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

APPEAL NO. 08N-00008

PETITIONER,

Vs.

ADMINISTRATOR

ER

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 21, 2008, at 8:50 a.m., at

er, in Miami, Florida. The petitioner was present and represented himself at the hearing, along with the assistance of s, nephew, and , sister. Also present on behalf of the petitioner was , from the Ombudsman Office. on, director, from Ja represented the facility. Appearing as witnesses for the facility were: ., attending physician; , clinical social worker; an nurse manager

ISSUE

At issue is the January 7, 2008 action by the respondent proposing to discharge the petitioner because his health has improved sufficiently so that he no longer needed

the services provided by the facility. The respondent will have the burden of proof that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12.

FINDINGS OF FACT

1. The petitioner is thirty-nine years old. He was admitted to the nursing facility in July 2003.

2. The petitioner is not eligible for Medicaid benefits due to his immigration status.

3. The facility notified the petitioner on or about January 7, 2008 that he was to be discharged by February 7, 2008. The discharge location was given:

Miami, Florida". This location is the petitioner's sister's home. Currently the petitioner resides at the [illegible]ter. The discharge notice was signed by the petitioner's physician.

4. The petitioner's attending physician testified that the petitioner has been receiving treatment and medication at the facility for severe and numerous medical problems since his discharge from the hospital. He states that the petitioner is completely independent in all activities of daily living and does not require 24-hour a day care.

5. The petitioner is not disputing the discharge issue. Ms. [illegible]xpressed that she needs more time to find another place for her brother to be discharged.

6. The respondent asserted that the facility is working hard to find an appropriate place of discharge. He proposed the [illegible]y and explained that [illegible]nter has contracted with the [illegible] to take patients for up to three months or longer as they have a new program to help people transition back into a normal life.

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:

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

The facility has indicated that the petitioner's health has improved and that he no longer needs skilled nursing care. This was not disputed by the petitioner.

Based on the evidence, the federal regulations and all appropriate authorities set forth in the findings above, the hearing officer concludes that

's proposed action to discharge the petitioner is appropriate, as his health has improved sufficiently that he no longer needs the services provided by the facility.

DECISION

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

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the

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

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

in Tallahassee, Florida.

Alfredo Fernandez

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

Copies Furnished To:

Mr. Harold Williams
Agency for Health Care Administration

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

APPEAL NO. 08N-00006

PETITIONER,

Vs.

Administrator
H
21

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 20, 2008, at 9:00 a.m., in Tamarac, Florida. The petitioner was not present. Present was f is, and D s from the Broward County Long Term Care Ombudsman Council. The respondent was represented by , attorney from (ne, P.A. Also present wa director of social services, and on the telephone was administrator

ISSUE

At issue is the ! action to discharge the petitioner from the facility. Prior to addressing the merits of the case, it is necessary to determine if the petitioner was properly represented at the hearing. The petitioner has the burden of proof concerning his representation.

FINDINGS OF FACT

1. Included in the evidence is statement from the petitioner naming his son, [illegible] as his representative. The petitioner or his son did not attend the hearing.

2. [illegible] and [illegible] from the Broward County Long Term Care Ombudsman Council, was present at the hearing, however they did not have written authorization from the petitioner giving permission for them to represent him at the hearing.

3. The respondent's representative made a motion at the hearing for the hearing officer to conclude that the petitioner abandoned the hearing, due to not appearing, and not having his representative appear at the hearing. The motion was granted.

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.

Fla. Admin Code 65-2.045 states:

> (3) A Request for Hearing may be made by the applicant/recipient or someone in his/her behalf. However, if the appeal is filed by someone other than the applicant/recipient, attorney, legal guardian, spouse, next of kin, the grantee relative in cash assistance, or a person allowed by the Department as an authorized representative to participate in the eligibility determination, the person making the appeal must have written authorization of the applicant/recipient. Such written authorization must accompany the Hearing Request. Should the request be filed without the written authorization, the authorization must be provided in response to a request from the

Department or hearing officer, prior to the appeal going forward. Without prior proper written authorization, the Department will treat a request for hearing as being made by someone not authorized to do so. Therefore, the appeal will be dismissed.

The order scheduling this hearing states that if either party has an authorized representative attend the hearing in their place, the representative is required to have a written statement from the party authorizing them to act on the party's behalf; otherwise , the hearing officer will conclude that the party abandoned the cause.

The petitioner or his representative, who is his son, did not appear for the hearing. The individuals from the Broward County Long Term Care Ombudsman Council were present at the hearing, however, they did not have written authorization from the petitioner allowing them to represent him. The respondent's representative made a motion for the hearing officer to conclude that the petitioner abandoned the hearing, due to not appearing, and not having his representative appear at the hearing. This motion is granted.

DECISION

This appeal is denied, as explained in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 1st day of April, 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 To: [illegible]

[illegible]ent
Ms. Diane Reiland
Agency for Health Care Administration

[illegible]

[illegible]

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

APPEAL NO. 08N-00025

PETITIONER,

Vs.

ADMINISTRATOR

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 13, 2008, at 10:30 a.m., in Tallahassee, Florida. The petitioner was not present bit was represented by her son, . Testifying on behalf of the petitioner were her sons, ery and The respondent was represented by , Director of Nursing and program manager for S Testifying on behalf of the facility was , acting administrator and director of nursing, n, director of social services, G LPN, unit manager, , business office manager, and assistant business office manager. Observing the proceedings was , assistant to director of social services.

ISSUE

At issue is whether or not the facility's action of February 7, 2008 to discharge the petitioner, was correct on the basis of nonpayment for care and services provided.

The nursing facility bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a resident of , Tallahassee, Florida. She entered the facility on July 17, 2007 under Medicare. The petitioner's coverage for nursing home care under Medicare has since ended.

2. On July 18, 2007, an application for Institutional Care Program (ICP) Medicaid assistance on behalf of the petitioner was submitted to the Department of Children and Families. The application was denied.

3. Another application for ICP benefits was filed on behalf of the petitioner on October 17, 2007. The second application was denied on November 21, 2007 based on the contention that the petitioner did not follow through on an application or eligibility review and did not apply for benefits for which she may have been eligible.

4. A third application for ICP benefits was filed on February 19, 2008. As of the date of the appeal, the third application was still pending.

5. As of the date of the appeal, the petitioner's outstanding bill was $38,285.32 for services provided from August 6, 2007 as a private pay resident. The petitioner's representative argued that he was unable to speak with anyone with the Department of Children and Families and that the Department does not return his telephone calls. He

believes more time is needed to complete the application process. The petitioner's income from Social Security has been delivered to the facility toward her unpaid balance.

6. The nursing facility sent a demand notice for payment to the petitioner's representative, [illegible] on December 4, 2007. At that time the amount due from the petitioner was $21,094.52.

7. The facility mailed the petitioner's representative, statements reflecting the balance due on her account and has also notified him of the need for payment of the outstanding amount.

8. On February 7, 2008, the facility, by Nursing Home Transfer and Discharge Notice, notified the petitioner of its intent to discharge her because the bill for services at the facility had not been paid, after reasonable and appropriate notice to pay.

9. The location to which the petitioner was to be discharged was listed on the above notice as home with her family. The nursing facility has stipulated that it will make arrangements through its social services office to insure the safe and orderly transfer of the petitioner to another appropriate living arrangement. The petitioner objects, as she wants to be allowed to remain at the facility.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Federal Regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this

case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility based on non-payment.

Federal Regulations at 42 C.F.R. § 483.12(a) 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...(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;...

The Findings of Fact show that the petitioner has an outstanding balance, owed to the facility, for the cost of her care and that the facility has notified the petitioner's representative of the balance due for the cost of her care. The petitioner's representative argued that more time is needed to complete the application for Medicaid coverage. However, the controlling federal regulations do not address any excusable situations which lead to a balance owed to the facility and therefore are not considered in the ruling.

According to the above authorities, the facility may not discharge except for certain reasons, of which one is when the resident has failed, after reasonable and appropriate notice to pay for the stay at the facility. Therefore, the Hearing Officer concludes that the nursing facility has met its burden to prove that the petitioner has not appropriately paid for her stay at the facility, and that reasonable and appropriate notice to pay for such stay has been made. Therefore, the hearing officer concludes that the discharge action is in accordance with the federal regulations.

DECISION

The appeal is denied. The respondent met the burden of proof to show the discharge reason meets the reasons stated in the Federal Regulation. The facility may proceed with the discharge in accordance with applicable Agency for Health Care Administration requirements, when appropriate placement is found.

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 April, 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

Ms. Barbara Alford,
Agency for Health Care Administration

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

APPEAL NO. 08N-00024

PETITIONER,

Vs.

ADMINISTRATOR

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 3, 2008, at 11:40 a.m., in Boynton Beach, Florida. The petitioner was not present. Representing the petitioner was his son, K. Appearing as a witness was director of benefits programs, V.I.P. Care Management. Representing the respondent was , administrator.

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 and discharge the petitioner because his "bill for services at the 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 B ince June 2005. He is ninety-five years old
2. On February 8, 2008, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner with an effective transfer date of March 9, 2008. The Notice indicated the reason for transfer as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".
3. The respondent explains that at the time of the discharge notice, the petitioner owed $88,496.10. The monthly billing accrues at approximately $5,500.
4. Currently, at the time of this hearing, the amount owed is $102,376. The respondent has received only two partial payments since August 2007; August 2007 and January 2008.
5. The petitioner had been receiving Institutional Care Program (ICP) Medicaid from the Department of Children and Families (DCF) but this was terminated when the petitioner and/or representative failed to recertify. The petitioner has been on private pay since September 2007.

6. When an application for the ICP was submitted by the respondent October 2007, questions arose as to the petitioner's assets. The respondent does not have access to the petitioner's bank statements, the son does.
7. When the asset questions were not addressed, the Department denied the application December 26, 2007, because the "client is over the asset limit of $2,000...."
8. The respondent explains that the monthly billing is sent to the son.
9. The son presents that the ICP application should have been followed up by the facility because it was the designated representative. The facility explains that it assists in the process but it is the ultimate responsibility of the family to provide all required documents.
10. The son presents that in June 2005 he signed a contract that covers his payment responsibilities. The contract was only signed by the son and it had many paragraphs crossed out. These paragraphs were not initialed.
11. Further, the son presents that the facility's accounting is atrocious and they "pad" the bills. He believes there is double billing.
12. Going into the petitioner's bank account is the only money he receives. This includes a monthly Social Security check and monthly pension check. Both total approximately $2,213.

13. The son explains that he has been sending this money to the respondent but there is no verification. The son will provide the respondent with cancelled checks.

14. However, even if the checks were provided, there would be an outstanding balance of over $80,000. This amount the son says is the responsibility of the DCF and the ICP.

15. When DCF denied the ICP application for over assets, the son was not aware that there was $2,000 limit. He says he was not informed of the denial until February 2008.

16. The son has made no payments to the respondent in February or March 2008.

17. The son explains that the DCF used his bank account in determining over assets and not the father's. Business record notes from the respondent (Respondent Exhibit 3) indicate that the DCF requested information about that account because money was being transferred.

18. Lastly, a new ICP application was submitted to DCF for approval but eligibility has yet to be determined.

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 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;

(iv) A statement that the resident has the right to appeal the action to the State....

Pursuant to federal guidelines, the nursing facility issued a Nursing Home Transfer and Discharge Notice to the petitioner February 8, 2008.

administrator, signed this Notice.

The Notice, as required, indicated the reason for transfer or discharge, as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The effective date of the transfer or discharge was given as March 9, 2008. The location to which the petitioner was to be transferred or discharged was given as the son's home or any other skilled nursing facility. This was noted on the Discharge Notice's accompanying cover letter.

It is the family's obligation to secure ICP Medicaid for the resident. The facility will assist in the process.

As the billing statements continued to show an ever increasing balance, the son states that he only provided partial payments because he felt this is all he owed and was responsible for. He wanted the DCF to pay the balance.

As noted, even if the son is able to provide cancelled checks that monthly payments were being sent to the respondent, there is still an outstanding balance of over $80,000. And, there have been no payments made for February or March 2008.

All requirements have been met by the nursing facility. By refusing to make payments and assuming that the DCF must pay its share of the outstanding billing, the son has not met his obligations to pay the respondent.

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 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 14th day of April, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: F

P Respondent

Ms. Diane Kellard
Agency for Health Care Administration

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

APPEAL NO. 08N-00019

PETITIONER,

Vs.

Administrator

ER

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 24, 2008, at 9:24 a.m., at the

er, in North Miami Beach, Florida. The petitioner was not present, but was represented at the hearing by , attorney. Also present on behalf of the petitioner was the petitioner's emergency temporary guardian,

Present for the petitioner was , ombudsman. The respondent was represented at the hearing by , administrator for

Present as a witness for the facility was , owner and clinical director,

ISSUE

The respondent provided notice the petitioner was to be discharged for the following reason: "Your bill for services at the facility has not been paid after reasonable

and appropriate notice to pay..." 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. § 400.0255.

FINDINGS OF FACT

1. The facility notified the petitioner on or about January 25, 2008 that she was to be discharged on February 26, 2008. The discharge location provided was: "Facility of Choice". The petitioner currently resides at . . . , Center. The facility representative, at the hearing, indicated that they had a couple of facilities in mind to discharge the petitioner, but had not started the process to transfer the petitioner to these facilities.

2. The petitioner has a $60,000 outstanding unpaid bill at this facility. The petitioner is considered private pay.

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:

> (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;...

This regulation continues and states in part:

> (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...

Additionally, this regulation continues and states in part:

(a)(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.

As shown in the Findings of Fact, the facility notified the petitioner on or about January 25, 2008 that she was to be discharged on February 26, 2008. The facility had not provided a discharge location on the notice or discharge location as of the date of this hearing.

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 not appropriate as the facility did not provide a discharge location. The facility has not met its burden of proof and is not in compliance with the appropriate federal regulation noted above for this discharge to be appropriate.

DECISION

This appeal is granted and the facility's action is not upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 1st day of April 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 To:

Mr. Harold Williams
Agency for Health Care Administration
OMBUDSMAN DADE COUNTY

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

APPEAL NO. 08N-00001

PETITIONER,

Vs.

CASE NO.

Administrator

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 13, 2008, at 9:47 a.m., in Lakeland, Florida. The petitioner was not present. She was represented by her daughter, . The facility was represented by [administrator. Present as a witness for the petitioner was her daughter, . Present as witnesses for the facility were orn, director of nursing; , risk manager; , unit L.P.N.; and '), risk manager.

ISSUE

At issue is the December 17, 2007 action by the nursing home proposing to discharge the petitioner for endangering the safety of other individuals in the facility. The burden of proof lies with the facility to prove that the discharge complies with the applicable laws.

FINDINGS OF FACT

1. On December 17, 2007, the nursing home issued a Nursing Home Transfer and Discharge Notice to the petitioner. The discharge notice indicated that the facility was proposing to discharge the petitioner due to her "endangering the safety of other individuals" in the facility. The notice was signed by the medical director and the administrator. The facility proposed discharging the petitioner on January 18, 2008.
2. The facility submitted copies of nursing notes from the petitioner's medical records. These notes outline multiple incidents of violation of the facility's cigarette smoking policies. The petitioner is on oxygen so when she smokes the oxygen must be removed. She requires supervision of her smoking due to cognitive deficits. The cigarettes are to stay at the nurse's station since the petitioner requires supervision of her smoking.
3. The medical records showed the following violations of the smoking policy:

   Smoking incidences:

9/12/07	smoking in room
9/17/07	smoking in room
9/23/07	smoking in bathroom
10/23/07	smoking while walking down the hall
11/17/07	found with new pack of cigarettes
11/21/07	smoking while sitting on bed
12/07/07	sitting on porch smoking unsupervised
1/3/08	sitting on porch smoking unsupervised
1/4/08	sitting on porch smoking unsupervised
1/9/08	sitting on porch smoking unsupervised
1/11/08	sitting on porch smoking unsupervised

4. Testimony by staff at the facility and the medical records reflect negative interactions between staff and the resident's sisters. Recorded incidents

report friction between nursing staff and the sisters. The cause of the friction was the staff's treatment of the petitioner, visiting hours, smoking rules, and interactions with other residents. The staff complains that the sisters threaten to sue them and they "fear" for their jobs.

5. The facility had the "family" sign an agreement on July 11, 2007 trying to set boundaries for the interactions of family members with the facility. The family agreed to visiting hours between 8:00 am and 8:00 pm; agreed not to bring sodas to other residents with dietary restrictions; agreed not to photograph other residents or common areas; agreed not to offer cigarettes to other residents; and to not make threatening statements or gestures to any staff member. The family was asked to help ensure that the petitioner followed the rules regarding cigarette smoking.
6. The evidence establishes that the sisters supply the petitioner with cigarettes that should be held at the nursing station, and they leave her smoking unsupervised on the porch. The family views the petitioner's smoking as a habit that she is entitled to "at her age". They believe that the facility should be more equitable in the application of the "rules" regarding smoking. They assert that other residents violate the rules and are not "singled out." The petitioner does not dispute that the incidents occurred or that the petitioner requires supervision to smoke safely.

CONCLUSIONS OF LAW

Federal Regulation limits the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case the petitioner was

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

> (2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...
> (iii) The safety of individuals in the facility is endangered;

The facility documented incidents by the petitioner that led to the facility issuing a notice for discharge. The documentation included multiple violations of the facility's smoking policy. Neither party disputes that the petitioner should not be smoking without supervision. The petitioner is a risk to herself and to others since she repeatedly smokes in unauthorized areas without supervision. Therefore, the hearing officer concludes that the facility established that the discharge is warranted based on the petitioner's uncontrolled smoking behavior.

DECISION

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

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the 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 1st day of April, 2008,

in Tallahassee, Florida.

Terry Oberhausen

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

Copies Furnished To: E

Ms. Patricia Reed Caufman, Agency for Health Care Administration

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

APPEAL NO. 08N-00016

PETITIONER,

Vs.

ADMINISTRATOR
E

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 19, 2008, at 8:40 a.m., in Gulf Breeze, Florida. The petitioner was not present. She was represented by her daughter, . The respondent was represented by ey, nursing home administrator. Testifying on behalf of the respondent was le, social worker; J , assistant administrator, and y, business office manager.

ISSUE

At issue is whether or not B ier's action of January 10, 2008 to discharge the petitioner, was correct on the basis of nonpayment for care and services provided.

The nursing facility bears the burden of proof.

FINDINGS OF FACT

1. The petitioner is a resident of [redacted] Florida. She entered the facility on June 5, 2007 under Medicare. The petitioner's coverage for nursing home care under Medicare expired in August 2007.

2. On September 25, 2007, the facility admissions coordinator applied for Institutional Care Program (ICP) Medicaid assistance on behalf of the petitioner through the Department of Children and Families. Additional information was due to the Department on October 8, 2007. The petitioner was determined ineligible for ICP and Medicaid benefits based on failure to verify value of assets and failure to follow through on an application and in establishing eligibility on October 31, 2007.

3. The facility filed another application for ICP benefits on behalf of the petitioner on November 20, 2007. An appointment was set with the petitioner's representative, by notice dated November 26, 2007. The appointment was scheduled for December 5, 2007. The petitioner was pended for additional information on December 27, 2007 due to the Department by January 7, 2008. The petitioner's application was denied on January 14, 2008 for failure to verify asset value and failure to follow through in establishing eligibility.

4. A third application for ICP benefits was filed on January 15, 2008. The petitioner was given until February 8, 2008 to supply information to the Department necessary for a determination of eligibility retroactive to August 2007. On March 11, 2008, an extension was granted until March 21, 2008. The information needed to

process the application was proof of a qualified Irrevocable Medicaid Income Trust. As of the date of the hearing, the petitioner has not completed the application process for ICP and Medicaid benefits.

5. As of the date of the appeal, the petitioner's outstanding bill was $34,347.84 for services provided from August 31, 2007 as a private pay resident. The petitioner's representative argued that she needed more time to complete the application process. The petitioner's income has been used by the petitioner's community spouse to meet his obligations. The only payment met by the petitioner is a payment of $300 received by the facility on December 7, 2007. Beginning March 2008, the petitioner's Social Security check in the amount of $1,054 was deposited directly to her resident trust account at the facility. The balance remaining in the trust account is $1,054.

6. The facility mailed the petitioner statements reflecting the balance due on her account and has also notified the petitioner of the need for payment of the outstanding amount.

7. On January 10, 2008, the facility, by Nursing Home Transfer and Discharge Notice, notified the petitioner that she was being discharged because her bill for services at the facility had not been paid, after reasonable and appropriate notice to pay.

8. The location to which the petitioner was to be discharged was listed on the above notice as home with her family. The nursing facility has stipulated that it will make arrangements through its social services office to insure the safe and orderly

transfer of the petitioner to another appropriate living arrangement. The petitioner objects, as she wants to be allowed to remain at the facility.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Federal Regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent/facility based on non-payment.

Federal Regulations at 42 C.F.R. § 483.12(a) 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...(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;...

The Findings of Fact show that the petitioner has an outstanding balance, owed to the facility, for the cost of her care and that the facility has notified the petitioner of the balance due for the cost of her care. The petitioner's representative argued that she was not given enough time to complete the application for Medicaid coverage. However, the controlling federal regulations do not address any excusable situations which lead to a balance owed to the facility and therefore are not considered in the ruling.

According to the above authorities, the facility may not discharge except for certain reasons, of which one is when the resident has failed, after reasonable and appropriate notice to pay for the stay at the facility. Therefore, the Hearing Officer concludes that the nursing facility has met its burden to prove that the petitioner has not appropriately paid for her stay at the facility, and that reasonable and appropriate notice to pay for such stay has been made. Therefore, the hearing officer concludes that the discharge action is in accordance with the federal regulations.

DECISION

The appeal is denied. The respondent met the burden of proof to show the discharge reason meets the reasons stated in the Federal Regulation. The facility may proceed with the discharge in accordance with applicable Agency for Health Care Administration requirements, when appropriate placement is found.

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 April, 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

Ms. Barbara Alford,
Agency for Health Care Administration

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

[redacted]

APPEAL NO. 08F-00659

PETITIONER,

Vs.

CASE NO. 1237425212

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on April 8, 2008, at 9:35 a.m., in Cocoa, Florida. The petitioner was not present. represented her. Stacy Robinson, district legal counsel, represented the respondent. Kane Lamberty, senior human services program specialist, and Bobbie VanCott, ACCESS supervisor, appeared at witnesses for the respondent.

The record was left open for 10 days to give the counsel for the petitioner the opportunity to submit parts of the redacted deposition of It was received timely, entered into evidence as the Petitioner's Exhibit 4, and the record was closed.

ISSUE

At issue is the action taken by the respondent on January 18, 2008 to deny the petitioner's application for Institutional Care Program (ICP) Medicaid based on the contention that her assets exceeded the Program limit, specifically, the value of her land trust. The petitioner holds the burden.

FINDINGS OF FACT

1. On September 4, 2007, an application for Institutional Care program (ICP) benefits through the Medicaid program was submitted to the Department on the petitioner's behalf. For an individual to be eligible to receive benefits through ICP the individual's available asset must be below program limits.

2. The petitioner created a revocable land trust for which the petitioner is the beneficiary. The petitioner funds were used to buy a partial interest in a piece of non-homestead property that is held in the land trust. It is not disputed that it was purchased for fair market value, or that it is returning income at fair market value. The U.S. Department of Housing and Urban Development Settlement Statement shows , Trustee of the G ı Land Trust dated August 10, 2007 was the buyer of 18.2 percent undivided interest in property located in Levy county. This settlement statement shows the buyer paid $53,000 for the interest. The Petitioner's Exhibit 1 is a document titled, " , Land Trust Dated August 10, 2007." Hereafter, it will be referred to as the land trust document. The land trust document shows that the trustee would "take title to the Property in accordance with the provisions of Section 689.071, Florida Statute."...

3. The land trust document on page two shows that the beneficiary has the power to direct the Trustee: to deal with all matters relating to the property in the trust with no liability to the Trustee, to manage, possess, use and control the Property, receive the earnings generated by the property, and enjoy all rights and privileges as if the Beneficiary was the legal and equitable owner of the Property. Such rights and powers, as well as the interest of the Beneficiary under this Trust Agreement, shall be personal property..." The petitioner can revoke or amend the Trust Agreement at any time.

4. The Department's policy manual does not contain any policy regarding land trusts. When the Department staff received the land trust document and the Petitioner's Exhibit 2, the Lease Agreement, they sought guidance from the Department's program office on whether to classify the asset in question as income producing or personal property, and what exclusions would apply. The Lease Agreement is between the Trustee of the land trust and Elder Planning Income Concepts, LLC.

5. The local program specialist in the policy unit who specializes in SSI-Related Medicaid researched the issue and asked the district legal counsel for an opinion on how to define the petitioner's partial interest in the property in the land trust before he submitted a policy clearance requesting guidance from the program office in Tallahassee. District legal opined that the land trust was personal property even though it was income producing. The land trust document and the Florida Statute refer to the land trust as personal property.

6. The Respondent's Exhibit 4 is the policy clearance that was issued on December 28, 2007. One of the questions raised by the specialist was to find out if the personal property was considered an item of unusual value, to receive interpretation on

applying the exclusions that apply to the value of the personal property. Central Office concurred that the land trust was personal property and cited Florida Statute 689.071 and terms of the trust itself as justification to define it that way. The opinion of the author of the clearance cited " The Center for Medicare and Medicaid Services Headquarters agree it is appropriate to evaluate the land trust as personal property if provided in the Florida statute".

7. The petitioner's assets include a car, a checking account, a life insurance policy, a home, and the land trust. The Department excluded the petitioner's car valued at $6,675, a NY life insurance policy valued at $1,000, and her home valued at $120,000. The Department counted assets of $49,783.10, which includes her checking account valued at $955.10 and determined the countable value of the land trust as $48,828.00. The applicable asset limit for ICP is $2000 (Respondent's Exhibit 3). Because this amount exceeded the asset limit, the Department denied the petitioner's application for ICP benefits. Notice of the Department's decision was sent on January 18, 2008.

8. A hearing was requested on the matter on January 24, 2008.

CONCLUSIONS OF LAW

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

> (15) Trusts...
> (c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of

> the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income.

The Department's Integrated Policy Manual, 165-22, guides the respondent on the process to analyze a trust in passage 1640.0576.02, How to Analyze Trusts (MSSI, SFP) and states:

> How to count funds held in a trust, whether as income or assets, depends on several factors:
> 1. who created the trust;
> 2. when it was created;
> 3. whether the trust is revocable or irrevocable; and
> 4. the conditions and terms of the trust.

The Department's Integrated Policy Manual, 165-22, section1640.0576.07 Trusts Established On or After 10/1/93 (MSSI, SFP), states in part:

> "If the trust is revocable:
> 1. Consider the entire principal as an available asset to the individual.
> 2. Consider any payments which can be made as countable income to the individual.
> 3. Consider any other payments from the trust as assets disposed of by the individual without fair compensation."

The findings show that the trust was created on August 10, 2007, it is revocable and it was created by and between the petitioner and her daughter. The above policy sets forth that the entire principal of the trust is considered an asset available to the applicant when it is revocable, created after 10/1/93 and either created by the individual, the spouse, or someone with legal authority, or a person acting at the direction of the applicant or spouse.

As the trust is revocable and the value available to the petitioner, a determination needs to be made as to whether the funds in the trust can be excluded under another provision.

The petitioner argued that the value of the trust should be excluded as income producing property.

Real property and the exclusion of income producing property are discussed in the Department's Integrated Policy Manual, 165-22, sections 1640.0577, 1640.0578 and 1640.0544. The Department's Integrated Policy Manual at 1640.0548, Income Producing Property (MSSI, SFP), states:

> Any income producing property (including equipment) may be excluded from assets if it annually produces income consistent with its fair market value. The individual's statement that the property produces a reasonable return may be accepted. If the rate of return is questionable, the eligibility specialist must require verification from a knowledgeable source. The following types of income producing property may be excluded:
> 1. Property that annually produces income consistent with its fair market value, even if used only on a seasonal basis. Such property shall include rental and vacation homes.
> 2. Property such as farmland, or work related equipment that is essential to the applicant/recipient's employment or self-employment.
> 3. Non-liquid assets against which a lien has been placed as a result of a business loan. The security or lien agreement must prohibit the applicant/recipient from selling the asset(s). This exclusion is limited to non-liquid assets such as land, crops, buildings, timber, farm equipment or machinery.
> 4. Real or personal property, directly related to the maintenance or use of an income producing vehicle. Only that portion of real property determined necessary for maintenance or use is excludable.

The argument is that the exclusion in paragraph 1 applies. "Property that annually produces income consistent with its fair market value, even if used only on a seasonal basis. Such property shall include rental and vacation homes." The Department's interpretation is that this exclusion only applied to real property owned by

the applicant. The petitioner argued that this should be applied as the trust owned real property. The policy language cited above and the Department's interpretation that this exclusion only applies to real property is consistent with the wording of the exclusion and the examples given; the only mention of personal property being excluded is in paragraph 4 in connection with maintenance or use of an income-producing vehicle. The hearing officer concluded the exclusion in paragraph 1 only applies to real property.

The petitioner argued that the real property exclusion should be applied to the Land Trust. Case law was presented to support the argument. The undersigned does not agree that the case law would be controlling as it deals with whether property in a land trust can be classified as homestead property. This is not the issue in this case and it should also be noted that the property in the land trust is non-homestead property.

The Florida Statute cited in the land trust is Florida Statute 689.071 Florida Land Trust Act and states:

> (2)(d) 'Land trust' means any express written agreement or arrangement by which a use, confidence, or trust is declared of any land, or of any charge upon land, under which the title to real property, both legal and equitable, is vested in a trustee by a recorded instrument that confers on the trustee the power and authority prescribed in subsection (3). The recorded instrument does not itself create an entity, regardless of whether the relationship among the beneficiaries and the trustee is deemed to be an entity under other applicable law...
> (6) PERSONAL PROPERTY.--In all cases in which the recorded instrument, as hereinabove provided, contains a provision defining and declaring the interests of beneficiaries thereunder to be personal property only, such provision shall be controlling for all purposes when such determination becomes an issue under the laws or in the courts of this state.

The Department's clearance on "Treatment of a Land Trust" is dated December 28, 2007 and states in part:

> **Background**: We have an application for SSI-Related Medicaid that includes a Land Trust which holds a partial interest in a rental property for the benefit of the applicant. The trust specifies that it is governed by Florida Statute 689.071 and that the interest of the beneficiary shall be considered personal property. The partial interest in the rental property has been verified to have been purchased for fair market value and is returning income at fair market value. ...
> **Questions and Answers**:
> **Question 1**: Should the property held by the land trust be considered an item of unusual value under personal property policy, or as income producing property under 1640.0548?
> **HQ Response**: We agree the land trust property should be treated as personal property. Florida Statute 689.071 defines a land trust as "any express written agreement or arrangement by which a use, confidence, or trust is declared of any land, or any charge upon land, under which the title to real property, both legal and equitable, is vested in a trustee by a recorded instrument...." As you noted, the statute also provides that if the recorded instrument contains a provision declaring the interest of beneficiaries to be personal property, it is to be treated under state law as personal property should it become an issue under the laws of the state. The land trust document in this case includes such a provision in the final paragraph on page 2 where it states '[s]uch rights and powers, as well as the interest of the Beneficiary under this Trust Agreement, shall be personal property.' The Center for Medicare and Medicaid Services Headquarters agree it is appropriate to evaluate the land trust as personal property if provided for in Florida statute.

Based on these arguments, the hearing officer concludes the land trust is personal property and not eligible to be excluded in the eligibility process as income producing property. The only other exclusion to be considered is an exclusion under personal property.

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

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions: ... (2) Exclusions. The department follows SSI policy prescribed in 20 C.F.R. Part 416 in determining what is counted as a resource with the following exceptions, ...

Federal Regulations at 20 C.F.R. Part 416.1216, states in relevant part:

> ...(2) Such items include but are not limited to: Personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments. We also do not count as resources items of cultural or religious significance to an individual and items required because of an individual's impairment. However, we do count items that were acquired or are held for their value or as an investment because we do not consider these to be personal effects. Such items can include but are not limited to: Gems, jewelry that is not worn or held for family significance, or collectibles. Such items will be subject to the limits in §416.1205.

The regulation provides for counting the value of personal items that are acquired for, or are held for their value, or as an investment. The land trust meets this definition and therefore would not be entitled to exclusion.

20 C.F.R. 416.1205, Limitation on resources, states in part:

> ...(c) *Effective January 1, 1985 and later.* The resources limits and effective dates for January 1, 1985 and later are as follows: ... Effective date ... Jan. 1, 1989 ... Individual ... 2,000.

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

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

The above authorities set forth the applicable ICP asset limit at $2000 for an individual. Therefore, the undersigned concludes that the Department correctly denied the ICP request due to countable assets exceeding the limit.

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 23rd day of April, 2008,

in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To: [illegible]
District 7 ACCESS Cassandra Johnson

Stacy Robinson, Esq.

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

APPEAL NO. 08F-00922

PETITIONER,

Vs.

CASE NO. 1263654509

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on March 12, 2008, at 1:15 p.m., in Sebring, Florida. \

, represented the petitioner. Griselda Penn, economic specialist I, and Barbara Haley, economic specialist supervisor, represented the Department.

The record was left open for additional documentation. It was received, entered into evidence as the Petitioner's Exhibit 4 and the record was closed.

An Order to Reconvene Hearing was issued on April 1, 2008. The hearing was reconvened on April 14, 2008, at 12:55 p.m., in Sebring, Florida. V

, represented the petitioner. No one from the Department

appeared at the reconvened hearing. The hearing proceeded with testimony given by the petitioner's representative.

ISSUE

At issue is whether the Department correctly denied Institutional Care Program Medicaid benefits for May, June, and July 2007, based on the contention that the petitioner's assets exceeded the Program limits. The petitioner holds the burden.

PRELIMINARY STATEMENT

Prior to hearing the merits of this case, jurisdiction had to be established. The Notice of Case Action under appeal is dated September 4, 2007. The date of the hearing request on record is February 5, 2008. Testimony and evidence revealed that the designated representative at the time of the application, [illegible]er, requested a hearing on September 7, 2007. [illegible] made another hearing request on December 3, 2007. The appeal was timely filed and the hearing proceeded.

Another matter of jurisdiction was raised concerning who requested the hearing. The Department produced a self-designated representative form showing had authorization to act on the petitioner's behalf throughout the eligibility process as her representative. He no longer works for [illegible], so he did not attend the hearing he requested. The record was left open in order to give [illegible] the opportunity to provide written documentation from the petitioner's spouse that he was acting in her behalf. The petitioner passed away last year. [illegible] provided a Designated Representative form signed by [illegible] It was accepted as the Petitioner's Exhibit 4.

FINDINGS OF FACT

1. On June 4, 2007, an application for Institutional Care Program (ICP) Medicaid was submitted to the Department on the petitioner's behalf. Retroactive ICP was requested for May 2007. To determine eligibility for ICP benefits, the Department must consider among other things, the assets of the petitioner and her husband, the community spouse.

2. The Respondent's Composite Exhibit 2 contains the verifications of various assets held by the petitioner and her husband. It also contains the Running Record Comments from June 4, 2007 through August 31, 2007. The Department records case narratives in the Running Records Comments, known as CLRC. An entry on July 20, 2007, shows that the Department received a level of care effective May 4, 2007, and information concerning the couple's IRA's, CD's and saving account statements. The worker noted that the community spouse had a savings account and a CD at MidFlorida, two IRA's that he would receive distribution income of $208.94 from Protective, and $203.78 from AG Edwards, starting in October 2007, and one IRA that he would retain as an asset. The petitioner had an IRA with Protective that would generate a distribution of $158.09 a month, and an IRA with AG Edwards that would have a distribution of $27.83 beginning in October 2007. The community spouse also has an investment account with Edward Jones. The Department determined that the petitioner's assets exceeded the limit for ICP benefits. The worker determined that "We have to count the IRA's because they will not get the distribution until 100107 and it is to *[sic]* far ahead and the system won't allow to enter the info. Case denied".

3. On August 10, 2007, the distribution dates were changed from the start date of October 1, 2007, to the start date of August 31, 2007. On August 31, 2007, an entry in CLRC shows that the Department received the new distribution forms, updated the computer, and authorized ICP Medicaid effective August 1, 2007. The application date became August 8, 2007. Notice was sent on September 4, 2007, informing the petitioner that ICP was approved for August 2007 and ongoing, but denied for May, June, and July 2007 because the asset values exceeded the Program eligibility limits (Petitioner's Exhibit 2).

4. The Department believes that the petitioner and the community spouse received interest only from the four IRA's in question, and no distributions until August 31, 2007, therefore, she was not eligible for ICP until then.

5. The petitioner has the following assets: a checking account at Independent Bank with a balance of $427.24 as of May 7, 2007, an IRA with Protective worth $16,125.10, and an IRA with AG Edwards valued at $2,838.57 (Respondent's Composite Exhibit 2 and Petitioner's Composite Exhibit 6). Without counting the IRA's, the petitioner has total assets of $427.24. If the IRA's are included, she has total assets of $19,391.31.

6. The petitioner's husband has the following assets: life insurance at New York Life with a cash value of $2,910.91, insurance at MONY valued at $6,331.47, and life insurance through the Veteran's Administration totaling $8,842.73. His checking account at I pendent Bank had a balance of $2,693.15 on May 7, 2007, which includes income of $868.70. He owns a $10,000 CD at nd a savings account with a $2,251.03 balance at the same bank. He has an AG Edwards account

with a $12.02 balance and another IRA account there with a balance of $62,465.50, which does not make a periodic payment. He has an IRA at Protective with a balance of $19,648.21 making an annual payment. The petitioner's representative believes this IRA is exempt when valuing assets because of its annual distribution. The asset limit for the community spouse is $101,640. Counting the IRA at Protective, the community spouse's assets total $114,899.10. If it is excluded as an asset due to making a periodic payment, the community spouse's assets total $95,806.81. The Department was not present to state its position as to how it counted the petitioner's and community spouse's assets.

7. The Petitioner's Exhibit 5 consists of four-Form 1099-R from 2006. These forms show gross distributions of $118, $739.79, $357, and $843.82 paid to the petitioner or her husband. The forms define these monies as "Distributions from pensions, annuities, retirement, or profit-sharing plans, IRA's, insurance contracts, etc." The petitioner's representative believes that the IRA's made periodic payments in 2006 on an annual basis and would have been again in 2007. If they had not made periodic or annual payments in 2006, he would agree with the Department's decision to deny benefits.

8. There is no definition of "periodic payment" in the Department's manual. The Department was not present to rebut the petitioner's interpretation of periodic payment.

CONCLUSIONS OF LAW

Florida Administrative Code 65A-1.710, SSI-Related Medicaid Coverage Groups, defines coverage groups and states in relevant part:

> (2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and

income as provided in 42 C.F.R. §§ 435.211 and 435.231 Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

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

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C. ...
(4) Spousal Impoverishment. The department follows 42 U.S.C. § 1396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse. Spousal impoverishment policies are not applied to individuals applying for, or receiving, HCBS waiver services, except for individuals in the Long-Term Care Community Diversion Program, the Assisted Living Facility waiver or the Cystic Fibrosis waiver.
(a) When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility.
(b) At the time of application only those countable resources which exceed the community spouse's resource allowance are considered available to the institutionalized spouse.
(c) The community spouse resource allowance is equal to the maximum resource allocation standard allowed under 42 U.S.C. § 1396r-5 or any court-ordered support, whichever is larger.

Florida Administrative Code 65A-1.716, Income and Resources, states in relevant part:

(5) SSI-Related Program Standards.
(a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:
1. $2000 per individual. ...
(b) The income standard which applies to an individual under the HCBS waiver programs, ICP and Hospice is 300 percent of the SSI FBR for an individual.
(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.

The Department's Integrated Policy Manual, 165-22, Appendix A-9 sets forth the eligibility standards for SSI-Related Programs. The applicable chart for May, June, and July 2007 was effective April 2007 and shows the Community Spouse Asset Allocation Standard at $101,640. The same chart shows the ICP asset limit for an individual at $2,000.

The Department's Integrated Policy Manual, 165-22, section 1640.0205 Asset Limits (MSSI, SFP), states:

> Total countable assets for an individual or a couple must not exceed $2,000 or $3,000 respectively. ... 4. for ICP, PACE, and Hospice individuals (admitted to an institution on or after September 30, 1989) and for Assisted Living Waiver (ALW) individuals (applying for ALW Medicaid on or after July 1, 2003) with community spouses, the individual's assets must not exceed $2,000 after the community spouse's asset allocation allowance is subtracted from the couple's total countable assets. For ICP-MEDS, the asset limit cannot exceed $5,000 for the institutionalized individual, after allocation of the assets to the community spouse.

The Findings of Fact show that the Department denied the ICP Medicaid request for the months of May, June and July 2007 due to exceeding the ICP asset limit. The Findings show that the petitioner has a community spouse. According to the above authorities, when an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility. At the time of application only those countable resources which exceed the community spouse's resource allowance are considered available to the institutionalized spouse. The community spouse's resource allowance for the time period at issue was $101,640 and the institutionalized spouse's resource limit was $2,000. The Department determined the assets to consider available to the

institutionalized spouse were in excess of $101,640, but offered no testimony to support that position.

The Department's position at the initial hearing was that the full value of the IRAs had to be counted as a resource as there was no distribution of income for the months at issue. There was no other eligibility issue presented that caused ineligibility other than the fact that the IRAs were a counted asset. The Department chose not to attend the reconvened hearing and therefore, offered nothing further to rebut that the annual distribution met the periodic payment requirement to exclude the IRA value.

The petitioner's position is that the value should be excluded as a resource as there was distribution, although it was only the minimum required by the IRS on an annual basis and was distributed in December 2006. The evidence supports this position as both the petitioner and her husband's IRAs had an annual distribution in December 2006, with the exception of the one IRA of the husband's valued at $62,465.50 which is a counted asset.

The Department's Integrated Policy Manual, 165-22, section 1640.0505.04 Retirement Funds (MSSI, SFP), states:

> Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., retirement plans administered by an employer or union, disability, or pension). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals (sometimes referred to as Keogh plans).
> Retirement funds must be considered as an asset or as income, unless they are considered unavailable. Retirement funds purchased on or after April 1, 1995, may be regarded as a transfer of assets under certain conditions (see special policy on ICP, etc., below).
> If an individual is eligible to receive regular periodic payments from a retirement fund, the payments are considered unearned income and the fund is not considered an asset to the individual. (If the individual is

eligible to receive payments but elects not to, he is ineligible due to failure to file for other benefits to which he is entitled.) If the individual is not eligible to receive periodic payments from the fund, the funds are considered an asset in the amount that is currently available. Any penalty imposed due to early withdrawal can be deducted when computing the value of the funds, but any taxes due are not deductible.
A retirement fund is not an asset if an individual must terminate employment in order to obtain any payment.
Retirement funds that are unavailable as assets or income due to legal restrictions are NOT counted (e.g., an individual must be a certain age to receive benefits). The ESS must obtain a written opinion from District Legal Counsel on availability.
In the month a previously unavailable retirement fund becomes available, it is neither an available asset nor income unless a periodic payment is received. If a periodic payment is received, it is considered unearned income. In the month following the month the fund becomes available, the fund must be considered an available asset to the individual unless periodic payments begin, in which case the payment is considered unearned income.
For example, the client owns an IRA which is unavailable until he turns age 59 in December. He must begin to receive periodic payments in January or the IRA will be considered an available asset to him. If he receives periodic payments, the payment is considered unearned income to him beginning in January, and is not considered an asset in December.
Refer to Chapter 1800 for policy on how to consider interest earned on retirement funds.
The following policy applies to ICP, institutionalized MEDS-AD, and HCBS only:

1. If a retirement fund purchased on or after 04/01/95 is established within the transfer of assets look-back period, an evaluation must be done to determine if the individual can expect to receive fair compensation from the fund in his lifetime (see passage 1640.0609.02).
2. If the individual can expect to receive fair compensation from the retirement fund in his lifetime, no transfer of assets (or income) has occurred. If he cannot expect to receive a fair return in his lifetime, the establishment of the account must be regarded as a transfer of assets. ...

The Department's Integrated Policy Manual, 165-22, section 1640.0505.05

Retirement Funds of Spouses (MSSI, SFP), states:

The following policy applies to the MEDS-AD, QMB, SLMB, QI1, QI2, EMA, Protected Medicaid, Medically Needy, and Working Disabled Programs: Pension funds owned by an ineligible spouse are excluded

from assets for deeming purposes; however, any income received is still deemed. Refer to Chapter 2200 for policy on deeming exclusions. The following policy applies to ICP, institutionalized MEDS-AD, institutionalized Hospice and HCBS Programs when the applicant has a community spouse (refer to Glossary, Chapter 4600, for definition):

1. At the time of application, if the community spouse receives periodic payments from the retirement funds he owns, the funds are not considered an asset when computing the couple's total countable assets. The periodic payment is considered unearned income to the community spouse when computing the community spouse income allowance.
2. At the time of application, if the community spouse does not receive periodic payments from a retirement fund he owns, but he has the option of withdrawing a lump sum, the total value of the funds must be considered an asset when computing the couple's total assets and the community spouse's asset eligibility. Early withdrawal penalties are excluded from the value of the funds, but any imposed taxes cannot be deducted.

The Social Security Program Operations Manual System (POMS) at SI01120.210, Retirement Funds, defines periodic retirement benefits as:

> "Periodic retirement benefits are payments made to an individual at some regular interval (e.g., monthly) and which result from entitlement under a retirement fund."

The Department has approved ICP ongoing ICP eligibility. According to the above authorities, if an individual is eligible to receive regular periodic payments from a retirement fund, the payments are considered unearned income and the fund is not considered an asset to the individual. Also according to the above authorities, if the community spouse receives periodic payments from the retirement funds he owns, the funds are not considered an asset when computing the couple's total countable assets. The Department's manual does not define "periodic" as related to this subject. The above Social Security authority, relied on in adult payments, defines periodic retirement benefit as being made at some regular interval and does not exclude an annual

payment as meeting the definition. The hearing officer concludes that an annual payment meets this definition. Therefore, the undersigned concludes that the Department erred in counting the value of the IRAs, which received a periodic annual payment, toward the couple's total asset value. However, because the Department failed to attend the reconvened hearing to show the total assets counted to determine ineligibility for the months at issue and because the only argument for ineligibility that was made had to do with the value of the IRAs, the undersigned concludes that the petitioner met the burden by a preponderance of evidence to prove eligibility. Therefore, the undersigned concludes there is ICP eligibility for May, June and July 2007, even counting the community spouse's one IRA that did not have periodic payments.

DECISION

The appeal is granted and the Department's denial action for May, June and July 2007 is hereby reversed. The Department is to authorize ICP coverage for these months within 10 days of receipt of this order.

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 23rd day of April, 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

14 DPOES: Karen Shank
John Short

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

APPEAL NO. 08F-00374

PETITIONER,

Vs.

CASE NO. 1257892363

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 08 Lee
UNIT: 88806

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 19, 2008, at 2:05 p.m., in Ft. Myers, Florida. The petitioner was not present. She was represented by her power of attorney, , paralegal. The respondent was represented by Yesid Hernandez, Access supervisor. Present as a witness for the respondent was Jane Morris, economic eligibility specialist.

ISSUE

At issue is the January 14, 2008 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program and Medicaid for the month of November 2007. The burden of proof lies with the petitioner as the applicant for benefits.

FINDINGS OF FACT

1. On December 13, 2007, petitioner filed a Request for Assistance to apply for benefits through the Institutional Care Program. She resided in a nursing facility and requested retroactive benefits for November 2007. The petitioner had three sources of income.
2. The petitioner received income from the following sources: monthly social security income of $862, monthly union fund of $231.64, and a once a year IRA distribution of $1,192.04. The IRA distribution occurs each year in November. Total gross monthly income for the petitioner in November 2007 was $2,285.68.
3. The respondent determined that the petitioner's income exceeded the limit for the Institutional Care Program in the month of November 2007. This limit was $1,869 monthly. Her application was approved December 2007 and ongoing. She met the income limit in months without the IRA distribution.

CONCLUSIONS OF LAW

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

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

establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.

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

2440.0510 How to Count Income for Eligibility (MSSI, SFP)

This policy is to be used to calculate the gross monthly income amount to be used in eligibility budgets for all SSI-Related Medicaid Programs at the time of application or eligibility review. This policy is not to be used for determining patient responsibility, except for determining income of the community spouse. For policy on how to count the individual's income for patient responsibility, see passage 2440.0512.
Both unearned and earned income are treated the same for the SSI-Related Medicaid Programs. All income must be converted into a monthly amount for budget purposes.
For applications, budget actual income for months available instead of computing an average. If you are prorating income, begin prorating in the month it is received in a month for which benefits are requested. For example, if an individual is requesting benefits beginning in July, and receives an annual payment every October, no income from the October payment would be counted in the budget until October. Then, schedule a partial for September to start counting the prorated income effective October.
The method used to determine a monthly amount depends on how often the income is received and the specific program...

Note: If converting income that is received quarterly, semiannually, or annually causes ineligibility, do not prorate; count income in the month it is actually received.

Note: For Institutional MEDS this step applies only to counting income for eligibility. Patient responsibility is computed using the same rules as ICP, Hospice, and HCBS.
2. For ICP, Hospice and HCBS: use the actual number of payments made in the month to convert to a monthly amount and determine client's eligibility:

a. for weekly: use five weeks in months that have five payments and four weeks in months that have four payments.
b. for biweekly: use two payments in months only two payments will

be received; three payments in months where three payments will be received.

c. for income received quarterly, semiannually, or annually, count income in the anticipated month of receipt.

2440.0512 How to Count Income for Patient Responsibility (MSSI)

Take the following steps to determine what income of the individual to count in determining patient responsibility. Patient responsibility is computed the same for ICP, ICP-MEDS, Institutional Hospice and HCBS. (To determine the amount of income for the community spouse, follow the rules in passage 2440.0510.)

Remember: For applications, budget actual income for months available instead of computing an average. If you are prorating income, begin prorating in the month it is received in a month for which benefits are requested. For example, if an individual is requesting benefits beginning in July, and receives an annual payment every October, no income from the October payment would be counted in the budget until October. Then, schedule a partial for September to start counting the prorated income effective October.

Step 1: Is the individual eligible for Medicaid for all months following the process described in passage 2440.0510, Step 4?

If yes, go to Step 2.
If no, you must count the income for the month in which it is actually received. You cannot prorate and create eligibility.

Example: Ms. Porter receives $1300 a month from a pension and receives an annuity of $200 quarterly. Her $1300 pension is budgeted with partials scheduled to budget the $200 annuity for the month received. Ms. Porter must be switched to Medically Needy for one month of every quarter, unless she elects to set up an income trust...

The evidence establishes that the petitioner receives a yearly distribution from an IRA. This distribution totaled $1,192.04 in November 2007. It caused the petitioner to exceed the income limit for the Institutional Care Program in that

month. The petitioner argues that the yearly distribution could be divided by 12 and prorated over the 12 month period. If the distribution were counted in this manner, the petitioner would be eligible for benefits year round, instead of ineligible in one month.

The respondent calls attention to the "note" in the above-cited policy 2440.0510 material. It states that the respondent may not prorate a yearly amount when the income in the month of receipt causes ineligibility. This is further reiterated in passage 2440.0512 when the material says "Step 1: Is the individual eligible for Medicaid for all months following the process described in passage 2440.0510, Step 4?" If not eligible in one of the months, the respondent is directed to count the income only in the month of receipt. Essentially, the petitioner must pass an income eligibility test each month before income may be prorated. Therefore, the respondent must deny the petitioner's Institutional Care Program benefits each November when the IRA funds are distributed.

After reviewing the evidence and testimony, the hearing officer concludes that the respondent has correctly interpreted the above-cited manual material. Since the distribution causes ineligibility in the month of receipt, it may not be prorated to give the petitioner year round eligibility. As long as the petitioner's IRA funds are distributed annually, the respondent would correctly deny Institutional Care Program benefits for November of that year (month of receipt).

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 4th day of April, 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

8 DPOES: Roseann Liriano

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

APPEAL NO. 08F-00553

PETITIONER,

Vs.

CASE NO. 1192676904

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 08 Lee
UNIT: 88806

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 19, 2008, at 11:03 a.m., in Ft. Myers, Florida. The petitioner was not present. She was represented by ina, business office w . The respondent was represented by Yesid Hernandez, Access supervisor. Present as a witness for the petitioner was business office manager.

The respondent was allowed 10 days to return further evidence. Evidence was received from the respondent on February 26, 2008. It was accepted as Respondent's Exhibit 5.

ISSUE

At issue is the January 18, 2008 action by the respondent denying the petitioner benefits through the Institutional Care Program for the month of July 2007. The burden of proof falls with the petitioner as the applicant for benefits.

FINDINGS OF FACT

1. The petitioner was a recipient of benefits through Institutional Care Program in May 2007. The respondent mailed an interim contact letter to the petitioner to conduct a review of her eligibility for these benefits. The petitioner failed to respond to the notices. On May 31, 2007, the respondent canceled the petitioner's benefits through the Institutional Care Program effective June 30, 2007.
2. The petitioner reapplied for Institutional Care Program benefits on November 6, 2007. On November 8, 2007, the respondent approved the petitioner for Institutional Care Program benefits. In addition, the respondent approved Institutional Care Program benefits for the three retroactive months of September, October, and November 2007.
3. The notices in the actions cited above were sent to the petitioner at the nursing facility, the nursing facility, and the designated representative.
4. The nursing facility changed management during the period in question. Therefore, they changed provider numbers. There was a delay between the old provider number ending and the new provider number beginning. This accounted for the length of time it took the facility to recognize the

gap in eligibility. However, the nursing facility asserts that they can file a claim for Medicaid benefits for a period of 12 months.

CONCLUSIONS OF LAW

The Fla. Admin. Code at 65A-1.204 discusses Rights and Responsibilities and states in relevant part:

> (1) Any person has the right to apply for assistance, have his/her eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing all necessary facts and documentation to establish eligibility, advise the Department of any changes in his/her circumstances which might affect eligibility and/or the amount of the public assistance benefit, and to provide the department with any channel of information concerning his/her affairs that may be determined necessary. If the information or documentation is difficult for the person to obtain, the department must provide assistance in obtaining the information or documentation when requested or when it appears necessary.

The Fla. Admin. Code at 59G-5.110 — Claims Payment states in relevant part:

> (1)(a) The agency provides eligible individuals with access to Medicaid services and goods by direct payment to the Medicaid provider upon submission of a payable claim to the fiscal agent contractor. Except as provided for by law or federal regulation, payments for services rendered or goods supplied shall be made by direct payment to the provider except that payments may be made in the name of the provider to the provider's billing agent if designated in writing by the provider. Direct payment may be made to a recipient who paid for medically necessary, Medicaid-covered services received from the beginning date of eligibility (including the three-month retroactive period) and paid for during the period of time between an erroneous denial or termination of Medicaid eligibility and a successful appeal or an agency determination in the recipient's favor. The services must have been covered by Medicaid at the time they were provided.

The evidence establishes that the respondent mailed forms to the petitioner to conduct a review of her eligibility for Institutional Care Program benefits. The forms were mailed to the petitioner, the facility and her representative. Her benefits were canceled when there was no response.

The respondent argues that they have 12 months to file for Medicaid benefits. However, this provision applies to the length of time to file claims in months of eligibility. The petitioner was not eligible for Medicaid benefits in July 2007 since she failed to participate in the required review. Once she reapplied, the respondent approved Institutional Care Program benefits as far back from the application date as was permitted by law (three months). The respondent correctly denied the petitioner's request for Institutional Care Program benefits in July 2007.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15th day of April 2008,

in Tallahassee, Florida.

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

Copies Furnished To: M . . . .
Roseann Liriano, Suncoast Region

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

APPEAL NO. 08F-00213

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
DISTRICT: 07 Seminole

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 11:15 a.m. on February 12, 2008 in Sanford, Florida. The petitioner was not present but was duly represented by his mother, . The respondent was represented by Lissette Knott, human services program specialist, with telephone testimony from Theresa Ashey, registered nurse reviewer with KePRO (an agency contracted with AHCA); Robert Anthony Buzzeo, MD, KePRO physician reviewer; and Edna Clifton, RN, with KePRO quality management. The hearing record was left open twenty days to receive additional data from both sides, now labeled as Petitioner's Exhibit 2, and Respondent's Exhibit 4.

ISSUE

At issue was whether AHCA correctly reduced private duty nursing (PDN) service hours. Burden of proof was on the agency.

FINDINGS OF FACT

1. The petitioner is not quite three years of age, with serious health problems that had justified home health care, including private duty nursing hours under AHCA. Respondent's Exhibit 3 was review data for recent past and current review period. ACHA authorized fewer PDN hours at the new review. A hearing was requested.

2. Review information said, "KePro last approved 1308 hrs (24 hrs Tues-Sat, 20 hrs Mon, 16 hrs Sun)." For new review period of December 5, 2007 to February 2, 2008, KePRO's Internal Focus Review Findings showed that 1424 private duty nursing hours were requested and 1208 were approved, with 216 denied. Review findings said, in part, "Mom works full-time...work hours are Tuesday-Saturday 8am to 4pm. Mom also has ongoing health issues possibly related to chronic fatigue. Father works full time, M-F, 8am to 6pm. Father is not involved with any of the care d/t [due to] culture."

3. On January 1, 2008 "PDN/PC Recipient Denial Letter" showed "Denied Hours: 36...Total Approved Hours: 1208 – 12/05/2007 – 02/02/2008." On December 17, 2007, "PDN/PC Recipient Reconsideration – Denial Upheld" letter was issued saying, "Denied Hours: 184...Total Approved Hours: 1196."

4. For review purposes, data was gathered from the health care provider, not directly from the family. This is the customary practice of KePRO.

5. The petitioner's mother disputed accuracy of some information gathered and conclusions reached. The petitioner's father works long hours as he is establishing his own business. He works Mondays through Saturdays, usually not coming home before 9:00 p.m. during the week, and working from 10:00 a. m. to 7:00 p.m. on Saturdays. The petitioner's mother also works on Mondays (abbreviated hours of 9-3). After his

Consistent with statute, Fla. Admin. Code 59G-1.010 (166) defines "medically necessary," informing that such services must:

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

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

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

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

Additionally, it is important to note that the Department's administrative hearing system affords opportunity for a de novo proceeding under Florida Administrative Code 65-2.056, **Basis for Hearing.** This 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.

Moreover, burden of proof as related to **Evidence**, is addressed at Fla. Admin. Code 65-2.060 as follows:

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

Facts, governing standards, and arguments have been carefully considered. Basis of reduction/denial appeared to be the father's nonprovision of services, his availability for care on Saturdays when mother works, and the mother's availability on Mondays when father works. Evidence has established that both parents do provide care when available, and that both parents are available on Sundays, but they have significant work responsibilities most other days.

While the respondent may have followed its internal review guidelines, it is not substantively evident that accurate information provided a reliable foundation for the conclusions reached. De novo evidentiary standards, and burden of proof criteria, preclude an administrative hearing conclusion that reduction (or denial as the term used

on the notices sets forth) has been justified by adequate evidence. Therefore, it is concluded that reduction in PDN hours has not been justified.

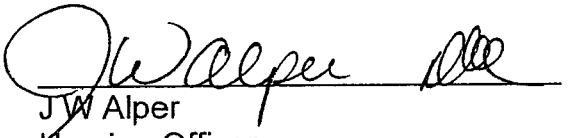
DECISION

The appeal is granted and reduction 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 21st day of April, 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:
Judy Jacobs, Area 7 Medicaid Adm.
Mary Wheeler
Karen Kinser, Nursing Consultant

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

APPEAL NO. 08F-01061

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 7, 2008, at 1:30 p.m., in Pensacola, Florida. The petitioner was present and represented herself. Testifying on behalf of the petitioner was her husband, . The Agency/respondent was represented by Cindy Henline, medical health care program analyst, Agency for Health Care Administration (AHCA). Testifying on behalf of the Agency, via speakerphone, was Theresa Ashey, RN reviewer, KePRO South, and Dr. Maureen Levy, medical director, KePRO South.

ISSUE

The petitioner is appealing AHCA's decision of January 11, 2008 to deny prior authorization for in-patient services for a bilateral knee replacement. The denial is based on the contention that the medical care request does not appear to require inpatient services and does not meet medical necessity.

The petitioner bears the burden of proof.

FINDINGS OF FACT

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

2. KePRO South received a prior authorization request for the petitioner to undergo bilateral knee replacement that was scheduled for January 31, 2008 through February 3, 2008. The petitioner was diagnosed with bilateral knee degenerative joint disease. She suffers from severe pain to both knees and uses a wheelchair.

3. The petitioner had a magnetic resonance imaging (MRI), which revealed "severe degenerative changes with extreme thinning of the cartilage of the medial condyl. Lateral tibial plateau appears to have denervation and full thickness cartilage defects".

4. On January 9, 2008, the initial RN screening was completed. "At the direction of AHCA, the nurse reviewer used InterQual criteria to determine necessity for acute inpatient care. The clinical information received from the patient's physician office did not meet the InterQual criteria under Adult Procedures subset: Total Knee Replacement criteria; it also did not meet the AHCA approved KePRO Business

Guidelines for Total Knee Replacement. The case was referred to a Physician Consultant (PC) Board-Certified in General Surgery".

5. The board-certified physician reviewed the request and denied prior authorization with the following determination. "Deny 1/31-2/3; Insufficient data to support dx [diagnosis] for tx [treatment]. Limited history and exam. Need more details" The nurse reviewer processed the denial on January 11, 2008 with an option of requesting a reconsideration review if the patient's physician did not agree.

6. A reconsideration review request was received from the petitioner's physician on January 14, 2008 with the following information: "Reconsideration - Severe Pain Bilateral Knees, loss of range of motion both knees uses wheelchair, only able to step few steps with quad cane. Overweight, has it pitting edema, intact peripheral pulses and hip ROM [range of motion] not painful. ..."

7. A reconsideration review was conducted on January 14, 2008 with a Physician Consultant (PC) board-certified in Orthopedic Surgery not involved with the first level denial and not practicing in the county where the Provider was located. The PC upheld the denial based on the lack of detailed individual radiology reports and physical exam. Details regarding each joint rather than a blend of both were required for approval of a bilateral procedure. To make a better determination of the medical necessity and length of stay, imaging studies of each knee separately as well as physical exam of each knee separately was necessary. Information regarding "pitting edema" referenced the ankle. There was no range of motion information regarding

each knee. Range of Motion studies for the hip did not address the knee replacement issue. On January 15, 2008 a Recipient Reconsideration Denial Upheld notice was mailed to the petitioner.

8. On January 29, 2008, a returned telephone message was left with the provider on his voice machine as well as with his office staff relating the required information to grant prior authorization for the bilateral knee replacement procedure. No further contact was received from the provider physician. The surgery was cancelled.

9. The petitioner provided a letter dated March 14, 2008 from her treating physician, Dr. C. n. The letter described the petitioner's diagnosis of a "severe degenerative joint disease involving both knees that has failed to respond to conservative measure, medicinal therapy, inclusive of rest, moist heat, Banalg Hospital Strength liniment, analgesics..." The correspondence further indicated the physician's recommendation for "bilateral total knee arthroplasty with her only alternative to become totally bedridden, in conjunction with incapacitating pain". The correspondence did not provide indication of ROM for each knee or other information necessary to determine medical necessity.

CONCLUSIONS OF LAW

Florida Statutes Chapter 409 Section 409.905 in part states:

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

Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216... (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(a) The agency is authorized to implement reimbursement and utilization management reforms in order to comply with any limitations or directions in the General Appropriations Act, which may include, but are not limited to: prior authorization for inpatient psychiatric days; enhanced utilization and concurrent review programs for highly utilized services; reduction or elimination of covered days of service; adjusting reimbursement ceilings for variable costs; adjusting reimbursement ceiling for fixed and property costs; and implementing target rates of increase.

Florida Statutes 409.913(1)(d) states in part:

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

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

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

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

The Findings of Fact show that the petitioner requested prior authorization for inpatient hospital services for bilateral knee arthroplasty. The request was made because the petitioner had severe degenerative joint disease involving both knees that failed to respond to conservative measure and other treatment. The prior authorization was reviewed by KePRO South and additional clinical information was requested from the hospital and the petitioner's physician to determine whether a bilateral knee arthroplasty was medically necessary and would be the best procedure for the petitioner with her condition. Additional information was also needed to evaluate the length of

stay. Detailed information was not received and the information that KePRO South had was not sufficient to establish that bilateral knee arthroplasty was medically necessary.

In weighing the evidence, the following conclusion is reached by the undersigned: AHCA presented evidence from the physician consultant of the medical necessity for the requested prior authorization. This is a medical expert who routinely determines medical necessity for Medicaid services. The physician's statement submitted by the petitioner did not provide information required to determine medical necessity as defined in the above authorities. In addition, the agency's Registered Nurse Specialist and two Board Certified Pediatric physicians who are considered medical experts, determined that the denial of prior authorization was appropriate based upon a review of the petitioner's medical records.

Based on the above findings, it is concluded that the respondent correctly denied the petitioner's request for prior authorization for inpatient hospital services for bilateral knee arthroplasty, as medical necessity was not demonstrated.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 24th day of April, 2008,

in Tallahassee, Florida.

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

Copies Furnished To:

Delphine Metarko, Area 1 Medicaid Adm.
Diane Weller, RN
Mary Wheeler

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

APPEAL NO. 08F-00478

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 February 14, 2008, at 11:07 a.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was present, but was represented at the hearing by the petitioner's mother, . The Agency was represented by Jeffrey Douglas, program administrator, from the Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Mittel Rakesh, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the Agency was Teresa Ashey, nurse reviewer from KePRO.

KePRO is located in Tampa, Florida. The hearing was left open for an additional fourteen days in order for the petitioner to submit additional information to KePRO through the petitioner's Home Health Service Provider and for KePRO to provide another possible

decision. The petitioner or his representative did not provide the information within the time frame allotted.

ISSUE

At issue is the Agency's action of January 10, 2008 and on reconsideration on January 14, 2008, to reduce the petitioner's request for continued Home Health Aide or PCA services a total of 96 hours, for the period of January 7, 2008 through March 6, 2008. The reduction of hours totals from 3:00 p.m. to 11:00 p.m., for Sundays of the above service. The Agency has the burden of proof.

FINDINGS OF FACT

1. The petitioner, who is approximately nineteen years of age, has severe and numerous medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "Agency".

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on January 10, 2008, that the petitioner's request for about 320 hours of Home Health Aide was going to be denied/reduced by 96 hours for the period of January 7, 2008 through March 6, 2008.

3. The petitioner's representative requested a hearing and benefits were restored. A reconsideration was also requested, but the decision on the reconsideration by the Agency; upheld the first decision.

4. KePRO's decision was based on the information provided by the petitioner's provider or home health agency as part of the request for the service. KePRO determined that petitioner's mother and father, though employed, are quite capable of caring for the petitioner for the hours of 3:00 p.m. to 11:00 p.m., on Sundays. Neither the petitioner's mother nor father, were reported as employed on the above noted hours by the Home Health Agency.

5. The KePRO witness indicated that KePRO had informed the petitioner's home health agency to advise KePRO if any of the petitioner's parents were now working on Sundays. KePRO indicated that the Home Health Aide service will be reevaluated based on if either is working on Sundays.

6. The hearing was left open for fourteen days for the petitioner's representative to provide information to KePRO through the petitioner's home health agency regarding the petitioner's representative statement that both she and her husband are employed at least part time on Sundays. The Agency informed the hearing officer, while the hearing was left open, no information was provided to KePRO though the petitioner's home health agency by the petitioner's representative while the hearing was left open.

CONCLUSIONS OF LAW

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

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

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

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

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

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

The Agency, through KePRO, took action first on January 10, 2008 to reduce the petitioner's request for continued home health aide services by 96 hours of the service. This decision was based (partly) on the information as provided by the petitioner's home health agency service and the petitioner's medical necessity need of the request for the service.

The petitioner's representatives argued that the petitioner is in need of the requested service, based on the petitioner's representative is employed on Sundays. The Agency argued that the Agency's decision is correct, based on the information received. The Agency argued that it was willing to revise the petitioner's hours on Sundays for the requested service if the petitioner's representative presented additional information while the hearing was left open. The hearing office agrees with the Agency's first argument.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer finds that the Agency has met its burden of proof and that the Agency's action of January 10, 2008, to reduce the petitioner's request for continued Health Aide services for the 96 requested hours of the service for the period of January 7, 2008 to March 6, 2008, which was for the hours on Sundays, from 3:00 p.m. to 11:00 p.m., is correct.

DECISION

This appeal is denied and the Agency's action 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 4th day of April, 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 To:

Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Mary Wheeler
Sharon Lang
Karen Kinser, Nursing Consultant

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

APPEAL NO. 08F-00240

PETITIONER,

Vs.

CASE NO. 1009270028

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 12 Volusia
UNIT: 88209

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned at 3:05 p.m. on February 13, 2008 in Daytona, Florida. The petitioner was represented by his daughter, . The respondent was represented by Patricia Klecan, ACCESS supervisor. Hearing Officer Leslie Green observed.

ISSUE

At issue was whether or not the community spouse allowance was correct as related to the petitioner's Institutional Care Program (ICP) benefits. As an applicant, the petitioner had the burden of proof.

FINDINGS OF FACT

1. The petitioner applied for ICP coverage in late September 2007 (Respondent's Exhibit 6), after entering a nursing facility. His wife remained in the community home.

2. ICP benefits were authorized effective August 2007 without any patient responsibility for that single month because it was the month of nursing facility admission. His income was "protected" for month of admission. His income was not expected for use at the nursing facility because he had not lived in the nursing facility the entire month of August 2007.

3. For September 2007 and later, all his income above a $35 personal needs allowance was earmarked for his own care and toward his wife's living expenses. His wife's income allocation was set at $1094.53 or $1095.16, using calculations shown in Respondent's Exhibit 3 and 5. Due to her expenses and situation, the community spouse was unsatisfied with allocation. The most recent calculation resulted in a community spouse income allowance or allocation at $1095.16.

4. Budget details were undisputed. The petitioner's recent 2008 income was $1520 from Social Security and Veterans' Benefits. The community spouse's income totaled $617.47 from a combination of SSI (Supplemental Security Income) and Social Security. The community spouse does not pay a mortgage or rent, but pays taxes ($12.12 pro-rated monthly), home insurance ($83.25 monthly) and with a food stamp monthly utility allowance of $198, total monthly shelter expenses became $293.37. (There were minor arithmetic disparities of a few cents, but these are insignificant to the main concern.) When the shelter costs of $293.38 were less than $514, which was 30% of the MMMIA (Minimum Monthly Maintenance Income Allowance), there was no excess shelter cost assigned.

5. Budgeting proceeded with MMMIA of $1712 minus the community spouse's gross income of $616.84, resulting in a community spouse income allowance or

allocation of $1095.16. For the petitioner, his income of $1520.07, minus his personal needs allowance of $35.00 and minus the $1095.16 of his income as allocated to his wife, the remaining patient responsibility was $389.91 monthly.

6. The petitioner's wife has Medicare, and she receives dialysis. As an SSI recipient, Medicaid would also be in place. She has medical costs of her own, household utilities actually cost closer to $250 per month not counting the additional taxes and insurance, and automobile payment plus automobile insurance total about $425 monthly, not including fuel.

CONCLUSIONS OF LAW

The financial matters under challenge relate to post-eligibility Medicaid ICP calculations. ICP basic eligibility is undisputed. The petitioner is eligible. Florida Administrative Code **65A-1.7141** is relevant and addresses **SSI-Related Medicaid Post Eligibility Treatment of Income,** informing as follows:

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or Assisted Living waiver (ALW/HCBS), the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income".
>
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
>
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance...
>
> (d) The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses.

The following policy applies to the ICP, institutionalized MEDS, institutionalized Hospice, Long Term Care Diversion, PACE, and the Assisted Living Waiver Programs. When an institutionalized individual has a community spouse whose gross income is less than the state's minimum monthly maintenance income allowance (MMMIA) plus the CS excess shelter expense costs, a portion of the individual's income may be allocated to meet the needs of his community spouse.

Fla. Integrated Pub. Policy Manual, passage 2640.0119.02 in part states:

Community Spouse's Monthly Income Allowance (MSSI)
A community spouse's monthly income allowance depends on the amount of monthly income available to the community spouse and the amount of excess shelter costs the community spouse must pay.
The actual community spouse monthly income allowance is equal to how much the state's MMMIA plus the community spouse's excess shelter costs exceed the community spouse's income.

Fla. Integrated Pub. Policy Manual, passage 2640.0119.03 in part states:

Formula for Community Spouse Income Allowance (MSSI)
The following is the formula used to determine the community spouse's income allowance:
(State's MMMIA + community spouse's excess shelter costs) - (the community spouse's total gross income) = (the community spouse's income allowance.)
The community spouse's income allowance is the total amount that can be allotted to the community spouse from the institutionalized individual.
The state's MMMIA plus CS excess shelter cost cannot exceed the state's cap on CS income allowance (see Appendix A-9).
The institutionalized individual's personal needs allowance and deduction for therapeutic wages is deducted prior to deducting the community spouse's income allowance.

Fla. Integrated Pub. Policy Manual, passage 2640.0119.04 in part states:

Determining Community Spouse's Excess Shelter Costs (MSSI)
The following steps are used to determine the community spouse's excess shelter costs:
Step 1 - Obtain verification of the community spouse's monthly assistance group expenses if questionable. Allowed expenses are limited to rent or mortgage payment (including principal and interest), taxes, insurance (homeowners or renters), maintenance charges if a condominium and mandatory homeowner's association fees. Do not include expenses paid by someone other than the community spouse. Add all of these expenses.

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

APPEAL NO. 08F-00520

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 01 Santa Rosa
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 5, 2008, at 3:10 p.m., in Pensacola, Florida. The petitioner was present. She was represented by her mother, . Testifying on behalf of the petitioner was , teacher, B School. Also testifying on behalf of the petitioner was , LPH, Interim Health Care. The Agency was represented by Cindy Henline, medical health care program analyst, Agency for Health Care Administration (AHCA). Testifying on behalf of the Agency, via speakerphone, was Dr. Robert Buzzeo, physician reviewer, KePRO and Theresa Ashey, RN reviewer, KePRO.

ISSUE

The petitioner is appealing AHCA's action of January 7, 2008 to reduce Private Duty Nursing (PDN) from a request of 335 hours to 216 for the period of December 7,

2007 through February 4, 2008 based on the contention that the intensity or level of medical care requested was not medically necessary. The Agency holds the burden of proof.

FINDINGS OF FACT

1. The petitioner (date of birth ,) is a Medicaid recipient. The petitioner has been receiving PDN services under Medicaid. A request for 335 hours of PDN was submitted by the provider, Interim Healthcare Services, for the period of December 7, 2007 through February 4, 2008.

2. Prior to the action under appeal, the petitioner was authorized to receive 335 hours of PDN. The provider requested PDN services as follows: Sundays and Mondays (10 hours), Tuesday (6.5 hours), Wednesday (7 hours) and Thursdays (6.5 hours). This totaled 340 hours however, the provider requested 335 hours.

3. The provider's request for PDN indicated that the child's biological mother was in the home and is a trained caregiver. She does not work but is a substitute teacher/assistant and works only when called. She typically works one to two days a month depending on the need for her services. The petitioner attends Elementary School when her health permits.

4. The petitioner's mother recently married in August 2007. The stepfather has not been trained to provide for the petitioner's care. Information provided by the petitioner's representative indicated the husband's work schedule is 6:30 a.m. to 3:30 p.m. Monday through Friday. At the hearing, the petitioner's representative

weekends. In addition, the petitioner's representative provided a copy of the monitoring results for the apnea monitor.

5. Requests for PDN are reviewed with a contract provider who completes prior authorization for the requested service. That contract provider is KePRO. The request for services is submitted by the home health care provider, in this case, Interim Health Care Services, Inc. The requests are for 60 day time periods. All communication is sent between KePRO and the provider until a decision is reached. KePRO reviews the written request for services to determine if the number of hours requested are medically necessary. If additional information is needed, KePRO contacts the provider. Once services, as in this case, were rejected or modified, a notice is sent to the recipient's family.

6. KePRO received the request for 335 hours of PDN submitted by the provider, Interim Health Care Services, Inc. A KePRO Registered Nurse Reviewer (RNR) completed a screening of the Plan of Care submitted on December 26, 2007.

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

6. The case was then referred to a Board Certified Pediatric Specialty Physician Consultant. A Board Certified Pediatrician reviewed the case and made the following determination: "4 yo developmentally delayed, hx [history] of seizures, insulin, SSI [sliding scale insulin], neb tx [nebulizer treatments], incont. [incontinent]. Mother only works prn as substitute teacher, The husband's schedule is 6:30am to 3:30pm M-F. Skilled nursing required for mother to do shopping, go to her doctor appointments, go to pharmacy for her and child, allow for at least 2 nights of uninterrupted sleep. Requested hours for LPN is Sunday 7p to 5a, Monday 7p to 5a, Tuesday 2p to 8:30p, Wednesday 2p to 9p, Thursday 2p to 8:30p. Dad off work at 3:30p. Not clear why he cannot do some shopping or provide care while mother shops. Unlikely to have doctor appointments after 5p. Request for 10 hr uninterrupted sleep is excessive. Recommend Sun, Mon 9p-5a, Tues, Wed, Thurs 2-5p"

7. The petitioner's diagnosis as submitted to KePRO is congenital abnormalities of heart, congenital anomalies of larynx, trachea, and bronchus, diabetes mellitus without mention of complication, Type I (Juvenile type, and unspecified lack of normal physiological development. The determination of the physician consultant was sent to Interim Healthcare Services, Inc. on January 7, 2008. Based on the documentation, the pediatric consultant denied 119 hours and approved 216 hours of the 335 requested hours of PDN.

8. The petitioner requires skilled observation and assessment, medication administration, glucose monitoring and tube feedings. She requires medication

administration and Pediasure when she fails to take enough nutrition. The provider informed KePRO that the petitioner was taken to the hospital emergency room and admitted on November 28, 2007 for elevated ketones. She was discharged home on November 31, 2007.

9. The provider did not request a reconsideration review. The Agency submitted a reconsideration review request. No additional information was received from the provider. According to the Agency for Health Care Administration (AHCA), if a fair hearing is requested and the provider does not submit a request for a reconsideration review, KePRO is to review the case as a reconsideration review with the information previously submitted by the Provider in the case for the certification period.

10. The reconsideration review was conducted on February 5, 2008 by a second KePRO Physician Consultant, Board-Certified in Pediatrics and who was not involved in the initial denial. The following decision was reached: "I agree with the other reviewer's recommendation. Notes indicate that dad can not provide care for the pt. But after work he can do the shopping / make appts [appointments] and do household chores while mom can provide the care". The provider reconsideration letter upholding the original decision was issued on February 6, 2008.

11. The program is operated with the understanding that parents or caregivers will be able to participate in providing care as they are trained in providing for the child's care. In addition, PDN services must be ordered by the attending physician.

12. As a result of the request for hearing, 335 hours of PDN was administratively approved in subsequent certification periods pending the outcome of the appeal. However, the petitioner did not avail herself of the hours approved because she was concerned that she would be responsible for repayment if her appeal were subsequently denied.

CONCLUSIONS OF LAW

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

Florida Statutes § 409.919 Rules (2006) states:

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

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

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

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

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

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

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

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

In order to be reimbursed, home health services must also be:

- Ordered by and remain under the direction of the attending physician...licenses under Chapter 461, 458 or 459 F.S. or licensed in the state in which the attending physician practices;
- Consistent with the individualized written physician-approved plan of care
- Provided by qualified staff; and
- Consistent with accepted standards of medical and nursing practice.

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

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

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

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

The Home Health Services Coverage and Limitations Handbook, Chapter 2,

p.2-16, states in part:

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

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

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

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

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

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

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

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

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

As a result of the reduction in PDN services paid for by Medicaid, the petitioner, through her representative, appeals this action, asserting that at least 335 hours of PDN services per 60 day period is necessary.

AHCA presented evidence from the pediatric physician consultant of the number of hours deemed medically necessary. This is a medical expert who routinely determines medical necessity for Medicaid services. The summary statements of apnea monitoring submitted by the petitioner did not show that the petitioner's condition would deteriorate as a result of the current plan. Therefore, greater weight was given to the agency's expert witness.

In addition, the agency's Registered Nurse Specialist and two Board Certified Pediatric physicians who are considered medical experts, determined that the reduction of private duty nursing care is appropriate for the petitioner. The decision was based upon a review of the petitioner's clinical medical state and the needs of the family. The respondent acknowledges that the petitioner is medically complex. However, according to the above authorities, 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. In addition, according to the above authorities, private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care.

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

The petitioner's caretakers play an important role and according to the above authorities, their involvement is strongly encouraged in taking care of her. The evidence submitted indicated that the mother has been providing care for the petitioner when private duty nurses were unavailable. In addition, the evidence indicated that the mother has recently married. The step-father, after training, is capable of providing care for the petitioner. If he is unable or unwilling to provide for the petitioner's care, he is certainly capable of doing household errands and chores to provide a measure of relief for the petitioner's mother. After careful consideration, it is determined that the action to reduce the private duty nursing hours from 335 to 216 for the period at issue is in accordance with the above authorities.

The evidence did not support a greater amount of nursing hours under the circumstances. Continuing the additional hours would help to achieve parental relief on

a daily basis, but the additional hours cannot accurately be described as medically

necessary.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

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

Copies Furnished To:
Delphine Metarko, Area 1 Medicaid Adm.
Karen Kinser, Nursing Consultant

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

APPEAL NO. 08F-1481

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 April 1, 2008, at 8:20 a.m., in Miami, Florida. The petitioner, a, was not present however he was represented by his parents, . Present, on behalf of the respondent was Monica Otoriola, program specialist with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the agency was Dr. Robert A. Buzzeo, physician reviewer and Theresa Ashey, nurse reviewer both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez, specialist with AHCA served as translator.

ISSUE

At issue is the agency's action in denying 64 hours of private duty nursing (PDN) and approving 1,376 hours from the requested 1,440 hours of PDN. The certification period is for January 30, 2008 through March 29, 2008. The agency has the burden of proof.

FINDINGS OF FACT

1. The petitioner is eighteen months old and a Medicaid beneficiary in the state of Florida. The petitioner is medically complex with a principal diagnosis as reported to the agency, "hypoplastic left heart syndrome." Services have been continued at their prior level throughout the hearing process.

2. On February 4, 2008, the provider (RGR LLC) requested 1,440 hours (24 hours a day, 7 days a week) of skilled nursing for the petitioner for the certification period of January 30, 2008 through March 29, 2008.

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

4. On February 5, 2008, an initial screening of the request was completed by the registered nurse reviewer. The nurse reviewer was unable to approve at her level of review, the amount of hours that were being requested. The nurse reviewer referred the case to a board certified pediatric specialty physician consultant, for review of level of care being requested.

5. On February 5, 2008, the physician consultant reviewed the information submitted and denied 180 hours and approved 1,260 hours of the request for PDN

services documenting, "...Has cyanotic spells due to heart condition has gtube, oxygen pulse ox [oximeter], monitor O2 saturation, and cardiopulmonary status. The parents could provide at least 3 hrs of care/night (8P-11P) despite fragility.

6. On February 7, 2008, a PDN/PC Recipient Denial Letter was issued to the petitioner denying 180 (3 hours a day from 8p-11p) hours of PDN 7 days a week.

7. On February 11, 2008, the provider then submitted a reconsideration request along with additional social information, "Mother is overwhelmed because she has a 5 month old baby... Her husband works... works overtime a lot... The patient requires constant attention because he doesn't like to be left alone... the MD has also suggested that he be under skilled nursing 24 hours."

8. On February 21, 2008, a different board certified physician reviewer determined that based on the information provided, he rescinded the previous determination and denied 64 hours (8 hours on Sundays) and approved 1,376 hours of PDN. The physician reviewer documents, "I suggest to rescind denial and modify the denial to only represent a denial of hours for Sundays only from 3pm to 11pm (a denial of 8 hours daily in the afternoon and evening only before 11 pm) when both parents would be available to share care for recipient and other child in the home. I would approve the rest of the hours during this cert period."

9. The physician reviewers considered that there was a six month old sibling in the home; the petitioner's father's work schedule and has to rest; the mother's fear when the petitioner continuously cries when not held; the treating physician's recommendation for 24 hour nursing; the corrective surgery received, however realize that he is not a totally

"normal" child; and the parent's training and experience for a year and a half, with the child.

10. On February 23, 2008, a PDN/PC Recipient Reconsideration-Denial Overturned notice was issued to the petitioner and provider informing them of the approval and denial of hours. The petitioner appealed the decision on February 260, 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.

Florida Statute 409.905 addresses Mandatory Medicaid services and states as follows:

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

services. The assessment of need shall be based on a child's condition, family support and care supplements, a family's ability to provide care, and a family's and child's schedule regarding work, school, sleep, and care for other family dependents...

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

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

(a) Meet the following conditions:

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

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

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

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

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

Administration for participation in the Medicaid program for home health care.

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

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

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

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

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

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

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

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

The parents state that they do "know how to handle the baby", however they do not know when he is going to have an episode and cannot be left alone. The mother states that she is under a lot of stress and has the home, her husband, chores and their other child to contend with. The parents also state that the petitioner has brain damage and his only form of expression is by crying and given his condition, demands to be held most of the times.

The parents state that on Sunday night by 9 p.m., the father has to take his other daughter back to her home (in Broward) when she is with him every other weekend. The father also uses the weekends to do chores.

The agency's physician consultant responded that given the information provided through the parent's testimony on the father's availability on the weekends and especially the new information on the petitioner's mental condition, he "would rescind and approve the 24 hours" request for PDN service.

The hearing officer finds that according to the information and documentation provided to the respondent, the denial of 64 hours for the certification period was appropriate as both parents were in the home and able to care for their son. However, as a de novo hearing the hearing officer takes into account information which should have been considered and therefore, reverses the agency's decision.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 24th day of April, 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:

Judith Rosenbaum, Prog. Adm., Medicaid Area 11
Mary Wheeler
Sharon Lang
Karen Kinser, Nursing Consultant

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 08F-00689

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 03 Gilchrist
UNIT: AHCO

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on March 27, 2008, at 10:10 a.m., in Chiefland, Florida. The petitioner was present and represented herself. The agency was represented by Christine Manley, senior human services program specialist. Present testifying by telephone as witnesses for the agency were Dr. Marcelino Oliva, associate medical director, KePRO, Dianne Weller, registered nurse consultant, KePRO and Theresa Ashel, registered nurse reviewer, KePRO.

ISSUE

The petitioner is appealing the respondent's denial of a prior authorization request for inpatient hospital services for a total abdominal hysterectomy.

FINDINGS OF FACT

1. The petitioner is Medicaid eligible and resides in Gilchrist County, Florida. The petitioner is 46 years old. Keystone Peer Review Organization (KePRO) is under contract with the Agency For Health Care Administration to perform medical reviews for the Medicaid prior authorization for Inpatient Hospital Medical Services Program for Medicaid recipients. KePRO determines medical necessity under the terms of the Florida Medicaid Program.

2. On December 5, 2007, KePRO received a prior authorization request from the petitioner to undergo a total abdominal hysterectomy. The total hysterectomy procedure was to be performed on December 6, 2007 with subsequent hospitalization through December 10, 2007 for a total of a four day inpatient hospitalization. The petitioner was diagnosed with intractable pelvic pain unresponsive to medication, uterine prolapse, severe dysmenorrhea and dyspareunia. The severe dysmenorrhea started after the petitioner had an endometrial ablation in 1997.

3. Physical examination of the petitioner revealed a normal cervix, vagina, recto-vaginal and a small midposition primary uterine prolapse. She had pelvis and vaginal pain, and severe menstrual cramping. The petitioner had a benign cervical biopsy on February 27, 2007 and on May 21, 2007 had a benign endometrial biopsy. MRI completed on July 26, 2007 revealed a normal pelvic.

4. On December 5, 2007 a KePRO physician consultant board-certified in gynecology reviewed the petitioner's prior authorization request for a total abdominal hysterectomy. The physician consultant denied the request because he needed more information from the petitioner's physician on the etiology of the pain, whether other

tests had been done and whether other treatments had been tried. Based on the medical information that was received, the physician consultant could not determine that there was a gynecological reason for the pelvic pain.

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

6. KePRO offered the petitioner's physician an opportunity to provide additional information and for a reconsideration to be requested. However, additional information was not provided and a reconsideration was not requested.

7. The KePRO registered nurse consultant and the agency's senior human services program specialist contacted the petitioner's physician's office and requested additional information. However, no additional information was received.

CONCLUSIONS OF LAW

Florida Statutes Chapter 409 Section 409.905 in part states:

> Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.
>
> (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency

shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

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

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

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

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

The petitioner requested prior authorization for inpatient hospital services for a total abdominal hysterectomy. The request was made because the petitioner had intractable pelvic pain unresponsive to medication, uterine prolapse, severe dysmenorrhea and dyspareunia. The medical information that was provided did not show that there was a gynecological reason for the pelvic pain. The reviewing physician needed additional information to determining whether a total abdominal hysterectomy was medically necessary. However, no additional information was provided. Based on the above findings, it is concluded that the agency correctly denied the petitioner's request for prior authorization for inpatient hospital services for a total abdominal hysterectomy as medical necessity was not demonstrated.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11 day of April, 2008,

in Tallahassee, Florida.

Morris Zamboca

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

Copies Furnished To:

Marilyn Schlott, Area 3 Medicaid Adm.
Toni Mitchell
Karen Kinser, Nursing Consultant

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

APPEAL NO. 07F-06223

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 January 23, 2008, at 11:55 a.m., in Fort Lauderdale, Florida. The hearing was rescheduled from November 16, 2007 and December 6, 2007, at the petitioner's request. The petitioner was present, and he was represented by ....., attorney. Also present were his parents, . s. The respondent was represented on the telephone by Brevin Brown, attorney. Present from the Agency was Sheila Samuels, registered nurse specialist, and Yvonne Vargas, human services program specialist. Present on the telephone from Kepro was Dr. Robert Buzzeo, medical director, and Theresa Ashey, registered nurse reviewer.

The record was held open for 14 days from the date of the hearing, which was through February 6, 2008, to allow the petitioner an opportunity to submit information into evidence. Information was submitted into evidence from the petitioner within the deadline.

The record was held open for 28 days from the date of the hearing, which was through February 20, 2008, to allow the respondent an opportunity to respond to the petitioner's new information. The respondent did not respond to the petitioner's new information within the deadline.

ISSUE

At issue is the Agency's October 11, 2007 action of approving the petitioner's skilled home nursing services for 840 hours, which is 14 hours 7 days per week for October 6, 2007 to December 2, 2007. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, date of birth is 7 year old, and he is a Medicaid benefits recipient in Broward County, Florida.

2. Included in the evidence is a copy of a Recipient Denial Letter dated September 30, 2007, stating that 480 hours of skilled home nursing services were approved, and 660 hours were denied for the petitioner for October 4, 2007 to December 2, 2007.

3. Included in the evidence is a copy of a Recipient Reconsideration Denial Overturned notice dated October 11, 2007. This notice informs the petitioner that upon reconsideration, the total hours of skilled home nursing services approved for him was 840, and 300 hours were denied.

4. Included in the evidence is a copy of a Synopsis Of Case, stating that the reconsideration approval was for skilled home nursing services for 3:00 p.m. to 8:00 p.m., and 11:00 p.m. to 8:00 a.m., 7 days per week from October 4, 2007 to December 2, 2007.

5. According to Dr. Buzzeo at the hearing, he was the physician, who is board certified in pediatrics, who made the determination of the reconsideration approval hours of skilled home nursing services, dated October 11, 2007.

6. Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner dated September 28, 2007, stating that the requested number of hours of home skilled nursing care for the petitioner is 1140, from 12:00 a.m. to 7:00 p.m., which is 19 hours daily.

7. According to the Kepro Internal Focus Review Findings report on the petitioner, it states that he was diagnosed with drowning and nonfatal immersion, anoxic brain damage, and pulmonary insufficiency following trauma and surgery.

8. Included in the evidence is a copy of a Kepro Synopsis of Case report, dated September 28, 2007, stating that a Pediatric Home Care Guide for hourly utilization was used by a registered nurse reviewer. It states that the petitioner achieved a score of 105, however a score of 161-190 points is required to support the number of hours requested by the petitioner.

9. The September 28, 2007 synopsis states that Dr requested 19 hours of daily home skilled nursing care for the petitioner. Included in the evidence is a copy of a Pediatric Home Care Guide for hourly utilization form dated January 18, 2008, from Dr. According to this doctor, the petitioner achieved a score of 168 on the Pediatric Home Care Guide.

10. Included in the evidence is a copy of a statement dated January 18, 2008, from Dr. He indicates that he disagrees with the agency's determination of 14 daily

hours of home skilled nursing care for the petitioner, requesting "as many nursing hours as possible".

11. The petitioner's father is a practicing ophthalmologist. According to information from the agency, his mother does not work outside the home, and they have two other minor children.

12. Included in the evidence are copies of statements from three physicians concerning the petitioner's mother, . A statement from Dr. , dated January 24, 2008, states that suffers from fibromyalgia, and she has constant back pain and spasms. A statement from Dr. , dated January 28, 2008, states that Ms. suffers from leg and back pain. A statement from Dr. , dated February 4, 2008, states that Ms suffers from fibromyalgia, and she has back pain and spasms. According to these statements, she cannot lift the petitioner, and she has limitations regarding caring for him due to her condition.

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. A physician at Kepro for the Agency, approved the petitioner for skilled home nursing services of 14 hours daily for 7 days per week, which is 840 hours from October 4, 2007 to December 2, 2007.

The petitioner was previously approved for 19 daily hours of skilled home nursing care, which is 1140 hours in a 2 month period, and these are the amount of hours that are being requested for him. There are two physicians that indicated that the petitioner should receive at least 19 daily hours of skilled home nursing care. After careful consideration of the proper authorities and evidence, including the petitioner's diagnosis and condition, it is determined that the petitioner needed skilled home nursing services of 19 hours daily for 7 days per week from October 4, 2007 to December 2, 2007. It is therefore determined that the Agency's action is not upheld, and the petitioner's request for 19 hours of daily skilled home nursing care is granted.

DECISION

The appeal is granted, as explained 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 10 day of April, 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 To: Ju
Gail Wilk, Area 10 Medicaid Adm.
Brevin Brown, Esq.

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

APPEAL NO. 07F-06629

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 15, 2008, at 11:24 a.m., in Lake Wales, Florida. The petitioner was not present. He was represented by his mother and father, (The respondent was represented by David Beavin, medical health/care program analyst. Present as witnesses for the respondent from KePRO were Dr. Robert Buzzeo, M.D., physician reviewer; and Mary Wheeler, review operations manager.

ISSUE

At issue is the November 5, 2007 action by the respondent approving the petitioner for 480 hours of skilled nursing services for the period of November 19, 2007 through January 17, 2008. The burden of proof lies with the respondent as this is a reduction in services.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient who has been receiving private duty nursing (PDN) services. Keystone Peer Review Organization (KePRO South) is the Peer Review Organization contracted by the Agency for Health Care Administration to perform medical review for the Private Duty Nursing (PDN) and Personal Care Prior Authorization Program for Medicaid beneficiaries in the State of Florida. They review to determine "medical necessity" under the terms of the Florida Medicaid Program. On October 31, 2007, the petitioner filed a request for Medicaid to pay for 656 hours of PDN services daily for the period of November 19, 2007 through January 17, 2008. The breakdown of the PDN hours requested was for 12 hours per day 5 days per week (7 p.m. to 11 p.m.), and 8 hours per day on weekends (11 p.m. to 7 a.m.).

2. On November 5, 2007, the reviewing authority denied the request citing the reason that both parents were home by 6 p.m. on weekdays and home on weekends. The reviewer recorded that the notes submitted do not mention why care is required from 7 p.m. to 11:00 p.m. He approved PDN services from 11 p.m. to 7 a.m. seven days per week. Total approved hours were 480.

3. On November 8, 2007, the provider submitted the following note:

> Requesting a reconsideration of hours requested 12 hours a day Mon-Friday and 8 hours a day on Sat and Sunday due to parents work scheduled (both work full time) and [redacted] needs constant monitoring due to him having PICA (eating/ingesting non food items) and having a poorly controlled seizure disorder. He receives continuous feedings via double lumen gastric tube. His meds and feeding is given via the J port and the stomach port is used for venting. Thank you.

4. The request for reconsideration was reviewed by a second KePRO Physician Consultant, Board-Certified in Pediatrics on November 9, 2007 with the following decision cited in part:

> Physician consultant questioned why services were required between 7 p.m. to 11 p.m. There was no response to this inquiry from provider. Therefore, there is no clinical or social information to support the medical necessity for skilled nursing during these hours when both parents would be available to provide the necessary care. I would therefore, uphold the denial as previously stated by physician consultant.

5. The petitioner is 16 years old. He has been diagnosed with: congenital quadriplegia, scoliosis associated with other conditions, unspecified lack of normal physiological development, cerebral palsy, neuromuscular scoliosis, broncho pulmonary dysplasia, GERD, gastric dismotility, convulsions, autism, chronic otitis media, urinary retention, severe developmental delay, and PICA. The petitioner requires skilled observation and assessment, medication administration, tube feeding/care, catheter care, and continuous adjustment of his Clonidine. The petitioner is continuously fed even in the night hours. The petitioner attends a school for special needs children during the day.

6. The father is the primary caregiver due to the petitioner's size and weight although both parents can provide some care. His mother cannot lift him. She log rolls him with difficulty. She can no longer manage his diapering or any transfer from bed to chair. All other care is provided by skilled nursing.

7. The petitioner receives benefits through the Developmental Services Home and Community Care Program. However, he is too medically complex for

personal care services. Recipients have to use all available PDN services available through the state plan Medicaid.

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

9. According to the caregivers, the 7 p.m. to 9 p.m. period is used to handle the petitioner's basic needs of bowel management, catherization, feeding, range of motion exercises, and monitoring his startle seizures and oxygen saturations.

9. The petitioner's caregiver has experienced increased medical problems. Gradually the father has become the primary caregiver due to the petitioner's size. His mother has a seizure disorder, severe hypoglycemia and is small in stature. The father has been diagnosed with bradycardia and hypertension. He is experiencing frequent dizzy spells and may need a pacemaker in the future. The father believes the stress of caring for the petitioner, long nights, shortened sleep and less support services are exacerbating his pre-existing conditions.

10. The information from the provider indicated that the petitioner receives PPEC services. This is not correct. The information submitted by the provider did not include information of the exertional limitations of the parents and their medical condition.

CONCLUSIONS OF LAW

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

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

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

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

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

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

Private Duty Nursing Services

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

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

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

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

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

The facts establish that the petitioner requested 12 hours of PDN services during the week. The prior authorization reviewer approved 8 hours of PDN hours during the week. The reviewer argued that these are the most hours that would be medically necessary on week nights since there are two parents that

are able to provide care beginning at 6 p.m. The reviewer asked the provider to explain "what was the purpose of the additional hours requested."

It is clear that the reviewers were not informed of the medical conditions of the parents that result in physical limitations. The assumption that there were two parents available to provide care was incorrect. The father bears a lot of responsibility for the care of the petitioner. However, he is having serious medical issues that are making his caregiver activities more difficult. The petitioner's increased size has seriously limited the ability of his mother to care for him due to her size and medical problems. The additional waking hours are requested to provide bowel care, catherizations, feeding, range of motion exercises, and monitoring his startle seizures and oxygen saturations.

The respondent has the burden of proof to establish that he petitioner's needs can be met with reduced services. After taking into consideration, the problems experienced by the caregivers, it is not reasonable to reduce the private duty nursing hours at this time. The additional hours are justified not for the convenience of the caregivers but to meet the medical needs of the petitioner.

DECISION

This appeal is granted. The respondent's action denying the requested 656 hours is reversed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with

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

DONE and ORDERED this 10 day of April, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: T.
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting