oxygen therapy.

The hearing officer finds that the respondent's decision to deny the petitioner 1,234 hours of PDN services for the certification period April 13, 2008 to October 9, 2008 based on the information submitted by the provider was correct. However, given the new information provided during the hearing, the case is being remanded to the respondent for further consideration of the new medical and social information.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11th day of Sept., 2008,

in Tallahassee, Florida.

Alfredo Fernandez

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

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

APPEAL NO. 08N-0117

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on September 4, 2008, at 12:20 p.m., in Miami, Florida. The petitioner was present and represented himself at the hearing along with the assistance of , ombudsman. Present for observation was , ombudsman. Representing the facility was , nursing home administrator. Present as witnesses for the respondent were: Dr. , facility physician; , unit manager; and social worker. The Rule was invoked by , no objections were made.

ISSUE

At issue is whether or not the facility's action of May 29, 2008 to discharge the petitioner is an appropriate action, based upon the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because, "Your health has improved sufficiently so that you no longer need the services provided by this facility."

The nursing home has the burden of proof to establish that the discharge action is consistent with federal regulations.

FINDINGS OF FACT

1. The petitioner is a resident of in Miami-Dade County. The petitioner was admitted to the facility in 2006 after a hospital discharge and complications with diabetes and hypertension. The petitioner is seen by the facility's physician. He has a Jackson Memorial Hospital (JMH) clinic card and he is seen there as well.
2. On May 29, 2008, the facility's physician authorized the facility to initiate the discharge process for the petitioner, as he was found medically ready for discharge.
3. A Notice of Discharge was issued to the petitioner with an intended discharge date of June 30, 2008. The petitioner filed for an appeal of that action on June 10, 2008.
4. At the hearing the physician stated that the petitioner is completely independent in his activities of daily living (ADL). He is ambulatory, can administer his own medication, he feeds himself and he does not require skilled nursing services. The petitioner is out of the facility a great deal of time. He goes shopping and to the north end of the county where he is a deacon at a local Church.
5. The physician states that the petitioner is able to live in the community and can continue to receive medical care in the community. He states that from a

medical standpoint, the petitioner has improved sufficiently where he can live in the community.

CONCLUSIONS OF LAW

42 C.F.R. § 483.12 Admission, transfer and discharge rights states in part:

> (a) *Transfer and discharge-* (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plants or not. (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- (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; (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident ... (iii) Include in the notice the items described in paragraph (a)(6) of this section. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for the transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; ...

The petitioner states that his stomach is "not right" and has problems in standing because he lost his toe on his foot. He feels that he would need a couple of months more at the facility.

The ombudsman expressed concern because of the listing of two locations where the petitioner could be discharged to, instead of the one that is required. The administrator explained in detail both locations listed on the notice and what they could offer to the petitioner.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The notice, as

required, noted the reason for the discharge as "your health has improved sufficiently so that you no longer need the services provided by this facility."

The hearing officer finds that the petitioner presented no medical evidence or testimony to contradict the medical opinion presented by the facility's physician. The physician emphasized that the medical issues that remain, can and are being addressed with medication that he could continue once he is in the community. The notice issued by the facility provided a location, to which the petitioner was to be discharged and therefore, all requirements were found to have been met by the nursing facility.

DECISION

The appeal is denied. Pursuant to 42 C.F.R. § 483.12(7), the "facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility."

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the 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 25th day of September, 2008,

in Tallahassee, Florida.

A. G. Littman

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

Copies Furnished To

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

PETITIONER.

APPEAL NO. 08N-00095

Vs

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 8:30 a.m. on August 5, 2008 at the nursing center , Florida. The petitioner was not present but she was duly represented by her sister, . The respondent was represented by and attorneys. Present as witnesses for the respondent were: M.D.; , speech and language pathologist who is program manager for facility rehabilitation department, , occupational therapist and , facility administrator.

ISSUE

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

FINDINGS OF FACT

1. On May 23, 2008, the petitioner was issued "Nursing Home Transfer and Discharge Notice" advising declaring "Your needs cannot be met in this facility." New

location was to . nursing facility. The Discharge Notice was Respondent's Exhibit 1, as under challenge in Petitioner's Exhibit 1. The notice was signed by the attending physician and brief explanation was: "customer needs cannot be met in this facility." It included listing for Long Term Care Ombudsman Councils and appeal rights.

2. The petitioner has resided at th / for more than three years. She has had open-heart surgery, cerebrovascular accidents, degenerative joint disease, among other multiple health problems. She suffers musculo-skeletal contractures and inability to speak.

3. Her sister, who is also her representative for hearing purposes and her Durable General Power of Attorney using the 2000 New York Statutory Short Form, has attempted to facilitate her care and address medical treatment concerns on her behalf.

4. The petitioner's representative (sister) is highly educated, having credentials along with past employment as a nurse and professor and she holds several academic degrees, including Ph.D. She is not a medical doctor. The petitioner's representative is very sensitive to needs of the petitioner and has been consistently involved in her care planning. She visits frequently but does not live in the facility.

5. The petitioner's personal attending physician, who attended the hearing, is also employed by the nursing facility administration.

6. Since at least late 2007, a brace (or splint) has been medically prescribed by her attending physician for the petitioner's right forearm. It is not a flexible or short brace. It reaches to the elbow area. It is removable. She used it for at least several months, several hours per day, including late 2007 through early 2008. The brace was prescribed, used, and administered, under medical direction of the attending physician

with supervision of occupational therapist and professional nursing staff at the facility. Nursing facility staff placed it on the arm and were responsible for all aspects of the petitioner's care, including the resting brace.

7. In October 2007 and April 2008 her sister noted what she described as some "open cracks" (Petitioner's Exhibit 2, section 9) also indicating "redness" with possible skin breakdown around the area of the brace and she expressed concern about adequacy/cleanliness of that particular brace. She then purchased a shorter and more flexible brace and brought it to the petitioner in April 2008. She truly believed the replacement brace would be more comfortable and would be adequately effective. She wanted the facility staff to use and agree to administer the brace she preferred.

8. The attending physician declined to order the alternate brace she preferred, but she was offered opportunity to sign an "informed consent note" (blank document Respondent's Exhibit 2). The petitioner's representative declined to sign the document. The document is used in normal course of facility business, for a person to decline or reject a medically recommended treatment. It enables the signatory to "...assume the risk and responsibility for injury or loss incurred as a result of my informed decision. I release the Center and all Employees, Affiliates, Agents, Officers, and Directors from liability for this action."

9. The petitioner's representative declined to sign the Informed Consent form and explained it was not adequately completed. On April 20, 2008, in her concern form (Respondent's Exhibit 3 and Petitioner's Exhibit 2, section 9), she said: "I am willing to sign an 'Informed Consent' if the potential harm to the center or release from liability is specific and clearly stated..." Section 15 of Petitioner's Exhibit 2 included the form,

which remained unsigned. On the form, the physician had recommended, "resting hand splint for R hand for up to 8 hours." The sister was offered to "provide her own splint and apply it personally." Possible/probable consequences were "further contracture of the wrist, fingers; hyperextension of finger; pain; skin breakdown." Section 16 showed nursing notations that on April 28, 2008, the attending doctor and the head of the facility rehabilitation department "do not recommend any other splint than the one they have provided..." (meaning - not the one the sister bought and brought to the facility on her own). The nursing notes of April 28, 2008 also showed that the sister did not intend to "come in to apply the splint herself & remove it..." Nursing notes between late April and early May 2008, as submitted into evidence, did not reflect open wounds.

10. On behalf of the petitioner, several other concern forms and memoranda were shared from her sister or an attorney to the facility between October 2007 and May 2008. Some were included in Petitioner's Exhibit 2 and Respondent's Exhibit 3. Petitioner's Exhibit 2, section 8, signed by the petitioner's representative and dated December 30, 2007, included the following:

MEMORANDUM

> SUBJECT: Continued neglect and abuse of my sister...
> ...
> I will repeat my goal as stated in Concern Form dated 11/30-12/17...problems surface everytime her regular CNAs are changed. I have always requested continuity of care but past experiences have shown that multiple CNAs do not provide continuity of care because they do not know her, are not given any supervision (emphasis included), and she cannot talk. I want her pain, suffering, and abuse to end.

11. When the hearing was requested, the Office of Appeal Hearings directed a survey be conducted by the Agency for Health Care Administration (AHCA). Results of

the non-controlling survey were Hearing Officer's Exhibit 1, which had previously been received by the petitioner as submitted in Petitioner's Exhibit 2, sections 3 and 4. Deficiencies were not cited in the AHCA discharge review.

12. On May 8, 2008, doctor's progress notes (Petitioner's Exhibit 2, section 29) showed the following:

> Update – Pts sister (proxy) refused to sign Informed consent for use of her own splint (proxy's) for R wrist as opposed to splint recommended by Occupational Therapy. In addition, proxy has possession of both splints and pt. currently using neither. In view of ongoing multiple concerns with care and other issues, I understand facility has issued a 30 day discharge notice.

13. On May 28, 2008, the doctor's Interim Order Form in section 17 of Petitioner's Exhibit 2, said, "hand splint on hold until further notice." Physician's order of same day (Petitioner's Exhibit 2 section 12) showed, "Discontinue the resting R wrist splint (recommended by OT) against medical advice (AMA) per pt's responsible party)." April 30, 2008, care plan noted, "refusal of splint application..."

14. May 28, 2008, memorandum regarding physician contact was submitted by petitioner's representative to the facility (Petitioner's Exhibit 2, section 13) said in part:

> He went on to inform me that he was discontinuing the order for the splint O.T. gave her, "against medical advice." I again reassured him that I was still willing to sign an informed consent for the splint I bought for her when the Consent form was accurately filled out and completed. I explained to him that I could not be there in the mornings to apply the splint as the form indicated, there are appropriate boxes to be checked, including whether or not I verbalize understanding of the possible/probable consequences of my decision. Dr. ... further stated that he had to discontinue the order because if the State came in they would hold the Center responsible for not carrying it out.
> Dr. ... has never informed me that I was going against medical advice until today when he decided to discontinue the order. I asked to meet with him to discuss the splint and stated that I would follow his recommendation: (see Concern Form Dated 4/20) but he never met with me. He brought

> the Therapists in ... room on 4/23 and told me that I am not the Therapist and should not question what they do. He does not recognize my right to make decisions related to my sister's care. ... has not been wearing a splint since April 23, 2008, although I have also told O.T. that they could provide another splint of their own but not the one she had before.

15. On April 28, 2008 concern form (Respondent's Exhibit 3) said the petitioner "is very sad about not having her splint and I am unable to explain to her the negative attitude O.T., the DON, and her own physician have adopted." She described, in that concern form, that she (sister) "never had the opportunity to meet with Dr... After his meeting with the Administration and the Therapists, he brought them into ... room while she was in bed and an open discussion took place in her hearing. He defended the Therapist's position and I was not afforded a 1:1 discussion with him as I requested. ..."

16. The doctor recalled the April 23 session as about forty minutes of splint discussion, led by him, in which the sister proposed care that he did not agree with because it was medically contra-indicated in his opinion. The occupational therapist also recalled the event and was concerned about the nonprescriptive brace proposed by the sister, and he attempted to justify use of the prescribed appliance rather than the sister's proposed brace.

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. Regarding transfer and discharge rights from a facility, 42 C.F.R. § 483.12 states 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...

42 C.F.R. § 483.10 Resident rights, states in part:

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:...
(b)(4) The resident has the right to refuse treatment, or refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section...

42 C.F.R. § 483.15(b) states in relevant part:

(b) Self-determination and participation. The resident has the right to (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;...(3) Make choices about aspects of his or her life in the facility that are significant to the resident...

The petitioner argued that residents have the right to refuse treatment and to make decisions regarding treatment and that these rights were inappropriately thwarted. The respondent is charged with responsibility to assure its residents are given the appropriate treatment and services. The respondent argued that while a resident has the right to refuse or reject a specific treatment, she does not have the right or responsibility to direct or dictate treatment. An individual can accept or reject care, according to the respondent. The respondent also noted that an individual may reject the medically ordered treatment and replace it with a treatment she then performs on her own, understanding potential consequences. Specifically, in this case, the petitioner's representative might have used her own splint and applied it on her own to the petitioner, but she cannot tell or ask staff to apply it for her. The respondent described the situation as one in which staff can no longer provide adequate care as

family interference has been crippling to staff efforts. The petitioner's representative noted that adequate care could occur if greater effort were taken. The petitioner's representative also argued the clinical record was insufficiently documented on the matter of discharge justification.

In analyzing the situation, it is evident there are serious problems. At a minimum, communication has deteriorated such that no one is satisfied. When the petitioner's representative declared she would sign the Consent Form, she significantly restricted that option, saying she would sign it when it was completed to her satisfaction. That level of satisfaction may never occur, so it may never be signed. Thus, it is inaccurate to conclude that the petitioner's representative will sign the Consent Form. Additionally, when she described the physician as "never" speaking with her about the brace she preferred, the more accurate description would be that he never spoke with her in a situation or setting that she considered satisfactory. The petitioner's representative is correct in saying that she has every right to be involved in care choices and plans. She may not, however, direct such care plans. When a person resides in a nursing facility under medical orders, it is the doctor who directs care provision with nursing staff supervision.

When the physician declined to change his prescription for the wrist brace, there was a profound disagreement with the petitioner's representative as to care. However, he is the attending physician and the petitioner's sister is not the petitioner's physician. If the petitioner's representative had successfully persuaded the prescribing doctor to authorize use of the alternate brace, perhaps the situation would have evolved differently; but that did not transpire, and the situation is now one of serious

disagreement regarding care. The nurse-sister-representative may use the brace she prefers for the petitioner and she may have intimate sensitivity and knowledge about the petitioner and care needs, but she cannot tell or instruct staff members to use the alternative unprescribed brace at times she is not there. The petitioner's representative may reject the doctor's prescription and she may replace it with her own preference under her own control, but she may not direct use by others of the alternate brace.

This situation evokes great sympathy, particularly in view of petitioner's impairments and her representative's affection and knowledge. However, the petitioner's representative's dissatisfaction with performance of administrative staff at the facility represents overwhelming obstacles to adequate care provision. Despite her declaration that satisfaction is potentially achievable, there is no indication of how that could occur with present staff and physician. There is such intense, long lasting and continuous administrative dissatisfaction and displeasure that needs of the petitioner cannot be met at this particular facility with this doctor and this staff. From levels of occupational therapy, rehabilitation therapy, physician, and nursing, dissatisfaction is profound, obvious and noteworthy to great magnitude. Additonally, the clinical record supports such a conclusion with nursing notes, physician notes, and documentation. The respondent has met the burden of proof. Discharge to another facility is justified because this facility cannot meet needs of the petitioner.

DECISION

The appeal is denied and discharge is upheld as issued in the May 23, 2008, notice.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of Sept., 2008, in Tallahassee, Florida.

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

Copies Furnished To: