FILED

JUL 2 0 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03070

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 04 Duval
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 12, 2006 at 11:05 a.m., in Jacksonville, Florida. The petitioner was not present. However, he was represented by Vecie Yasinac, waiver support coordinator. Appearing as witnesses for the petitioner were \ father, r, mother, Jeanne Klusman, Director of Residential Habilitation Programming, Barbara Splater, Waiver Support Coordinator and Lisa Connelly, facility Director of Operations. Ann Cocheu, attorney, Office of the Attorney General, represented the agency. Appearing as witnesses for the agency were Chris Chrusciel, Agency for Persons with Disabilities and Dr. Emma Guilarte, Maximus, Inc. Dr. Guilarte

participated in the hearing by telephone. Sheryl Starkgraf appeared as a notary for the telephone witness.

ISSUE

The petitioner is appealing the agency's action of April 17, 2006 to reduce residential habilitation (with behavior focus) services from 16 hours a day to 9 hours a day due to the lack of medical necessity. The request was for payment under the Developmental Services Home and Community-Based Services Medicaid Waiver Program. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a participant in the Home and Community-Based Services Medicaid Waiver Program. The petitioner is diagnosed with Schizophrenia-undifferentiated type, impulse control, seizure disorder, gastroesophageal disease, Barrett's esophagitis and mental retardation.

A cost plan was submitted requesting residential habilitation at the behavior focus level with 16 hours of direct care staff a day/350 days a year. This service had been previously approved in this amount and intensity because the petitioner was transitioning from a home and respite setting to a residential habilitation placement. The petitioner moved into the group home in September 2005. The agency evaluated this request and determined that 9 hours a day of residential rehabilitation with behavior focus services was more appropriate. The agency notified the petitioner of its action on April 17, 2006.

The justification for the agency's initial decision states in part:

"The request is for 350 days of Residential Habilitation at the behavior focus Level with 16 hours of direct care staff per day for Mr. .. A previous request (PSA # 28961) approved the service at this level when Mr. first transitioned from home and respite settings into a Residential Habilitation placement. By 3/13/06 (the end of this cost plan year), Mr. will have had six months to transition to this new setting. The information indicates that after a fairly stable period, Mr. was told that this placement was permanent and that he was not going back home with his parents. Mr. began to exhibit more instances of problem behaviors. Mr. s also reported to rush through personal care and activities of daily living and requires verbal prompts and training to perform these tasks adequately. The Residential Habilitation staff coordinate medical and dental appointments and monitor Mr. . Mr. r attends an Adult Day Training Program not funded through the Developmental Disabilities Waiver. The request to continue this intensive level of support is primarily based on a history of behavior issues. It is noted that although Behavior Analysis was approved since 9-20-05, and a behavior intervention plan was written on 1-19-06. Baseline data is provided from 10-05 to 12-05 indicating that Mr. exhibited physical and verbal outbursts, however, it appears that there was no intervention in place for staff to assist Mr. in these situations until January.

Medical necessity is demonstrated for Residential Habilitation at the behavior focus level but not at the intensity requested. Residential Habilitation at the behavior focus level is approved for nine hours of direct care staff per day to provide assistance, supervision, training in personal care and activities of daily living, as well as the implementation of the behavior intervention plan. The competency based training of Residential Habilitation staff in the behavior intervention plan to reduce target behaviors should have been completed in the transition period and it would be expected that Mr. will continue to adjust to his new residential situation with the level of supports provided...

It appears that the lack of a behavior intervention plan within the 30 days after the service was approved may have contributed to the reported, frequency and intensity of Mr. s target behaviors during a transition period. It is recommended that the Area Behavior Analyst review the circumstances that may have led to significant delays, in the development of a behavior intervention plan for Mr. and take appropriate action, if needed. It is recommended that the Behavior Analysis provider track the behaviors for which medication in given and share with prescribing physicians to determine efficacy of medications to assure Mr. is on the least amount of medication to achieve a therapeutic outcome.

If requests for services continue at the currently requested level, it is recommended that a review for eligibility for Residential Habilitation - Intensive Behavior services be considered."

The petitioner requested a reconsideration. During the reconsideration the petitioner's need for services was restated and no additional information to demonstrate medical necessity was provided. The Maximus Unit determined that the initial decision should be upheld. The justification for the decision states in part:

"The request is for reconsideration of 350 days of Residential Habilitation services with a behavior focus at the intensity of seven (additional) direct care staff hours per day for Mr. T r. The initial request was for the same service in the same amount at the intensity of 16 direct care staff hours per day. The initial determination was to approve the services at the reduced intensity of nine hours of direct care staff hours per day. The determination was based on the lack of information sufficient to demonstrate its medical necessity at the intensity requested.
The documents submitted with the request for reconsideration included only restatement of need and a request that the documents submitted with the initial request be reviewed by a different review team. The documents do not offer any additional information such to demonstrate medical necessity for the service as it was initially requested. Consequently, the initial determination is upheld."

The petitioner participates in the ADM Program (Adult Mental Health) which is a meaning day activity for approximately six hours daily Monday through Friday with one hour for travel. It was also noted the Adult Day Training is available to the petitioner under the Waiver Program. The petitioner was described as fairly independent needing verbal prompts. The petitioner has some minor chronic health issues. However, it was the behavioral issues that warranted the most concern. The record shows the petitioner has on occasion demonstrated physical aggression and violence and on two occasions in the last year, had to be physically restrained.

The agency witness noted that the petitioner's participation in meaningful day activities as well as the petitioner's ability to function with verbal prompting were key considerations in its determination. It was also noted that if problematic behavior persists, despite coordinated intervention techniques, then Intensive Behavioral Residential Habilitation services may be more appropriate to meet the needs of the petitioner. It was explained that such services are provided at a specialized facility designed to accommodate more intense behaviors.

Although sleep disturbances was not identified as an issue in the support plan, the testimony at the hearing reflected the petitioner goes to bed at different times and gets up occasionally during the night. The group home staff performs bed checks every 15 minutes.

CONCLUSIONS OF LAW

42 C.F.R. §440.180 **Home or community-based services** states in part:

"(a) Description and requirements for services. Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter."

Florida Administrative Code 59G-13.080 **Home and Community-Based Services Waivers** states in part:

"(5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs:

(a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ('care plan', individual support plan', or 'family support plan'). Care plan requirements are outlined in subsections (6) and (8) of this rule.

(b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient.

(6) Program Requirements – General...(f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish each service...

(12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent."

Florida Administrative 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; 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."

Developmental Disabilities Services Waiver Florida Medicaid Coverage and Limitations Handbook dated June 23, 2005, states in part:

"**Description - Residential habilitation** provides specific training activities that assist the beneficiary to acquire maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the beneficiary to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the beneficiary and reflects the beneficiary's goal(s) from their current support plan.

Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the

Developmental Disabilities Program Office...Residential Habilitation with a Behavioral Focus Service characteristics for residential habilitation with a behavioral focus include:
• A Board Certified Behavior Analyst or Associate Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or 491, F.S., provides on-site-oversight for residential services,
• Integration of behavioral services throughout residential and community programs,
• No fewer than 75% of the provider's direct service staff who work with the recipient(s) for whom the residential habilitation with a behavioral focus rate applies have completed at least 20 contact hours of face-to face competency-based instruction with performance-based validation in the following content areas;
_ Introduction to applied behavior analysis – basic principles and functions of behavior.
_ Providing positive consequences, planned ignoring, and stop redirect-reinforce techniques.
_ Data collection and charting.
• The service provides for comprehensive monitoring of staff skills and their implementation of required procedures. Monitoring for competence must occur at least once per month for 50% of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each recipient's behavior analysis services plan.
• Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans...Recipients exhibiting one of the following characteristics may need residential habilitation with a behavioral focus services. Recipients receiving the service have behavioral challenges that fit one or both of the following two categories of behavioral problems, labeled A and B:
A. The person does not engage in an adaptive behavior that, if not performed by the person or taught by a caregiver, would result in a real and present threat of substantial harm to the person's health or safety. This includes not engaging in adaptive behaviors such as following safety rules, responding in acceptable ways to conflict, performing daily living activities safely and maintaining basic health.
B. The person has exhibited a problem with behavior during the past year or currently exhibits a problem with behavior that meets one of the criteria below:
• Requires visual supervision during all waking hours and intervention

as determined by a certified behavior analyst or licensed behavior analysis professional.
• Is being addressed through the use of behavior analysis services and reviewed by the Local Review Committee (LRC).
• Has led to the use of restraint or emergency medications within the past year.
Has resulted in one or more of the following:
1. Self-inflicted, detectable, external or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
2. External or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behavior include hitting others, biting others and throwing dangerous objects at others.
3. Arrest and confinement by law enforcement personnel.
4. Major property damage or destruction in excess of $500 for any one intentional incident.
5. A life-threatening situation. These types of behaviors include but are not limited to excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.
Intensive Behavioral Residential Habilitation
Intensive behavioral residential habilitation rates for a recipient shall be approved and authorized through the prior service authorization process performed by the Department or an agent of the Department.
Authorization shall require review by at least one board certified behavior analyst or a Florida certified behavior analyst with expanded privileges who holds a master's degree with a primary emphasis in applied behavior analysis. The review process shall include evaluation of the proposed rates for the service being sought. Authorized rates for this service may vary across providers and recipients based on the specific service needs of the recipient. Service authorization shall occur prior to service delivery, for new services, within 30-days of the adoption of this rule for existing services and at least once every six months while the recipient is receiving the service.
The provider must meet provider qualifications for this level of service. Further, the following recipient characteristics and service characteristics must be met in order to receive an intense behavioral residential habilitation rate. Service authorization shall be based on established need and reevaluated at least every six months while the recipient is receiving the services. The provider must document evidence of continued need as

well as evidence that the service is assisting in meeting the needs so that transition to less restrictive services may be possible."

In a cost plan, the petitioner requested that the agency pay for 16 hours daily of residential habilitation services with behavior focus. Although the petitioner is described as fairly independent, he requires some verbal prompting with activities of daily living because he will sometimes rush through such activities. The petitioner must be frequently redirected. In evaluating this request for services, the agency noted that even though the petitioner can demonstrate challenging behaviors, he typically spends seven hours a day in a meaning day activity. It was noted that Behavior Analysis was approved in September 2005 yet an intervention plan was not written until January 2006. There was speculation that the petitioner's behaviors may have escalated due to the lack of an intervention plan during this period. It was also noted that 16 hours of the service had been previously approved to assist the petitioner with transitioning into a different living environment. In considering all of these factors the agency determined that the request for 16 hours daily of residential habilitation services was excessive. As such, the agency determined that nine hours daily of residential habilitation services was medically necessary.

Upon a careful evaluation of the evidence presented, and in the absence of any medical necessity evidence to the contrary, the hearing officer concludes that the agency's action to approve nine hours daily of residential habilitation services instead of the requested 16 hours a day, due to the lack of medical necessity, is an action that is consistent with the above cited authorities and is therefore, correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, 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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20th day of July, 2006,

in Tallahassee, Florida.

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:
District 4 APD: Gayle Granger
Ann Cocheu, Esq.
Vecie Yasinsac, CWSC

FILED
JUL 12 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-02879

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT:

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 7, 2006, at 9:51 a.m., at the Caleb Center, in Miami, Florida. The petitioner was present and represented herself at the hearing. The agency was represented by Wanda Nitiss, senior human service program specialist, Agency For Health Care Administration (AHCA). Present as witness for the agency, via the telephone, was Dr. Frank Castrina, physician reviewer and medical director, from KePRO. Also present, via the telephone, as witnesses for the agency were Debra Parthemore, registered nurse and Katarina Peters, registered nurse, both from KePRO. KePRO, for the action under appeal, is located in Harrisburg, Pennsylvania. Lisandra Lantiqua was present as an interpreter. The hearing was left open for six additional days in order for the petitioner to submit additional information. The hearing was left open for three more additional days for the respondent's witness to respond to the information if submitted.

The petitioner submitted additional information after the deadline; however it was allowed to be accepted into evidence. The respondent was provided additional days past the original deadline in order to respond. The respondent responded within the additional time frame allotted.

ISSUE

At issue is the agency's action of March 31, 2006, to cancel/terminate the petitioner's request for continued private duty nursing services for the period of March 3, 2006 through May 1, 2006. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner has 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".

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 March 31, 2006, that the petitioner's request for continued private duty nursing was going to be cancelled/terminated for the period of March 3, 2006 through May 1, 2006. More specifically, the petitioner was approved for approximately two weeks of private duty nurse service that were to expire on March 31, 2006. The agency's witness indicated that after review of the information provided to KePRO from the petitioner's nursing service provider; did not indicate a need for skilled nursing services for the petitioner, beyond the two week period. According to the

respondent's witness; the approximate two week period of private duty nursing was intended to help train the petitioner in providing herself with her daily insulin injections.

The petitioner submitted as evidence while the hearing was left open, Petitioner Exhibit 1, copies of her lab reports and copies of prescriptions from her psychiatrist. On one of the prescriptions, dated June 7, 2006, the petitioner's psychiatrist states in part: "...she needs a person to be with her to help her with regular duties at her apartment and supervise her medication."

The respondent's consulting physician responded to the above provided information in Petitioner Exhibit 1, while the hearing was left open and stated in part: "The records available for review do not document medical, psychiatric or other factors that would preclude self administration of insulin. The patient is receiving Home Health Aide visits twice daily."

CONCLUSIONS OF LAW

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

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

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

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

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

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

The agency, through KePRO, took action on March 31, 2006 to cancel/terminate the petitioner's request for continued private duty nursing services for the period of March 3, 2006 through May 1, 2006. The agency had provided the petitioner with an

approximate two week period of nursing care so as to train her in self injection of insulin. This decision was based on the information as provided by the petitioner's nursing service and the petitioner's medical necessity need of the request for the service.

The petitioner argued that she needs the continued private duty nurse to inject her with the insulin because of her fear of injecting herself with the insulin. She argued that this "need" (for the nurse) is based on her mental disability. The respondent argued that with the information provided from the nursing agency, the petitioner can; after the training by the private duty nurse, inject herself with the insulin. The respondent further argued that a home health aide has been provided to assist her with her daily activities. The respondent argued that the petitioner's medical necessity need of the request for the service has not been demonstrated. The hearing officer agrees with the last respondent 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 affirms the agency's action of March 31, 2006, to cancel/terminate the petitioner's request for continued private duty nursing services for the period of March 3, 2006 through May 1, 2006.

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 12th day of July, 2006,

in Tallahassee, Florida.

Robert Akel

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

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

FILED

JUL 2 1 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-01911

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 June 19, 2006, at 1:13 p.m., at the Sony Service Center, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's mother, [redacted]. The agency was represented by Rafael Copa, program administrator, Agency For Health Care Administration (AHCA). Present as witness for the agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present, via the telephone, as witnesses for the agency was Cheryl Vanhorn, registered nurse, KePRO. KePRO is located in Tampa, Florida. A continuance was granted on behalf of the petitioner for a hearing previously scheduled on May 18, 2006. The hearing was left open for seven additional days in order for the petitioner to submit additional information and another seven days for a total of

fourteen days for the respondent to respond to the information. Additional information and a response was submitted within the time frame allotted.

ISSUE

At issue is the agency's action of February 17, 2006, to deny the petitioner's request for continued private duty nursing services of 120 hours additional hours of the service (720 total hours requested, 600 hours approved) for the period of February 13, 2006 through April 13, 2006. The reduction is from 12 hours a day to 10 hours a day of the above service. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about nineteen month 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".

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 February 17, 2006, that the petitioner's request for continued 720 hours of private duty nursing was going to be denied/reduced to 600 hours for the period of February 13, 2006 through April 13, 2006. The agency's witness indicated that after review of the information provided to KePRO, from the petitioner's nursing service provider, did not indicate a need for the level or amount of skilled nursing services for the petitioner.

The hearing was left open for a total of fourteen days in order for the petitioner to submit additional information and for the respondent to respond to the additional information if submitted. The petitioner submitted additional information and it was accepted into evidence as part of Petitioner Exhibit 1. This exhibit is a clearer copy of what was originally submitted at the hearing as Petitioner Exhibit 1. The respondent (the local AHCA representative) responded verbally and submitted what has been accepted into evidence as Respondent Exhibit 2. Respondent Exhibit 2 is a copy of a computer printout indicating that KePRO has approved the petitioner for the total of 720 hours of private duty nursing service. The verbal response from the AHCA representative to the hearing officer was that the petitioner's representative had apparently changed her service provider while the hearing was left open; the new provider apparently provided KePRO with information regarding the petitioner's medical condition; and KePRO approved the full request for the requested hours of the private duty nursing service of 720 hours.

CONCLUSIONS OF LAW

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

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

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

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

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

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

The agency, through KePRO, took action on February 17, 2006 to reduce the petitioner's request for continued private duty nursing services from a total of 720 hours of

the service to 600 hours for the period of February 13, 2006 through April 13, 2006. The reduction amount, considered on a daily basis, is from 12 hours a day to 10 hours a day of the service. This decision was based on the information as provided by the petitioner's nursing service and the petitioner's medical necessity need of the request for the service.

The petitioner's representative disagreed with the agency's decision. KePRO or the agency, while the hearing was left open, approved the petitioner for the total amount of hours of the private duty nursing service requested.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer does not uphold the agency's action of February 17, 2006, to reduce the petitioner's request for continued private duty nursing services from 720 hours of the service to 600 for the period of February 13, 2006 through April 13, 2006.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21st day of July, 2006,

in Tallahassee, Florida.

Robert Akel

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

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

FILED

JUL 3 1 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03946

PETITIONER,
Vs.

CASE NO. 1196575436

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 6, 2006, at 10:30 a.m., in Pensacola, Florida. The petitioner was not present but was represented by his daughter [redacted]. The department was represented by Franzaro Dudley, economic self-sufficiency specialist supervisor. Testifying on behalf of the department was Jennifer Brenson, economic self-sufficiency specialist I.

ISSUE

The petitioner is appealing the department's action of January 11, 2006 to deny Institutional Care Program (ICP) and Medicaid benefits for the months of August through October 2006 based on the contention that the petitioner had resources in excess of allowable program limits.

FINDINGS OF FACT

The petitioner applied for ICP and Medicaid program benefits on November 28, 2005 requesting ICP benefits retroactively for August through October 2005 and ongoing. On January 11, 2006 the department determined that the petitioner's asset value exceeded program eligibility limits. A Notice of Case Action dated January 11, 2006 was sent to the petitioner advising him that his ICP application for August through November 2005 was denied based on excess resources.

On June 14, 2006, the department received a request for a hearing of the January 11, 2006 ICP and Medicaid denial from the petitioner. The hearing request was received on the 154th day from the date of the January 11, 2006, Notice of Case Action. The hearing request was not received within 90 days of the Notice of Case Action. The 90th day from the January 11, 2006 Notice of Case Action was April 11, 2006.

CONCLUSIONS OF LAW

Florida Administrative Code section 65-2.046 in part states:

> "Time Limits in Which to Request a Hearing. (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs. Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following:
>
> (a) The date on the written notification of the decision on an application.
>
> (b) The date on the written notification of reduction or termination of program benefits.
>
> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or

action is other than an application decision or a decision to reduce or terminate program benefits."

The above rule states that an individual must request a hearing within 90 days of the date of the written notification of the decision on an application. In this case, written notification of the decision on the application was mailed to the petitioner on January 11, 2006. On June 14, 2006, the petitioner requested a hearing as he disagreed with the decision. This request was not filed within 90 days of the written notification as required by the above rule. Therefore, the correctness of the denial of the application for ICP and Medicaid cannot be addressed as it is non-jurisdictional.

DECISION

The appeal is denied as non-jurisdictional.

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 31st day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
1 DPOES: VeeVee Brown
JANETTE DYER

FILED
JUL 2 1 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03730

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT:

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 12, 2006, at 9:45 a.m., in Miami, Florida. The petitioner was present and represented herself. The agency was represented by Oscar Quintero, senior human service program specialist, Agency for Health Care Administration. Also present on behalf of the agency was Hector Gutierrez, senior human service program specialist, Agency for Health Care Administration. Present as witnesses for the agency, via the telephone, were Dr. Amelia Tunanidas, medical director for KePRO and Diane Weller, KePRO contract manager at the Agency for Health Care Administration. [illegible], petitioner's daughter, served as an interpreter.

ISSUE

At issue is the agency's denial to pay for inpatient hospital medical services provided to the petitioner from April 12 through April 18, 2006, because the medical care

as described to them does not appear to require impatient services. The authorization request was denied pursuant to rule 59G-4.150. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, is an adult female, 55 years of age, who was admitted for jaundice and pancreatic mass at Jackson Memorial Hospital on April 7, 2006.

Keystone Peer Review Organization (KePRO) is the Peer Review Organization contracted by the Agency for Health Care Administration (AHCA) to perform medical review for the Medicaid Prior Authorization for Inpatient Hospital Medical Services Program for Medicaid beneficiaries in the state of Florida.

On May 4, 2006, KePRO received a request from the provider (Jackson Memorial Hospital) for authorization for a retrospective review for 11 days of inpatient stay from April 7, 2006 through April 18, 2006. Initial screening review performed by KePRO nurse reviewers at the direction of AHCA using Interqual Criteria under Surgery/Trauma acute, determined that the clinical information sent by the provider did not meet medical necessity.

On May 11, 2006, the case was referred to a Board-Certified Internal Medicine Physician who recommended approval for five days, from April 7, 2006 though April 12, 2006 and denial for six days, from April 12, 2006 through April 18, 2006. The physician concluded that there was limited data to support acute level care as documented and noted that no data for April 12, or April 15, 2006 was given. KePRO's attempts to obtain additional information were unsuccessful. The facility did not request a reconsideration. The petitioner was notified on May 23, 2006 of the agency's split decision.

The petitioner expressed that she is not working and cannot pay the hospital bill.

The agency responded that the petitioner will not be responsible for any charges related to this admission.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.901(14) **Definitions** states in part:

> "Medicaid agency" or "agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

Fla. Admin. Code 59G-4.150, defines Inpatient Hospital Services and states as follows:

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

Fla. Admin. Code 59G-1.010, which applies to the Florida Medicaid Program states in part:

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

These rules established guidelines for the definition and authorization of Inpatient Hospital Services. The agency has reviewed the petitioner's eligibility for this service from April 7, 2006 through April 18, 2006, and determined that the service does not meet the conditions of medical necessity from April 12, 2006 through April 18, 2006.

Based on the evidence, testimony and above authorities, the hearing officer concludes that the agency was correct in its denial to pay for inpatient hospital medical services provided to the petitioner from April 12, 2006 through April 18, 2006.

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 21st day of July, 2006,

in Tallahassee, Florida.

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

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

FILED
JUL 14 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-02555

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 23 Hillsborough
UNIT:

RESPONDENT.

FINAL ORDER

Pursuant to notice, an administrative hearing was convened on June 7, 2006, at 9:13 a.m., in Tampa, Florida. The respondent agency was represented by Glorybell Ramirez, senior human services program specialist with the Agency For Health Care Administration (AHCA). The petitioner himself was not present, but was represented by his father, [illegible], who also testified.

ISSUE

The petitioner is seeking a secondary medical opinion, specifically a medical evaluation by the Cleveland Clinic, or an examination by another asserted competent physician.

FINDINGS OF FACT

The petitioner is currently a resident of the e nursing facility. There is no belief or evidence to suggest that this nursing facility is seeking to transfer or discharge the petitioner from this facility. The petitioner's primary medical insurance is Medicare, and the petitioner is also eligible for Medicaid benefits.

The petitioner's representative is seeking another medical evaluation of the petitioner's condition to include evaluation of the petitioner's diagnoses, and a review of present medical findings. AHCA has not denied any recently requested services that are potentially payable by Medicaid, per testimony of the AHCA representative.

CONCLUSIONS OF LAW

The jurisdiction to conduct hearings related to an intended transfer or discharge of an individual from a nursing facility is conveyed to the Department by Federal Regulations appearing at 42C.F.R.§431.200. 42C.F.R.§431.220(3) further clarifies an individual's right to request a hearing when:

> "(3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged...."

There is no evidence to indicate that there is intent to transfer or discharge the petitioner from the nursing facility where he presently resides,

Therefore, since such discharge or transfer action has not been initiated, jurisdiction is not conveyed to this hearing authority by virtue of such.

Florida Statutes 120.80(7) further defines the jurisdiction of this hearing authority to those social and economic programs formerly administered by the Department of Health

and Rehabilitative Services, which would include medical services potentially payable by Medicaid as administered by the Agency For Health Care Administration (AHCA). Florida Administrative Code Rule 65-2.056 entitled "Basis of Hearings" further defines this jurisdiction, as follows:

The hearing shall include consideration of:

(1) Any agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.
(2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.
(3) The Hearing Officer shall determine whether the action by the agency was correct at the time the action was taken.

The Findings of Fact show that AHCA has not recently denied any recently requested medical services potentially payable by Medicaid. Findings show that the petitioner is seeking a secondary medical evaluation of the petitioner's medical evaluation. This matter is not included in the jurisdiction of this hearing authority for review, as verbally advised or directed the parties on the date of the hearing. The petitioner was referred to confer with the AHCA representative, off the verbatim record, to explore any potential options for a secondary medical evaluation. Therefore, this appeal is denied or dismissed as non-jurisdictional to this hearing authority.

DECISION

The appeal is denied or dismissed as asserted hearing matters are non-jurisdictional to this hearing authority, as described in the above conclusions. This same verbal verdict was directed the parties on the date of the hearing.

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 July ,2006,

in Tallahassee, Florida.

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

Copies Furnished To: S
Patrick Glynn, Area 6 Medicaid Adm.

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

APPEAL NO. 06F-01548

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 June 19, 2006, at 9:17 a.m., at the Sony Service Center, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's mother, [illegible] The agency was represented by Helena Glassberg, program operations administrator, Agency For Health Care Administration (AHCA). Present as witness for the agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present, via the telephone, as witnesses for the agency was Cheryl Van Horn, registered nurse supervisor, KePRO. KePRO is located in Tampa, Florida. Continuances were granted on behalf of the petitioner for a hearings previously scheduled on April 21, 2006 and May 31, 2006.

ISSUE

At issue is the agency's action of December 28, 2005, to cancel/terminate the petitioner's request for continued home health aide services for the period of January 8, 2006 through March 8, 2006. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about one year and five months old, has medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner is a sibling to two other children (triplets). The other children have similar medical problems and are consumers receiving services as described above. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "agency".

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 December 28, 2005, that the petitioner's request for continued use of home health aids was going to be cancelled/terminated for the period of January 9, 2006 through March 9, 2006. The agency's witness indicated that after review of the information provided to KePRO, from the petitioner's nursing and home health aide service provider, it did not indicate a need for home health aide services for the petitioner. The agency noted that the petitioner is not ill at this time and may receive care from a regular day care center.

CONCLUSIONS OF LAW

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

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

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

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

5. Reasonable and necessary to the treatment of a specific documented illness or injury;
6. Consistent with the nature and severity of the individual's condition or the disease state or stage...

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

The agency, through KePRO, took action on March 24, 2006 to cancel/terminate the petitioner's request for continued home health aide(s) services for the period of January 8, 2006 through March 8, 2006. This decision was based on the information as provided by the petitioner's nursing and home health aide service and the petitioner's medical necessity need of the request for the service.

The petitioner argued that the petitioner has medical problems. She argued that she needs help with taking care of the petitioner and his siblings. She argued that the home health aide is not "baby sitting" for the petitioner as was described to her from someone at KePRO. The respondent reiterated that the petitioner does not have a medically necessary condition for the need of home health aid(s) and can receive assistance through a normal day care center. The hearing officer agrees with the respondent's 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 affirms the agency's action of December 28, 2005, to cancel/terminate the petitioner's request for continued home health aide services for the period of January 8, 2006 through March 8, 2006.

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 5th day of July, 2006,

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:
Gail Wilk, Area 10 Medicaid Adm.

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

APPEAL NO. 06F-01549

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 June 19, 2006, at 9:17 a.m., at the Sony Service Center, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's mother, The agency was represented by Helena Glassberg, program operations administrator, Agency For Health Care Administration (AHCA). Present as witness for the agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present, via the telephone, as witnesses for the agency was Cheryl Van Horn, registered nurse supervisor, KePRO. KePRO is located in Tampa, Florida. Continuances were granted on behalf of the petitioner for a hearings previously scheduled on April 21, 2006 and May 31, 2006.

ISSUE

At issue is the agency's action of December 28, 2005, to cancel/terminate the petitioner's request for continued home health aide services for the period of January 8, 2006 through March 8, 2006. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about one year and five months old, has medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner is a sibling to two other children (triplets). The other children have similar medical problems and are consumers receiving services as described above. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "agency".

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 December 28, 2005, that the petitioner's request for continued use of home health aids was going to be cancelled/terminated for the period of January 9, 2006 through March 9, 2006. The agency's witness indicated that after review of the information provided to KePRO, from the petitioner's nursing and home health aide service provider, did not indicate a need for home health aide services for the petitioner. The agency noted that the petitioner is not ill at this time and may receive care from a regular day care center.

The petitioner, along with his other triplet siblings, was preterm infants. Based on this and the mother being the only caretaker of the triplets, they were previously approved for the home health aide service by the agency.

CONCLUSIONS OF LAW

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

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

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

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.

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

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

The agency, through KePRO, took action on March 24, 2006 to cancel/terminate the petitioner's request for continued home health aide(s) services for the period of January 8, 2006 through March 8, 2006. This decision was based on the information as provided by the petitioner's nursing and home health aide service and the petitioner's medical necessity need of the request for the service.

The petitioner argued that the petitioner has medical problems. She argued that she needs help with taking care of the petitioner and his siblings. She argued that the home health aide is not "baby sitting" for the petitioner as was described to her from someone at KePRO. The respondent reiterated that the petitioner does not have a medically necessary condition for the need of home health aid(s) and can receive assistance through a normal day care center. The hearing officer agrees with the respondent's 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 affirms the agency's action of December 28, 2005, to cancel/terminate the petitioner's request for continued home health aide services for the period of January 8, 2006 through March 8, 2006.

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 5th day of July, 2006,

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: I
Gail Wilk, Area 10 Medicaid Adm.

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

APPEAL NO. 06F-02663

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 June 19, 2006, at 9:17 a.m., at the Sony Service Center, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's mother, ' The agency was represented by Helena Glassberg, program operations administrator, Agency For Health Care Administration (AHCA). Present as witness for the agency, via the telephone, was Dr. Robert Buzzio, physician reviewer, from KePRO South. Also present, via the telephone, as witnesses for the agency was Cheryl Van Horn, registered nurse supervisor, KePRO. KePRO is located in Tampa, Florida. A continuance was granted on behalf of the petitioner for a hearing previously scheduled on May 31, 2006.

ISSUE

At issue is the agency's action of March 24, 2006, to cancel/terminate the petitioner's request for continued home health aide services for the period of March 9, 2006 through May 7, 2006. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about one year and five months old, has medical problems that require medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner is a sibling with two other children (triplets). The other children have similar medical problems and are consumers receiving services as described above. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA, as noted above, will be further addressed as the "agency".

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 March 24, 2006, that the petitioner's request for continued use of home health aids was going to be cancelled/terminated for the period of March 9, 2006 through May 7, 2006. The agency's witness indicated that after review of the information provided to KePRO, from the petitioner's nursing and home health aide service provider, it did not indicate a need for home health aide services for the petitioner. The agency noted that the petitioner is not ill at this time and may receive care from a regular day care center.

The petitioner, along with his other triplet siblings, was preterm infants. Based on this and the mother being the only caretaker of the triplets, they were previously approved for the home health aide service by the agency.

CONCLUSIONS OF LAW

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

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

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

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.

> (b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
> 1. Ordered by and remain under the supervision of a physician;
> 2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
> 3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
> 4. Required on a daily basis;
> 5. Reasonable and necessary to the treatment of a specific documented illness or injury;
> 6. Consistent with the nature and severity of the individual's condition or the disease state or stage...

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

The agency, through KePRO, took action on March 24, 2006 to cancel/terminate the petitioner's request for continued home health aide(s) services for the period of March 9, 2006 through May 7, 2006. This decision was based on the information as provided by the petitioner's nursing and home health aide service and the petitioner's medical necessity need of the request for the service.

The petitioner argued that the petitioner has medical problems. She argued that she needs help with taking care of the petitioner and his siblings. She argued that the home health aide is not "baby sitting" for the petitioner as was described to her from someone at KePRO. The respondent reiterated that the petitioner does not have a medically necessary condition for the need of home health aid(s) and can receive assistance through a normal day care center. The hearing officer agrees with the respondent's 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 affirms the agency's action of March 24, 2006, to cancel/terminate the petitioner's request for continued home health aide services for the period of March 9, 2006 through May 7, 2006.

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 5th day of July, 2006,

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: I
Gail Wilk, Area 10 Medicaid Adm.

FILED

JUL 2 1 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs.

APPEAL NO.06F-2140

AGENCY FOR HEALTH CARE ADMINISTRATION
AREA: 23 Pinellas
RESPONDENT.
_______________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 2, 2006, at 1:15 p.m., in St. Petersburg, Florida. The petitioner was present. assisted the petitioner. The respondent was represented by Brevin Brown, Esq., assistant general counsel with the Agency for Health Care Administration (AHCA). Witnesses for the respondent from the Department of Public Health were Kris Russell, Brain and Spinal Cord Injury Program director, and Leonard Erwin, senior case manager. The hearing was reconvened to June 30, 2006.

The administrative hearing was reconvened on June 30, 2006, at 1:15 p.m., in St. Petersburg, Florida. The petitioner was present. and were present to assist the petitioner. The respondent was represented by Brevin Brown, Esq., assistant general counsel with the Agency for Health Care Administration (AHCA). Witness for the respondent from the Department of Public Health was Kris Russell, Brain and Spinal Cord Injury Program director.

The record was left open until July 6, 2006 for the respondent to provide the petitioner's date of reapplication and position on the waiting list and the policy in effect at the time of the reapplication. A copy of all documents was to be sent to the petitioner.

On June 30, 2006, the date of reapplication was received and entered into record as Respondent Exhibit 4. On June 30, 2006, an email was sent to the respondent indicating that the date of reapplication was received and the petitioner's position on the waiting list and the policy in effect at the time of the reapplication was pending. On July 6, 2006, the respondent submitted the Home and Community Based Waiver for Traumatic Brain Injury and Spinal Cord Injury 1915(c) Waiver Renewal Request Waiver #0342. The waiver was entered into record as Respondent Exhibit 5. The petitioner's position on the waiting list was not received.

ISSUE

The petitioner is appealing the denial of service for the Brain and Spinal Cord Injury Program (BSCIP) and continued placement the petitioner on a waiting list for the petitioner's reapplication on July 18, 2006. The petitioner has the burden of proof for eligibility.

FINDINGS OF FACT

The petitioner is Medicaid recipient who is quadriplegic as a result on an injury in 1985. The petitioner requires assistance with his activities of daily living (ADL's), as well as other tasks, such as help with bathing, dressing, eating, re-positioning and taking daily medications. In addition to need for help with his ADL's, the petitioner suffers from hypertension, depression, renal failure, decubitus ulcers and bladder infections. He was

registered and enrolled in the Brain and Spinal Cord Injury Program (BSCIP) in June 2003.

The BSCIP is a waiver program that provides home and community based services to allow individuals who would otherwise require nursing home care or other institutional care to receive services in their own homes or in home-like settings. Under the provisions of the Medicaid Act, states may include as medical assistance the cost of home and community based services, which if not provided, would require care to be provided in a nursing home, hospital or other institutional setting.

In 2002, a waiting list methodology had been developed which would assign a prioritization score to those people on one of three waiting lists. As of 2005, there would no longer be three waiting lists. There would be one waiting list, and the person with the highest score on the screening tool that has been on the waiting list the longest, would be the next person to be served on the Waiver.

In February 2005, the petitioner was admitted to Morton Plant Hospital. On February 14, 2005, the petitioner contacted his waiver coordinator to request assistance locating a nursing facility. On February 25, 2005, the waiver coordinator visited the petitioner where the petitioner was residing at the [illegible], a skilled nursing facility. At the time, there was no viable discharge plan and no community supports. The waiver coordinator and the petitioner discussed the suspension from the program and that the petitioner would be placed on the waiting list. The petitioner was given a Notice of Rights to Appeal - Due to Suspension/Refusal of Services Template. The notice indicated that the petitioner's services with the BSCIP were suspended. On

March 21, 2005, the petitioner's case was closed and he was placed on the waiting list. At that time he was on the "A" list, as a priority.

On July 18, 2005, the petitioner requested BSCIP service with the intent to return to the community. The petitioner had made arrangements for in home support. At the time of the request, the respondent indicated that all the 300 slots for the BSCIP waiver were full. The petitioner was notified that there were no longer three lists and he was no longer on the priority list. The petitioner was denied BSCIP services and remained on the waiting list.

The petitioner requested a hearing on March 22, 2006. A motion to dismiss was made by the respondent, on the grounds that the hearing request exceeded the 21 day time limit in which to request a hearing from the last notice the petitioner received on February 25, 2005. A Motion hearing was held on June 22, 2006. The motion was denied. The reason for the denial was that the petitioner was denied BSCIP services on July 18, 2005 and as no notice was issued on July 18, 2005, the petitioner's right to seek an appeal based on that denial had not expired.

The petitioner is currently residing in the nursing facility. There is no anticipated date of discharge. There is no current plan of discharge.

The respondent stated that there are 300 slots on the waiting list. The respondent indicated that the handbook was not promulgated into rule until April 2006. The respondent was unable to locate any policy from 2005 regarding the waiting list. The respondent relied on the Home and Community Based Waiver for Traumatic Brain Injury and Spinal Cord Injury 1915(c) Waiver Renewal Request Waiver #0342. The waiver indicated 300 slots on the waiting list. According to the respondent, in July 2005 all of the

slots were full. Currently, 298 of the 300 slots were full with two individuals completing the process for the remaining two slots. The respondent did not provide the petitioner's position on the waiting list or how the petitioner was assigned to the waiting list.

CONCLUSIONS OF LAW

The Florida Statutes at Fla. Stat. 381.76 sets forth the eligibility for the brain and spinal cord injury program:

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

The Florida Administrative Code at Fla. Admin. Code 64I-1.002 sets forth services for BSCIP:

> (1) All Services must be directed specifically to an individual applicant or eligible person by prior authorization of BSCIP...
> (3) The applicant shall be determined ineligible for the General Program if the applicant...
> (b) Does not require services to achieve reintegration into the community...
> (4) The eligible person's case shall be closed if the eligible person is:
> (c) Is not reasonably expected to return to an appropriate level of functioning in the community through services.
> (5) Previous closure under paragraph (3)(b) or (4)(b) above does not prevent an individual from becoming an applicant.

The petitioner has the burden of proof for eligibility. When the petitioner entered the nursing home in February 2005 without a date of discharge the respondent was correct to terminate waiver service. The petitioner reapplied on July 18, 2005. Having already previously registered with the registry and his type of injury, the petitioner met the

criteria for the program. The denial was based on insufficient slots for service for the petitioner in the waiver. The petitioner was placed in a "pending funding" waiting list. The burden then shifts to the respondent to show why services cannot be provided.

The Home and Community Based Waiver for Traumatic Brain Injury and Spinal Cord Injury 1915(c) Waiver Renewal Request Waiver #0342 set forth that there are 300 slots for the waiver. The unrefutted testimony of the expert witness was that in July 2005 there were no available slots. On June 30, 2006, the expert testified that 298 of the slots are filled with pending placement of the two remaining slots. The respondent has met their burden that there are no available slots at this time for placement on the waiver.

However, the respondent failed to submit documentation of completing their procedure for the wait list or policy, handbook or rule for July 2005 for the waiting list. The respondent was unable to locate any policy from 2005 regarding the waiting list. They indicated that there was a change in the waiting list in 2005 to one waiting list, from the three tiered list in 2003. The evidence was that the petitioner was on the priority waiting list in 2003.

The April 2006 Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook indicates that there is a TBI/SCI Prioritization Screening Tool. The handbook states that the applicants on previous waiting lists will be screened under the new procedures using the screening instrument and will be placed on the wait list according to the screening score and original date of contact is the date of initial contact with the Central Registry.

The policy and handbook indicate that the petitioner should have had a screening in 2005 and a rescreening in 2006. The respondent did not provide documentation of the

petitioner's screening in either July 2005 or April 2006. Therefore, it is hereby ordered that the respondent is to screen the petitioner using the new screening tool and to use the petitioner's original date of contact with the Central Registry of June 2003. The respondent has 14 days from the date of this Order to complete the screening instrument and notify the petitioner of his placement on the waiting list.

DECISION

This appeal is found as follows.

The appeal is denied for immediate placement on the Brain and Spinal Cord Injury Program.

The appeal is granted for reconsideration of the petitioner's placement on the waiting list. The respondent is ordered to screen the petitioner using the new screening tool and to use the petitioner's original date of contact with the Central Registry of June 2003. The respondent has 14 days from the date of this Order to complete the screening instrument and notify the petitioner of his placement on the waiting list.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 21st day of July, 2006,

in Tallahassee, Florida.

L. J. Nicholson
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: [illegible]
Noreen Hemmen, Area 5 Medicaid Adm.
Brevin Brown, assistant general counsel for the respondent

FILED
JUL 2 1 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-02911

PETITIONER,

Vs.

CASE NO. 1058592882

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 07 Orange
UNIT: 66292

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 12, 2006, at 10:54 a.m., in Orlando, Florida. The petitioner appeared and represented herself. Reginald Schofield, economic self-sufficiency specialist supervisor, appeared and represented the department.

ISSUE

At issue is the department's action of March 3, 2006, determining there to be no change in the patient responsibility amount ($543.00) of nursing home care for the petitioner's spouse. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

The petitioner's spouse resides in a nursing facility. The petitioner applied for Institutional Care Program (ICP) Medicaid benefits for her husband through

the department. These benefits were approved. The department determined that based on the couple's income, assets, and expenses, the spouse's responsibility for his nursing home care amounted to $543.00 per month.

The department completed a re-certification of the spouse's patient responsibility in March 2006. The petitioner reported the following information to the eligibility specialist: shelter and utilities ($2,038), institutional spousal income ($1,136), and community spousal income ($1,931). The department completed the eligibility process based on this information. It was determined that the institutional spouse's patient responsibility remained $543.00 per month (Respondent's Composite Exhibit 2). The department issued an official notice informing of this dated March 3, 2006 (Respondent's Exhibit 1).

At the hearing, the petitioner seeks to have the hearing officer either raise the shelter cap in the budgetary process or raise the community spouse Minimum Monthly Maintenance Income Allowance (MMMIA). Ultimately, she seeks to have her husband's patient responsibility decreased from $543.00 to $0.00 per month. She states her expenses are too high for her to maintain and is unable to pay his responsibility of $543.00. Her total income per month is around $2,500.00. Her shelter and utilities expense is approximately $2,158.00 (including homeowner's insurance not counted in the re-determination). This leaves her with $342.00 per month. She also has to pay off a personal loan taken out to purchase a hospital bed for her husband prior to his admission to the nursing facility. This loan is $200.00 per month. Once subtracted from her remaining income, this leaves her with $142.00 per month to pay for car

insurance, food, gas, and personal items and ultimately, her husband's $543.00 monthly patient responsibility. She is struggling financially to meet these obligations.

CONCLUSIONS OF LAW

Fla. Integrated Pub. Asst. Policy Manual 165-22 HRSM, section 1840.0102 states in part:

> Some deductions withheld from gross income must be included as income. Examples of these deductions include:
> 1. premiums for Supplemental Medical Insurance (SMI/Medicare) from a Title II (Social Security) benefit,
> 2. premiums for health insurance or hospitalization,
> 3. premiums for life insurance,
> 4. federal and state income taxes,
> 5. Social Security taxes,
> 6. optional deductions.
> 7. a garnished or seized payment,
> 8. guardianship fees, and
> 9. child support if redirected irrevocably from the source.

The department has counted all income in the eligibility determination correctly.

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

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

for institutional care benefits. The standards used are found in subsection 65A-1.716(5), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses...
(g) Effective January 1, 2004, the department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.
1. The medical/remedial care service or item must meet all the following criteria:
a. Be recognized under state law;
b. Be medically necessary;
c. Not be a Medicaid compensable expense; and
d. Not be covered by the facility or provider per diem.
2. For services or items not covered by the Medicaid State Plan, the amount of the deduction will be the actual amount for services or items incurred not to exceed the highest of a payment or fee recognized by Medicare, commercial payers, or any other contractually liable third party payer for the same or similar service or item.
3. Expenses for services or items received prior to the first month of Medicaid eligibility can only be used in the initial projection of medical expenses if the service or item was provided during the three month period prior to the month of application and it is anticipated that the expense for the service or item will recur in the initial projection period.
4. For the initial projection period, the department will allow a deduction for the anticipated amount of uncovered medical expenses incurred during the three month period prior to the date of application, and that are recurring (reasonably anticipated to occur) expenses in the initial projection period.
5. Actual incurred and recognized expenses will be deducted in each of the three months prior to the Medicaid application month when an applicant requests three months prior Medicaid coverage and is eligible in the prior month(s).
6. The initial projection period is the first day of the first month of Medicaid eligibility beginning no earlier than the application month through the last day of the sixth month following the month of approval. A semi-annual review is scheduled for the fifth month after the month approved to evaluate the recipient's actual incurred medical expenses for the prior six months.

42 C.F.R. § 435.725 states in relevant part:

(4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including...(I) Medicare and other health insurance premiums, deductible, or coinsurance charges...
(f) Determination of medical expenses--
(1) Option. In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.
(2) Basis for projection. The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.
(3) Adjustments. At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

The department has complied with the above provisions in deductions of expenses in determining the amount of income to be counted in the patient responsibility calculation.

Fla. Admin. Code 65A-1.716(5)(c) sets forth "Spousal Impoverishment Standards" as follows:

"(c) Spousal Impoverishment Standards
1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. §1396r-5.
2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMMIA X 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.
4. Food Stamp Standard Utility Allowance: $198.

> 5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. §1396r-5. This standard changes January 1 of each year."

The department has complied with the above provision in establishing the spousal impoverishment amount for the community spouse.

Fla. Admin. Code 65A-1.716(5)(f) states in relevant part:

> Either spouse may appeal the amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist.

The petitioner claims a hardship and has sought remedy through the fair hearing process, asking for the patient responsibility amount to be zero. The language of the preceding rules indicates that a couple must prove the existence of exceptional circumstances which result in significant inadequacy of the income allowance to meet their needs, before such income allowance can be upwardly revised. Any revision cannot exceed the maximum allowed.

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

> 3703.4 Maintenance Needs Of A Spouse At Home – For an individual with only a spouse at home, deduct from the individual's total income an amount for the maintenance needs of the spouse. Base this amount on a reasonable assessment of the needs of the spouse, which includes consideration of the spouse's income and resources...3703.8 Expenses for Health Care: Deduct from the **individual's** total income amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including: Medicare and other health insurance premiums,

> deductibles, or coinsurance charges; and necessary medical or remedial care recognized under State law but not covered under the State plan, subject to reasonable limits the agency may establish on amounts of these expenses. 3710.1 **Definitions...Exceptional Circumstances Resulting in Extreme Financial Duress. Pending publication of regulations, a reasonable definition is: Circumstances other than those taken into account in establishing maintenance standards for spouses. An example is incurment** [sic] **by community spouses for expense for medical, remedial and other support services which contribute to the ability of such spouses to maintain themselves in the community and in amounts that they could not be expected to pay for amounts already recognized for maintenance and/or amounts held in resources...** (emphasis added)

In examining the relative nature of what may be defined as an individual's "needs", it is necessary to define a standard of such "needs" that is consistent with the intent of public assistance programs in general, and more specifically with the Institutional Care Program.

Since the Institutional Care Program sets the Minimum Monthly Maximum Income Allowance (MMMIA) to equal 150 percent of the federally defined Poverty Level, it is evident that the intent of the Institutional Care Program is confined to address an individual's basic needs of food, shelter, medical costs, and work-related expenses. Therefore, any other indicated expenses would potentially be beyond the scope of this basic need definition of the Institutional Care Program and thus, are not included or allowable in determining such basic needs.

The petitioner claims that she is repaying a personal loan of $200 per month for a hospital bed that she purchased prior to her husband's admission into the nursing facility. This expense is related to her husband's care not her

own as required in the above listed policy. The hearing officer acknowledges that the petitioner is on a limited amount of income and has many obligations to meet. However, none of the obligations meets the criteria required to demonstrate extreme financial duress that would ultimately keep the petitioner from continuing to reside in the community. As a result, the petitioner's request to adjust the patient responsibility amount to zero is denied. The department's calculation of the institutional spouse's responsibility is correct.

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 21st day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:
7 DPOES: Dana Johnston

F I L E D
JUL 2 1 2006
OFFICE OF APPEAL HEARIN
DEPT. OF CHILDREN & FAMII

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

APPEAL NO. 06F-02777

PETITIONER,

Vs.

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

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in DeLand, Florida, on May 25, 2006 at 1:33 p.m. The petitioner was not present but was duly represented by his mother, k, with testimony available from Theresa Brinkley, RN with Pediatric Services of America. The respondent was represented by Gwendolyn Mathis RN with the Children's Multidisciplinary Assessment Team (CMAT) of AHCA. Present to testify on behalf of AHCA were Elizabeth Legary, social worker with CMAT, and Sharol Robinson, RN with CMAT, Children's Medical Services.

ISSUE

At issue was whether or not skilled nursing services could be provided at a Prescribed Pediatric Extended Care (PPEC) services setting rather than at home. The burden of proof is upon the agency.

FINDINGS OF FACT

On April 18, 2006, following a CMAT session, notice was issued that effective May 25, 2006, the agency intended to authorize nursing services for the petitioner at a PPEC rather than at home. Notice and staffing comments were Respondent's Exhibit 1, as under challenge. CMAT concluded "that the skilled nursing services...can be provided during the day in a PPEC setting. The recommendation is to start PPEC services May 25th, 2006 up to five full days with transportation."

At the time of the April 2006 CMAT review, the petitioner was receiving six hours of skilled nursing at home after school, from 11 a.m. to 5 p.m. Nurse Brinkley described his situation as fragile. She opined a delay in changing the situation would be prudent.

The petitioner has a complex medical history, receives Medicaid through Supplemental Security Income (SSI) eligibility, is just over 5 years of age, attends school for a couple of hours a day, with hope of increasing to several hours a day, takes daily naps but has problems resting. He suffers Chiari malformation, syringomelia, tether spinal cord (surgery 8/2/04), tracheoesophageal fistula and esophageal atresia, low bone density, neurological and congenital anomalies, asthma, heart murmur, renal abnormality, failure to thrive and reflux. He is not cognitively impaired. He receives medications orally, inhalation, and via J-tube. He has a G tube and pump and does not tolerate feedings well. He receives Xopenex neb treatments one or two times a day. He has not required suctioning in the two months prior to the April 2006 review, according to records. There is occasional incontinence. Review data from the CMAT summary is Respondent's Exhibit 3. AHCA concluded the situation was sufficiently stable to authorize PPEC.

Using procedural guidelines in Respondent's Exhibits 2 and 4, from the Children's Multidisciplinary Assessment Team Statewide Operational Plan and the Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, respectively, AHCA staff determined efforts to attempt PPEC should occur. CMAT Operational Plan, excerpts from page 11, was used as follows:

> The primary goal of the CMAT process is to provide recommendations for medically necessary long term care services for medically complex children....Recommendations for services include the setting in which the service will be delivered, the type, frequency, and duration of the service and, when appropriate, the child's level of care.
>
> A second goal of the CMAT process is to recommend services in the most appropriate, lease restrictive and most inclusive setting that will meet the needs of children while considering cost efficiency. The CMAT aids in reducing costs and avoiding escalation of costs by reducing the overall number and length of hospitalizations of medically complex children while meeting their medical needs, avoiding placement in acute care settings for the provision of non-acute care, and coordination with all programs serving the child.

CMAT staff described a responsibility to provide care in a cost efficient manner, in an environment as unrestrictive as possible, and that under guidelines which a reasonable determination was made. They noted that PPEC was responsible for adapting to the child's needs. The issue in this matter was one of venue (where service should be provided rather than if service should be provided), and that if the modification was unsuccessful, the AHCA CMAT decision could be rescinded. They noted rescission had occurred in the past in another situation.

The petitioner's mother questioned the wisdom of changing the status quo at this time. She believed her son would suffer social skill regression or lack of development, resting problems and she alleged the PPEC facility would be inadequate for his needs.

Having toured the facility and talked with the facility director, she described the facility as having one nurse for three children, all children in one room, the playroom was also the nap room, and the facility would not accommodate his needs and develop his skills as well as the home care does. His mother opined that psychosocial needs were not adequately addressed during CMAT review. In addition to the hearing request (Petitioner's Exhibit 1) she presented medical and nursing assessments shown in Petitioner's Exhibits 2 and 3, respectively.

CONCLUSIONS OF LAW

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

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

Fla. Admin. Code 59G-4.130 states in relevant part:

Home Health Services.
(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. Both handbooks are available from the Medicaid fiscal agent.

The Home Health Services Coverage and Limitations Handbook (pages 2-15 through 2-17) establishes guidelines for 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.

...
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. ...

CMAT Referrals
A recipient who is medically able to attend a PPEC and whose needs can be met by the PPEC, should have PPEC services recommended by CMAT. Private duty nursing may be provided as a wraparound alternative for an individual needing additional services when PPEC is not available.
...
Service Authorization
All private duty nursing services must be prior authorized by a Medicaid service authorization nurse prior to the delivery of services. ...

Place of Service Exclusions
Medicaid does not reimburse for private duty nursing services provided in the following locations;
...
- Prescribed Pediatric Extended Care Centers.

Additionally relevant are rules of 59G-4.260, addressing **Prescribed Pediatric Extended Care Services**. Subsection (2) informs as follows:

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

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

Purpose
The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Program is to enable children with medically-complex conditions or the need for acute medical care to receive medical care at a non-residential pediatric center. PPECs provide a cost effective and less restrictive alternative to institutionalization, and reduce the isolation that homebound children may experience.

...

Description
A PPEC is a rehabilitative facility that serves three or more children under the age of 21 who require short or long-term continual medical care due to medically-complex conditions or the need for acute medical care. A PPEC offers services that meet the child's physiological, developmental, physical, nutritional, and social needs.

...

Who Can Receive Services
To receive PPEC services, a recipient must meet the following criteria:

- Be Medicaid eligible;
- Be medically fragile or technologically dependent;
- Be age 20 or under;
- Be medically stable; and
- Must require short or long-term health care supervision due to medically-complex condition or the need for acute care.

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

CMAT Referrals
If the primary care provider has not ordered PPEC services at the time of a CMAT staffing, the CMAT may recommend PPEC services. The recipient's case manger will communicate the CMAT recommendation to the primary care provider and request an order for PPEC services.

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

Under appropriate statute and administrative authorities, CMAT is charged with determining whether medical necessity has been adequately established and AHCA must assess whether the Medicaid reimbursement criteria have been met. While the mother argued that medical necessity standards were met in the current situation and sustaining that would be critical to prevent regression, and that the PPEC facility might cause set-backs, substantive evidence did not support such a contention. The evidence

as submitted did support the determination made by the agency as to appropriateness of transition to an equally effective and more conservative or less costly alternative.

Based upon the evidence it is concluded that the plan to authorize skilled nursing services at a PPEC is a reasonable determination. Thus, it is concluded the agency action has been justified.

DECISION

The appeal is denied and the agency action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21st day of July, 2006, in Tallahassee, Florida.

J. W. Alper

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

Copies Furnished To: [illegible] Petitioner
Lisa Broward, Area 4 Medicaid Adm.
Jeff Reinersten, Medical Director
William Roberts, Esq.

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

FILED
JUL 10 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

PETITIONER,

Vs.

APPEAL NO. 06F-1879

AGENCY FOR HEALTH
CARE ADMINISTRATION
DISTRICT: 13 Marion
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 19, 2006, at 11:05 a.m., in Ocala, Florida. The petitioner was not present. Present representing the petitioner was his aunt, !

The respondent was represented by Zolika Heath, registered nurse. Testifying by telephone on behalf of the respondent were Dr. Rakesh Mittal, Keystone Peer Review Organization (KePRO) and Cheryl Vanhorn, registered nurse, review operations supervisor, KePRO.

The hearing was scheduled for April 18, 2006. However, at the petitioner's request a continuance was granted.

ISSUE

The petitioner is appealing the respondent's action to reduce his private duty nursing hours from 20 hours per day to 18 hours per day.

FINDINGS OF FACT

Prior to the action under appeal, the petitioner was receiving 20 hours per day, seven days per week, of private duty nursing services through the Agency for Health Care Administration. The petitioner is disabled and has been diagnosed with chondrosystropy and specified congenital anomalies of the optic disc.

Keystone Peer Review Organization (KePRO) is the Peer Review Organization (PRO) contracted by the Agency for Health Care Administration to perform medical review for the private duty nursing and personal care Prior Authorization Program for Medicaid recipients in the State of Florida.

A prior authorization review was completed by KePRO to determine whether the petitioner would continue to receive 20 hours per day of private duty nursing. On February 21, 2006, KePRO determined that 20 hours per day of private duty nursing was not medically necessary. However, KePRO approved 18 hours per day, seven days per week of private duty nursing services. This was a reduction of two hours per day, seven days per week.

The petitioner was hospitalized approximately three to four times during December 2005 and January 2006 and was admitted into the intensive care unit at Shands Hospital. The petitioner was last discharged from Shands Hospital on January 17, 2006. The petitioner's medical condition was severe and complex and he required constant medical supervision. KePRO had no knowledge of the change in the petitioner's medical condition or of his hospitalization prior to the date of the hearing. At the hearing, KePRO determined that due to the change in the petitioner's medical condition 20 hours per day, seven days per week of private duty nursing services was

medically necessary. KePRO approved 20 hours per day, seven days per week, of private duty nursing service from the review period of November 11, 2005 through January 9, 2006 and also until the completion of the next review for private duty nursing services.

CONCLUSIONS OF LAW

Fla. Stat. ch. 409.9132(d) states in part:

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

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; and

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

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

The Findings of Fact show that the respondent approved the petitioner's request for 20 hours per day, seven days per week, of private duty nursing, during the period that was at issue. Therefore, the respondent's action to reduce the petitioner' private duty nursing to 18 hours per day is reversed.

DECISION

The appeal is granted. The respondent's action is reversed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the respondent. 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 respondent has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 10th day of July 2006,

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.

FILED

JUL 06 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

.PPEAL NO. 06F-02396

PETITIONER,

Vs.

CASE NO. 1150079762

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 08 Lee
UNIT: 88805

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 9, 2006, at 2:25 p.m., in Ft. Myers, Florida. The petitioner was not present. He was represented by his spouse, . The department was represented by Bernice Gorman, economic self-sufficiency supervisor.

ISSUE

At issue is the request by the community spouse to have her income allowance raised due to exceptional circumstances.

FINDINGS OF FACT

The petitioner receives benefits through the Institutional Care Program (ICP) and Medicaid. On March 14, 2006, the department notified the petitioner that they reviewed his eligibility for continuing benefits. The determined that the petitioner's patient responsibility for the ICP Program was $328.73 monthly. The

community spouse was allowed to keep $789.27 of the petitioner's income to help support her in the community.

The petitioner receives social security benefits of $1,153 monthly. The community spouse receives total gross monthly income of $882.09 consisting of employment, interest income, and her monthly social security benefit. The community spouse pays rent of $549.36 monthly.

In computing the amount that the community spouse could keep from her spouse's income, the department subtracted 30% of Minimum Monthly Maintenance Income Allowance (MMMIA) or $482 from her shelter expense of $549.36 establishing her excess shelter cost as $67.36. This was added to the MMMIA of $1604 for an allowable shelter deduction of $1,671.36. The department subtracted the community spouse's gross income from the allowable shelter deduction to set the community spouse income allowance at $789.27. On March 14, 2006, the department notified the petitioner of his patient responsibility and of the community spouse diversion amount.

The petitioner asserts that her gross income in combination with the amount the department determined that she can retain of her spouse's income is insufficient to pay her expenses. She stipulates that the amounts used by the department as the couple's income and her rent amount were correct. The spouse provided an itemized list of her expenses. They are as follows:

Rent	549.36
Cable	53.00
Cell phone	38.00
Telephone	48.00
Life insurance	40.00
Medical insurance	141.20
Car insurance	54.98
Storage unit	104.00
Credit card	45.00
Credit card	25.00
Gasoline	150.00
Newspaper	15.00
Church	25.00
Haircuts	38.00
Food	200.00
Total	$1526.54

The petitioner expects further expenses for car repairs, clothes and her own household supplies that were not calculated at the time of the hearing.

CONCLUSIONS OF LAW

The Florida Administrative Code Rule 65A-1.716(5)(c) sets forth "Spousal Impoverishment Standards" as follows:

"(c) Spousal Impoverishment Standards

1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. §1396r-5.
2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMMIA X 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.
4. Food Stamp Standard Utility Allowance: $194.
5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the

> maximum amount allowed under 42 U.S.C. §1396r-5. This standard changes January 1 of each year."

The Department's budgeting methodology as outlined in the Findings of Fact and in the Department's Composite Exhibit 2 correctly reflect the budgeting methodology set forth in the above Florida Administrative Code Rule in calculating the amount Ms. I can retain of Mr. income. However, Florida Administrative Code Rule 65A-1.712(4)(f) permits possible adjustment to this methodology and the resulting income allowance as follows:

> (f) Either spouse may appeal the amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist.

The language of the preceding rule indicates that a couple must prove the existence of exceptional circumstances which result in significant inadequacy of the income allowance to meet their needs, before such income allowance can be upwardly revised. In examining the relative nature of what may be defined as an individual's "needs", it is necessary to define a standard of such "needs" that is consistent with the intent of public assistance programs in general, and more specifically with the ICP Program. Since the ICP Program sets the Minimum Monthly Maximum Income Allowance (MMMIA) to equal 150 percent of the Federally defined Poverty Level, it is evident that the intent of the ICP program is confined to address an individual's basic needs of food, shelter, medical costs, and work-related expenses. Therefore, any other indicated expenses would

potentially be beyond the scope of this basic need definition of the ICP Program and thus, is not included or allowable in determining such basic needs.

Consistent with the above interpretative conclusion on the definition of basic needs, the community spouse would be allowed all of the expenses listed in the Findings of Fact with the exception of cable ($53), the charges for the cell phone ($38), the credit card payments ($45 + $25), and the payment for life insurance ($40). Storage unit ($104), newspaper ($15), church ($25), and haircuts ($38). The community spouse may only receive benefits of an expense for insurance when it is for health or dental. Life insurance and other such policies are considered beyond the scope of basic needs. It cannot be considered a basic need for the community spouse to maintain a credit rating by making payment to a listed creditor for a credit card.

The United States Department of Agriculture, Food and Nutrition Services defines a one person "Thrifty Food Plan" to be $152 monthly. Therefore, the community spouse's listed $200 monthly expense for food expenses cannot be considered reasonable. The standard food stamp benefit level of $152 for one person was allowed.

The list of expenses allowed using the above methodology is as follows:

Rent	549.36
Telephone	48.00
Car insurance	54.98
Medical insurance	141.20
Gasoline	150.00
Haircuts	25.00
Food	152.00
Total	1120.54

Ms. monthly income is established as $882.09. Her allowable monthly expenses of $1,120.54 minus her monthly income of $882.09 equals $238.45. This amount could be diverted monthly from Mr. income to Ms. y using the above methodology. The methodology used by the Department provided Ms. with $789.27 monthly of Mr. income. As that amount is larger, it is more beneficial for the petitioner to use the Department's standard computation.

DECISION

This appeal is denied. The department'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 6th day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To: V
Gladys Dorsett, Southern Zone ESS Program Adm.

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

APPEAL NO. 06F-03160

PETITIONER,

Vs.

CASE NO. 1227278152

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
DISTRICT: 12 Volusia
UNIT: 88216

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 10:20 a.m. on May 31, 2006. The petitioner has passed away, but was duly represented by his wife and son, E and J , respectively. The respondent was represented by Susan Mauro, senior economic self-sufficiency specialist and Karen Bell, specialist.

ISSUE

At issue was whether or not Institutional Care Program (ICP) and Medicaid denial was correct based upon income level or insufficient application follow through. As an applicant, the petitioner would have the burden of proof.

FINDINGS OF FACT

On behalf of the petitioner, ICP application was filed on November 8, 2005, following admission to the nursing facility on October 11, 2005. Application submission

was facilitated by staff at the nursing facility where he resided and the application gave the address of the petitioner as that of the nursing facility (Respondent's Exhibit 1). It showed authorized representative as his wife.

Upon receipt of the application, a DCF interview appointment was set for November 29, 2005, but no one appeared for the interview. There was disagreement as to where the notice of appointment was sent, and discussion included hearsay information. Evidence did not include official appointment letters, requests for information, or electronic verification of same. DCF testified that the appointment notice would have been sent to the address at the nursing home, as that appeared in the application as the mailing address. Resolution of this problem is not critical for adjudication purposes.

Petitioner's Exhibit 1 narrated difficulty of the situation, the wife's trauma, need for her own surgery, and death of the petitioner as the process unfolded. In any case, no one appeared on November 29, 2005, and a finding to that effect must be made.

During December, the petitioner's wife began to realize that a DCF eligibility processing problem of some sort existed. At that point, the family "weighed the cost of my father's short December stay…against the legal cost and time required for completing the Medicaid qualification procedures and opted to pay n directly for my father's December charges…"

The petitioner died on December 15, 2005.

On January 20, 2006, declaring insufficient application "follow through," the ICP application was denied. Denial was Respondent Exhibit 2, and the family disputed reason for denial. The family believed it had followed through as sufficiently as

possible, based upon information it had received from appropriate sources, including nursing facility staff and DCF staff.

With declared income exceeding $2000 per month on the face of the November 8, 2005 application, DCF had also made a preliminary determination of excess income. DCF opined that eligibility would have been possible only if a proper trust had been created, approved and funded, citing policy submitted in Respondent's Exhibit 3. It is found that declared gross income exceeded $1737 per month.

(Additional information was received from DCF on June 13, 2006, but the hearing record had been closed on the date of hearing and exparte involvement is impermissible. Therefore, such information could not be reviewed or admitted to the hearing record.)

CONCLUSIONS OF LAW

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

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

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

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

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

SSI-Related Medicaid Income Eligibility Criteria.

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:...

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(15), F.A.C.

Consistent with these regulatory standards, Fla. Integrated Pub. Policy Manual 165-22 Appendix A-9 sets ICP income limit for an individual at $1,737 during the period in question. Appendix A-10 sets forth the federal benefit rate at $579. Three hundred percent of the federal benefit rate was $1,737.

Fla. Integrated Pub. Policy Manual, 165-22, Section 1840.0110 further states:

Income Trusts (MSSI)
The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

It is established on or after 10/01/93 for the benefit of the individual;
It is irrevocable;
It is composed only of the individual's income (social security, pensions, or other income sources); and
The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.
The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested**. (emphasis added)

The above rules and policy provide for establishment of an income trust by an ICP applicant in order to reduce monthly income below the state income limitations. This opportunity was created at federal level by the 1993 Omnibus Reconciliation Act. If an applicant so desired, in order to reduce monthly income below the state standard, a trust could be established. This opportunity to create eligibility is a federal option, not a state or a federal mandate. However, if a person selects the income trust account option, it is necessary for the instrument to appropriately exist and to be sufficiently funded during a particular month, so as to reduce income below standards. Funding of the trust must occur before Medicaid or the related ICP eligibility may occur. The rule clearly and unequivocally declares that "the individual must make the deposit each month..." Problems with financial institutions, misunderstandings or communication

difficulties with trusted entities do not provide for favorable mitigation of the situation. Under regulatory standards, there are no exceptions permitted.

In the case at hand, the critical fact was that all standards necessary for approval were not fulfilled at any time during the application processing period. Thus, while recognizing the predicament faced by the family, and realizing efforts to pursue eligibility were intended, it must be concluded that denial was justified.

DECISION

The appeal is denied and the agency action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 12th day of July, 2006, in Tallahassee, Florida.

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

Copies Furnished To:

12 DPOES: Brigette Hall
SC

FILED
JUL 17 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03644

PETITIONER,

Vs.

CASE NO. 1053078498

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 09 Broward
UNIT: 88374

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 13, 2006, at 10:24 a.m., in Delray Beach, Florida. The petitioner was not present. Representing the petitioner was , husband. Representing the department was Rosa Martinelli, specialist II.

ISSUE

At issue is the request by the community spouse to have his income allowance raised due to exceptional circumstances.

FINDINGS OF FACT

The petitioner was approved for Institutional Care Program (ICP) Medicaid benefits effective February 10, 2006 and ongoing. The petitioner currently resides in a nursing facility and for ICP purposes, her husband , is referred to as the community spouse.

Mr. ....s monthly income consists of Social Security of $1,092 and a Veteran's Administration pension of $1,385. The gross monthly income is $2,477.

In determining the amount of Ms. 's income that Mr. can retain each month, the department considered that Mr. total countable shelter cost of $927.89 exceeded 30% of the listed Minimum Monthly Maintenance Income Allowance (MMMIA) of $495 by $432.89. This amount is defined as the "excess shelter cost".

There is a maximum MMMIA of $1,650. This amount is added to the excess shelter for a total of $2,082.89. The $2,082.89 is compared to the community spouse gross income of $2,477. Because the gross income exceeds the $2,082.89, the community spouse "can keep $0.00 of your [petitioner's] monthly income to help meet their monthly living expenses".

From the petitioner's monthly income, she receives a $35 personal needs allowance. The remainder of $511.03 is the patient responsibility.

Mr. asserts that his income is insufficient to pay for his expenses. There are unpaid medical expenses for the petitioner from the nursing facility and pharmacy. These expenses have to be resubmitted to the providers with the petitioner's Medicaid number for payment.

There are also monthly credit card bills, automobile expenses such as repairs, gasoline, and insurance, food, and excess utilities, telephone, electric, and water.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.716 **Income and Resource Criteria** states in part:

(5)(c) Spousal Impoverishment Standards.

1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. § 1396r-5.

2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.

3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMIA × 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.

4. Food Stamp Standard Utility Allowance: $198.

5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. § 1396r-5. This standard changes January 1 of each year.

The department's budgeting methodology, as outlined in the Findings of Fact correctly reflects the budgeting methodology set forth in the above Florida Administrative Code in calculating the amount Mr. (:an retain as part of Mrs. C income. However, Florida Administrative Code 65A-1.712(4) permits the possible adjustment of this methodology and states:

> (f) Either spouse may appeal the amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist.

The language of the preceding rule indicates that a couple must prove the existence of exceptional circumstances which result in significant inadequacy of the income allowance to meet their needs before such income allowance can be upwardly revised. In examining the relative nature of what may be defined as an individual's

"needs", it is necessary to define a standard of such "needs" that is consistent with the intent of the public assistance programs in general, and more specifically with the ICP Program.

Since the ICP sets the MMMIA to equal 150 percent of the federally defined poverty level, it is evident that the intent of the ICP is confined to address an individual's basic needs of food, shelter, medical costs, and work related expenses. Therefore, any other indicated expenses would potentially be beyond the scope of this basic need definition of the ICP and, thus, is not included or allowed in determining such basic needs.

The hearing officer cannot consider the vehicle expense as the husband is not employed and it is not used for that purpose. The petitioner's medical expenses are being paid by the ICP Medicaid save for $511.03 for uncovered medical expenses that must be met on a monthly basis.

Mr. [illegible] ıonthly income is sufficient to meet the monthly mortgage, maintenance, and utilities. Credit card payments and automobile expenses are not considered exceptional circumstances in this case.

The evidence and testimony presented did not show that an exceptional circumstance exists. Therefore, the hearing officer cannot supplement the income and the MMMIA must be used instead.

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 17th day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Gladys Dorsett, Southern Zone ESS Program Adm.

FILED

JUL 27 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03248

PETITIONER,
Vs.

CASE NO. 1214871976

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 02 Leon
UNIT: 88416

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 14, 2006, at 10:40 a.m., in Tallahassee, Florida. The petitioner was not present but was represented by her goddaughter and power of attorney, The department was represented by Sue Bunch, economic self-sufficiency specialist supervisor. Testifying on behalf of the department was Verla Barr, economic self-sufficiency specialist I.

The hearing record was held open for 10 days or until June 24, 2006 to allow the petitioner to submit additional evidence which was received and entered as Petitioner's Exhibit 4.

ISSUE

The petitioner is appealing the department's action of April 26, 2006 to terminate Institutional Care Program (ICP) Medicaid benefits based on an improper transfer of assets. The department holds the burden of proof.

FINDINGS OF FACT

Prior to the department's action at issue, the petitioner was receiving ICP and Medicaid benefits. The petitioner's goddaughter originally applied for Hospice ICP benefits on her behalf, on March 10, 2005 prior to placement in a nursing home. She was admitted to a nursing home on April 26, 2005 and approved for ICP benefits and Medicaid effective that date.

The petitioner solely owned homestead property located at (Tallahassee, Florida 32304. The petitioner intended to devise the property to her goddaughter upon her demise according to her Last Will and Testament. The petitioner's goddaughter, who also held power of attorney, intended to make the necessary repairs and move into the house but was unable to accomplish this due to insufficient credit. In addition, she determined that the property was not located in a desirable neighborhood. Subsequently, the petitioner's goddaughter transferred the property to herself on January 5, 2006 and sold the property on January 8, 2006. The proceeds of the sale in the amount of $49,995.39 were paid to the petitioner's goddaughter, who used the money to pay for repairs and indebtedness on her

automobile. In addition, the petitioner's goddaughter used some of the proceeds to pay for rent on an apartment. None of the proceeds were made available to the petitioner.

On April 25, 2006, the petitioner's representative and goddaughter, completed an annual redetermination for ICP benefits. At that time, the department determined that the petitioner improperly transferred property to her goddaughter, through a Quit Claim deed on January 5, 2006 and that the property was subsequently sold on January 8, 2006.

The department considered the transfer of the property to be an improper transfer of assets. An ineligibility penalty of 17 months was established from the date the Quit Claim Deed was signed in January 2006, which was the date that the department considered the property transferred. The department determined the value of the property from the Leon County Property Appraiser tax roles for 2006. The transfer penalty period was determined by dividing the value of the property, established at $54,644, by $3,300 to arrive at a penalty period of 17 months.

On April 26, 2006, the department, by Notice of Case Action, terminated ICP benefits effective May 31, 2006, based on improper transfer of assets. Also on April 26, 2006, the department sent a Notice of Determination of Resource/Income Transfer to the petitioner allowing her the opportunity to rebut the presumption that the transfer was for some reason other than to become eligible for Medicaid. The petitioner had until May 11, 2006 to accomplish this. The petitioner submitted a letter dated May 9, 2006 to

rebut the presumption of transfer. The department evaluated the rebuttal and the policy regarding transfer of assets and determined that the rebuttal was unsuccessful.

The department stipulated that it prematurely terminated the ICP benefits on April 26, 2006 prior to allowing the petitioner to rebut the transfer of asset. In addition, the department sent a revised Notice of Determination of Resource/Income Transfer on May 11, 2006 correcting the Fair Market Value to $64,287. The department determined that the Leon County Property Appraiser assessed property value at 85% of market value. Based on the revised Fair Market Value (FMV), the department divided the FMV of $64,287 by $3,300, to arrive at a transfer penalty of 19 months from January 2006 through July 2007.

The petitioner's representative sold the property for $55,000 based on a comparable market analysis of properties sold in the geographic area. The hearing record was held open for an additional 10 days to allow the petitioner to provide verification that the Fair Market Value was lower than the one used by the department in its calculation of the transfer penalty. In addition, the petitioner's representative presented verification of expenses for the termite inspection and treatment for termites in the amount of $75 and $495 respectively. She also presented a damage report from the inspection for termites indicating that there was some wood damage to portions of the home. She was unable to obtain a loan for approximately $5,000 for repairs to the property due to a low credit score (Petitioner's Exhibit 1). The petitioner submitted the

comparable Market Analysis (Petitioner's Exhibit 2) indicating that the property at the low value could possibly sell for $69,000.

The petitioner's representative stated that she was unaware that transferring the property to herself and placing the home for sale would interfere with the petitioner's ICP and Medicaid benefits. It was her godmother's wish that the property be given to her upon her death, as evidenced by the Last Will and Testament.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.716, Income and Resource Criteria, states in relevant part:

> (3) The resource limits for the Medically needy program are as follows…1…$5,000…(5) SSI-Related Program Standards. (a) SSI (42 U.S.C. §§1382-1383c) Resource Limits: 1. $2000 per individual…(d) Average monthly private pay nursing facility rate: $3,300.

Fla. Admin. Code 65A-1.712(3) SSI-Related Medicaid Resource Eligibility Criteria, states:

> (3) Transfer of Resources and Income. According to 42 U.S.C. §1396p(c), if an individual, the spouse, or their legal representative disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was done to become Medicaid eligible and impose a period of ineligibility for nursing facility care services or HCBS waiver services. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application but no earlier than October 1, 1993. These transfer policies apply to actual transfers made by applicants for institutional Hospice services that occur on or after October 1, 1998. Transfers made prior to October 1, 1998, will not be subject to a penalty.
>
> (a) The department follows the policy for transfer of assets mandated by 42 U.S.C. §§1396p and 1396r. For transfers prior to October 1, 1993, transfer policies apply only to transfers of resources. For transfers

on or after October 1, 1993, transfer policies apply to the transfer of income and resources.

(b) When funds are transferred to a retirement fund, including annuities, within the transfer look back period the department must determine if the individual will receive fair market compensation in their lifetime from the fund. If fair compensation will be received in their lifetime there has been no transfer without fair compensation. If not, the establishment of the fund must be regarded as a transfer without fair compensation. Fair compensation shall be calculated based on life expectancy tables published by the Office of the Actuary of the Social Security Administration. See Rule 65A-1.716, F.A.C.

(c) No penalty or period of ineligibility shall be imposed against an individual for transfers described in 42 U.S.C. §1396p(c)(2).

1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual under age 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.

2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life expectancy tables noted in (b) above), it is not considered to be established for the sole benefit of the indicated individual and any potential exemption from penalty or consideration for eligibility purposes is void.

3. A transfer penalty shall not be imposed if the transfer is a result of a court entering an order against an institutional spouse for the support of the community spouse.

4. A transfer penalty shall not be imposed if the individual provides proof that they disposed of the resource or income solely for some purpose unrelated to establishing eligibility.

5. A transfer penalty shall not be imposed if the department determines that the denial of eligibility due to transferred resources or income would work an undue hardship on the individual. Undue hardship exists when imposing a period of ineligibility
would deprive an individual of food, clothing, shelter or medical care such that their life or health would be endangered. All efforts to access the resources or income must be exhausted before this exception applies.

(d) Except for allowable transfers described in 42 U.S.C. § 1396p(c)(2), in all other instances the department must presume the

transfer occurred to become Medicaid eligible unless the individual can prove otherwise.

1. An individual who disposes of a resource for less than fair market value or reduces the value of a resource prior to incurring a medical or other health care related expense which was reasonably capable of being anticipated within the applicable transfer look back period shall be deemed to have made the transfer, in whole or part, in order to qualify for, or **continue to qualify for**, medical assistance.

2. In cases where resources are held by an individual in common with others in a joint tenancy, tenancy in common, or similar arrangement, the individual is considered to have transferred resources or a portion thereof, as applicable, when action is taken by the individual or any other person authorized to access the resources that reduces or eliminates the individual's ownership or control of such resource.

(e) Each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the purpose of qualifying for Medicaid eligibility. No period of ineligibility shall be imposed if the individual provides proof that they intended to dispose of the resource or income at fair market value or for other valuable consideration, or provides proof that the transfer occurred solely for a reason other than to become Medicaid eligible.

(f) The uncompensated value of a transferred resource is the difference between the fair market value of the transferred resource at the time of the transfer, less any outstanding loans, mortgages or other encumbrances on the resource, and the amount of compensation received at or after the time of the transfer.

(g) Periods of ineligibility based on transfer policy are calculated beginning with the month in which the transfer occurred. The period of ineligibility cannot exceed 30 months if the transfer occurred prior to October 1, 1993. If the transfer occurred on or after October 1, 1993, the period of ineligibility shall be equal to the actual computed period of ineligibility, rounded down to the nearest whole number. There is no limit on the period of ineligibility for transfers which occur on or after October 1, 1993.

1. Monthly periods of ineligibility due to transferred resources or income are determined by dividing the total cumulative uncompensated value of all transferred resources or income computed in accordance with Rule 65A-1.712(3)(f), F.A.C., by the average monthly private cost of nursing facility care at the time of application as determined by the department.

Florida Integrated Public Policy Manual, passage 1640.0615 states in part:

Whenever the individual disposes of income or assets within the transfer look-back period and does not receive fair compensation, he is potentially ineligible for Medicaid institutional care, HCBS, or PACE for a period of time. The ineligibility period is dependent on the amount of the uncompensated value of the transferred funds...

Florida Integrated Public Policy Manual, passage 1640.06.0903 states: The transfer of a homestead is considered allowable if the individual transfers his home to his spouse or any of the following relatives:

1. His legal spouse
2. A child under 21
3. A blind or permanently disabled adult child (Receipt of SSI or Title II Social Security disability is acceptable proof of disability. Otherwise a disability decision must be obtained in all situations, including adult children over 65. These policies apply to all blind/disabled adult children.);
4. A sibling of the individual who has an equity interest in the home and was residing in the home for at least one year immediately before the individual became institutionalized (the ESS or Economic Self-Sufficiency Specialist must accept the sibling's statement unless there is reason to question); or
5. An adult son or daughter of the individual who was residing in the home for at least two years immediately before the date the individual became institutionalized and who provided care to the individual that delayed the individual's institutionalization (the ESS must accept the son/daughter's statement unless there is reason to question).

If the home is transferred to any individual not listed above, the transfer of assets policy is developed. The individual must be given the opportunity to rebut and gather data on the compensation received from the transfer.

Florida Integrated Public Policy Manual, passage 1640.0606 states:

1640.0606 Transfer of Assets (MSSI)
This policy applies only to the Institutional Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services programs (HCBS), and the Program for All-Inclusive Care for the Elderly (PACE). This policy applies to transfers made by SSI-DA recipients applying for these programs. (It does not apply to Community Hospice, ICF/DD, or state mental hospitals programs.)
NOTE: Transfers made prior to 10/1/98 by institutionalized Hospice recipients are excluded from a transfer penalty. Transfers do NOT affect other SSI related Medicaid programs.
A "transfer" occurs when an individual, their spouse, a legally authorized representative, or a joint owner of a jointly held asset:

2. disposes of an asset (by selling it or giving it away) or decreases the extent of the individual's or spouse's ownership interest in an asset; or
3. decreases the value of a countable asset in the process of converting it to an excluded asset; and
4. does not receive a fair amount of compensation in return.
   Effective 10/1/93 transfer policies apply to transfers of income as well as transfers of assets.
   When an asset or income is disposed of or transferred for less than fair market value within the transfer look-back period of the date of application, the individual may be ineligible for Medicaid nursing facility services and HCBS services for a specified period of time.
   A transfer is presumed to be made for the purposes of obtaining Medicaid eligibility and a period of ineligibility will be imposed unless the individual presents convincing evidence of one of the following:
3. the individual intended to dispose of the assets either at fair market value (FMV) or in exchange for other valuable compensation (for example, support and/or maintenance); or
4. the asset was transferred solely for reasons other than to become eligible for Medicaid; or
5. the transfer was considered allowable under policies in passages 1640.0609.03, 1640.0609.04, 1640.0610, 1640.0611 or 1640.0612; or
6. all of the assets transferred for less than fair market value have been returned to the individual (refer to passage 1640.0620); or
7. imposing the transfer penalty on the individual would place an undue hardship on the individual (see passage 1640.0613).
   If a person is ineligible due to the uncompensated value of a transfer, they are ineligible for Medicaid nursing facility or HCBS services. However, they are entitled to regular Medicaid benefits if they meet all other factors of eligibility (including level of care). This coverage group is identified as "MI T" on the FLORIDA system.

The department's Integrated Program Policy Manual HRSM165-22 section1640.0609.01, Criteria for Applying Asset Transfer Policy (MSSI) states in part"

> ...Apply the transfer of asset policy to the following individuals:
> Transfers made by applicants or **recipients** for nursing home care (i.e., institutionalized) and HCBS programs. This includes **recipients** of ICP, institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS), and Program for All-Inclusive Care for the Elderly (PACE). This does not apply to Community Hospice, ICF/DDs, or state mental hospitals.

Transfers made by the individual, their spouse, or **legally authorized representative, such as a legal guardian, parent of minor child, or individual possessing a power of attorney.**
Transfers made by SSI recipients applying for nursing home care (ICP or MEDS-AD, institutionalized Hospice), HCBS, or PACE.
Transfers by a joint owner, for transfers on or after 10/01/93.
Apply the transfer of asset policy to the following situations:
Transfers of funds which were constructively received by the individual (e.g., funds paid directly into a trust unless paid into a qualified trust in accordance with policies in passage 1640.0576.01, et seq.).
Transfers on or after April 1, 1995, to annuity funds or other retirement funds which fail to give the individual fair compensation during their lifetime.
Transfers of homestead property, or property excluded from counted assets due to a bona fide effort to sell, unless the property is transferred to a relative according to criteria in passage 1640.0609.03.

The department's Integrated Program Policy Manual HRSM165-22

section1640.0578 states in part:

Real estate that is not a homestead and does not involve life estate is included as an asset.

The department's Integrated Program Policy Manual HRSM165-22

section1640.0622 states in part:

1640.0622 Complete Eligibility Reviews (MSSI)
The transfer of asset provisions applies to reviews of **currently eligible individuals**. No special development is required in eligibility reviews unless you have reason to believe that the individual has transferred an asset. It is not necessary to redevelop transfers which occurred before the initial application or last eligibility reviews.
Transfer policies do apply to the following assets which were previously excluded as countable assets unless the property was transferred to an allowable relative according to 1640.0609.03 or transferred for a reason other than to remain Medicaid eligible:
1: transfers of homestead property, or
2: transfers of property excluded due to a bona fide effort to sell.

The Findings of Fact show that the petitioner's goddaughter transferred property belonging to the petitioner on January 6, 2006 and subsequently sold the property on January 8, 2006. The petitioner's goddaughter then used the proceeds from the sale of the property for her personal needs and has made none of the proceeds available to the petitioner. In addition, the Findings show that the transfer of the homestead property did not meet the criteria for an allowable transfer. The Findings of Fact show that the transfer occurred in January 2006. The market comparison value sheet indicated that the market value of the property was valued at approximately $69,000. The Leon County Property Tax Appraiser showed that the Fair Market Value was approximately $64,287.

The department stipulated that it prematurely terminated ICP Medicaid eligibility without allowing the required time for rebuttal. However, the department determined that since the rebuttal was received within the allotted time limit and since it was considered unsuccessful, the termination would still have been effective May 31, 2006. Therefore, the department did not reinstate the ICP benefit as the termination date would have remained the same. Had the rebuttal been successful, the department stipulated that the benefit would have been reinstated. The department's action to terminate the ICP benefit prior to receiving the petitioner's rebuttal is considered a harmless error as the termination of ICP benefits would have remained the same.

According to the above authorities, if a transfer is not specifically excluded, then the department must presume the transfer occurred to become Medicaid eligible or **continue to remain eligible**, unless the individual can provide sufficient evidence to prove otherwise. Also, based on the above authorities, an individual who disposes of a resource for less than fair market value or reduces the value of a resource prior to incurring a medical or other health care related expense which was reasonably capable of being anticipated, within the applicable transfer look back period, shall be deemed to have made the transfer, in whole or part, in order to qualify for, or continue to qualify for, medical assistance.

The petitioner's representative, in rebutting the presumption that the transfer was an improper transfer of assets, argued that the transfer of the property was made because it was the intent of the petitioner to leave the property to her in her will. In addition, she was unaware that transferring the property to herself would have a negative impact on her godmother's Medicaid and ICP eligibility. No authority could be found to allow a transfer of assets in the ICP Program because it was intended to become inheritance property.

The property in question was originally considered an excluded resource as it was the petitioner's homestead. Because the petitioner's representative determined that she was going to move into the property, it is apparent that the exclusion of the petitioner's intent to return to her homestead was no longer valid. Therefore, the homestead property could no longer be considered an excluded resource for ICP

purposes. The property value would therefore be considered a countable resource and render the petitioner ineligible based on resources in excess of the allowable resource limit for the ICP program (either $2000 or $5000). Subsequently, a countable asset was transferred causing the transfer of asset penalty to be applicable.

Therefore, the undersigned authority concludes the department met the burden of proof to show that the ICP termination was proper and in accordance with legal authorities. The department correctly terminated the ICP benefit and determined that the petitioner was not eligible to receive ICP benefits for 19 months based on a FMV of $64,287, beginning with the month of transfer (January 2006 through July 2007).[1]

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.

[1] The hearing officer is aware that the transfer divisor figure has been changed to $5000 effective June 1, 2006, which does not affect this case.

DONE and ORDERED this 27th day of July, 2006,

in Tallahassee, Florida.

Linda Garton

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

Copies Furnished To:
2 DPOES: Denise Parker

FILED

JUL 12 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs. APPEAL NO. 06F-1360

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on May 17, 2006, at 4:05 p.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was her mother,

The respondent was represented by Marilynn Schlott, field office manager, Agency For Health Care Administration.

The hearing was scheduled for March 21, 2006. However, at the request of the petitioner a continuance was granted.

ISSUE

The petitioner is appealing what she believes to be the respondent's denial of her request for Medicaid approval for a "Say-It Sam" speech generating device.

FINDINGS OF FACT

The petitioner is 26 years old and is eligible to receive Medicaid. The petitioner has been diagnosed with dysarthria, a motor speech disorder secondary to quadriplegic cerebral palsy. The petitioner has a severe speech-language impairment that significantly affects her ability to communicate functionally.

A speech generating device evaluation and treatment plan was completed on February 4, 2005, by Doreen M. Blischak, Ph.D. The evaluation stated that the petitioner would be a good candidate for a speech generating device to increase expressive communication with family, friends, persons in the community and employers. The evaluation also stated that the use of a speech generating device would enable the petitioner to communicate her needs effectively and efficiently and to further develop autonomy, independence and personal safety.

The petitioner requested Medicaid approval for a "Say-It-Sam" which is a speech generating device. The speech generating device is considered durable medical equipment in the Medicaid Program. Medicaid approval was not given for the "Say-It-Sam" as there was no Medicaid approved eligible provider in the State of Florida who could provide the petitioner with the "Say-It-Sam" speech generating device. The respondent did not deny the petitioner's request for the speech generating device and according to the respondent, the request for the "Say-It-Sam" would most likely be approved if there was an eligible provider in the State of Florida.

CONCLUSIONS OF LAW

Fla. Admin. Code 65-2.056 in part states:

The Hearing shall include consideration of:

(1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.

(2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.

(3) The Hearing Officer shall determine whether the action by the agency was correct at the time the action was taken.

The Findings of Fact show that the respondent has not taken action to deny, terminate or reduce the petitioner's Medicaid benefits. The Findings of Fact show the authorization of Medicaid approval for the petitioner's request for the "Say-It-Sam" speech generating device was not given because there was no approved eligible provider in the State of Florida who could provide the petitioner with the "Say-It-Sam" speech generating device. Therefore, it is determined that there is no basis for the petitioner's hearing request and the request is considered premature because the respondent has not denied the petitioner's request for the "Say-It-Sam" speech generating device. If the respondent should deny the petitioner's request for the "Say-It Sam" speech generating device in the future, she would have the right to appeal the action at that time.

DECISION

The appeal is denied as not ripe for appeal.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the respondent. 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 respondent has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 12th day of July, 2006,

in Tallahassee, Florida.

Morris Zambosca

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

Copies Furnished To:
Marilyn Schlott, Area 3 Medicaid Field Office Manager

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

FILED
JUL 2 1 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

APPEAL NO. 06F-02881

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 May 25, 2006, at 10:45 a.m., in Miami, Florida. The petitioner, (was not present however he was represented by, Representing the agency was Oscar Quintero, senior human services program specialist with the Agency for Health Care Administration (AHCA) and Doris Rivera, senior human services program specialist. Appearing as witnesses telephonically were: Diane Weller, AHCA contract manager; and Dr. Amy Tunanidas, medical director with KēPRO South. Mara Perez served as translator.

ISSUE

At issue is the agency's March 6, 2006 and March 24, 2006 denial of hospital inpatient days for November 20, 2005 through December 6, 2005, due to medical necessity. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner is a beneficiary of the Florida Medicaid Program. On November 3, 2005, the petitioner fell from a tree and was transferred to the hospital. The petitioner was unable to move his lower extremities and was given a diagnosis of spinal fracture of T-4 with complete paraplegia and he underwent surgery.

On February 22, 2006, the provider submitted a request to AHCA for thirty-three hospital inpatient days, from November 3, 2005 through December 6, 2005. This request was reviewed by KēPRO, an organization under contract with AHCA that conducts medical reviews for Medicaid prior authorizations, for inpatient hospital medical services for Medicaid recipients in the state of Florida. This review is for determining medical necessity under the terms of the Florida Medicaid Program. KēPRO considered all clinical information made available to them by the provider, on the petitioner's condition. The facility was notified that according to the information provided, they had approved seventeen days of inpatient hospital days from November 3, 2005 through November 20, 2005. This approval was made by a board certified general surgeon.

According to information provided, as of November 20, 2005, the petitioner was receiving physical therapy, occupational therapy for activities of daily living, mobility, transfers and sitting balance. Therefore, according to medical documentation the petitioner could be transferred to the rehabilitation center instead of being in the hospital. Medical necessity had not been justified for the days requested. On December 6, 2006, the petitioner was transferred to rehab.

On May 8, 2006, the facility requested that the decision be reconsidered. On May 11, 2006, contact was made with the facility physician where she states that they reviewed their patient's file and they accepted the denial.

CONCLUSIONS OF LAW

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

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

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

(a) Meet the following conditions:

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

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

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

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

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

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

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

(1) This rule applies to all hospital providers enrolled in the Medicaid program.

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

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

Authorization for Inpatient Admissions Effective March 1, 2002, Medicaid recipient admissions in Florida for medical, surgical, and rehabilitative services must be authorized by a peer review organization (PRO). The purpose of authorizing inpatient admissions is to ensure that inpatient services are medically necessary. Certain types of admission, e.g., emergencies, are exempt from prior authorization by the PRO; other types do not require authorization to be admitted to the hospital, but the PRO must authorize the concurrent and continued inpatient stays. ...

The petitioner listened to the reasons stated by the agency on why not all the days requested were approved and stated that she had nothing to say on Mr.

behalf.

After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer finds that the medical consultant's decision to deny November 20th through December 6, 2005 coverage was correct.

DECISION

The 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 21st day of July, 2006,

in Tallahassee, Florida.

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

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

FILED

JUL 27 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-02418

PETITIONER,

Vs.

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, and good cause for reschedulings, an administrative hearing was convened before the undersigned hearing officer in DeLand, Florida, on July 19, 2006 at 3:00 p.m. The petitioner was not present but was duly represented by her mother, J , with testimony available from Theresa Brinkley, RN of Pediatric Services of America (PSA). The respondent was represented by Gwendolyn Mathis, RN with the Children's Multidisciplinary Assessment Team (CMAT) of AHCA. Present to testify on behalf of AHCA were Elizabeth Legary, social worker with CMAT, and Sharol Robinson, RN with CMAT, Children's Medical Services.

ISSUE

At issue was whether or not skilled nursing services could be provided at a Prescribed Pediatric Extended Care (PPEC) services setting rather than at home. The burden of proof is upon the agency.

FINDINGS OF FACT

On March 21, 2006, following a CMAT session, notice was issued that effective March 31, 2006, the agency intended to authorize some of the daily nursing services for the petitioner at a PPEC facility rather than at home. Notice and staffing comments were Respondent's Exhibit 1, as under challenge. The CMAT recommendation was to start PPEC services for up to five full days and transportation was also recommended.

At the time of the March 2006 CMAT review, the petitioner (date of birth

as receiving daily in-home skilled nursing services under Medicaid. She and her twin sister were born prematurely and the petitioner has faced many challenges, with substantial progress, including weight gain and significant development. Nevertheless, there is a remaining medical necessity for skilled nursing services on a daily basis and this is undisputed. Medicaid eligibility is undisputed and is also not at issue. •

The AHCA-CMAT determination would not terminate all in-home nursing services, but would change the location during the day to a PPEC facility in a different city in the same county. As the twin sister has not been referred for PPEC, this change would be likely to cause separation for the babies during part of a day, five days a week.

The petitioner has a complex medical history including a tracheostomy (capped several times a day), respiratory insufficiency, ongoing suctioning, more frequently when ill, nebulizer, and G-tube feedings. Some of the past problems have improved and some medical procedures have been reversed, such as the ileostomy. The petitioner eats some baby food and cup use training is occurring.

Using procedural guidelines in Respondent's Exhibits 2 and 4, from the Children's Multidisciplinary Assessment Team Statewide Operational Plan and the Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook, respectively, AHCA staff determined efforts to attempt PPEC should occur. CMAT Operational Plan, excerpts from page 11, was used as follows:

> The primary goal of the CMAT process is to provide recommendations for medically necessary long term care services for medically complex children....Recommendations for services include the setting in which the service will be delivered, the type, frequency, and duration of the service and, when appropriate, the child's level of care.
>
> A second goal of the CMAT process is to recommend services in the most appropriate, least restrictive and most inclusive setting that will meet the needs of children while considering cost efficiency. The CMAT aids in reducing costs and avoiding escalation of costs by reducing the overall number and length of hospitalizations of medically complex children while meeting their medical needs, avoiding placement in acute care settings for the provision of non-acute care, and coordination with all programs serving the child.

CMAT staff described a responsibility to authorize care in a cost efficient manner in an environment as unrestrictive as possible and that under guidelines a reasonable determination was made. They further noted that if the modification was unsuccessful, the AHCA CMAT decision could be rescinded. They noted rescission had occurred in the past in another situation.

The petitioner's mother questioned the wisdom of changing the status quo at this time, with regard to separation of the twins, as well as the petitioner's emotional well being. Also she believed that regression as well as greater medical care costs might result from exposure to other children and their illnesses. The petitioner has tested positive for MRSA (Methicillin-resistant Staphylococcus Aureus). She is not receiving

active treatment for that. Other than while in the hospital, the petitioner has never been separated from the family.

Petitioner's Exhibit 1 was the hearing request and a brief statement of objections to the change. Petitioner's Exhibit 2 showed medical information and additional care of the petitioner following birth, including the MRSA alert. Petitioner's Exhibit 3 showed medical need for constant care, recommending continuing nursing care. It appeared to reflect that Dr. Kosko believed there was a "revocation of required and medically necessary skilled nursing care" planned by the agency. Evidence established there was a plan to change the venue for some nursing care, but there was no plan to revoke nursing care. Respondent's Exhibit 4 showed the certification and plan of care from the home health agency, signed by the PSA nurse.

CONCLUSIONS OF LAW

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

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

Fla. Admin. Code 59G-4.130 states in relevant part:

Home Health Services.
(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. Both handbooks are available from the Medicaid fiscal agent.

The Home Health Services Coverage and Limitations Handbook (pages 2-15 through 2-17) establishes guidelines for 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.

...
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. ...

CMAT Referrals
A recipient who is medically able to attend a PPEC and whose needs can be met by the PPEC, should have PPEC services recommended by CMAT. Private duty nursing may be provided as a wraparound alternative for an individual needing additional services when PPEC is not available.
...
Service Authorization
All private duty nursing services must be prior authorized by a Medicaid service authorization nurse prior to the delivery of services. ...

Place of Service Exclusions
Medicaid does not reimburse for private duty nursing services provided in the following locations;
...
- Prescribed Pediatric Extended Care Centers.

Additionally relevant are rules of 59G-4.260, addressing **Prescribed Pediatric Extended Care Services**. Subsection (2) informs as follows:

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

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

Purpose
The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Program is to enable children with medically-complex conditions or the need for acute medical care to receive medical care at a non-residential pediatric center. PPECs provide a cost effective and less restrictive alternative to institutionalization, and reduce the isolation that homebound children may experience.

...

Description
A PPEC is a rehabilitative facility that serves three or more children under the age of 21 who require short or long-term continual medical care due to medically-complex conditions or the need for acute medical care. A PPEC offers services that meet the child's physiological, developmental, physical, nutritional, and social needs.

...

Who Can Receive Services
To receive PPEC services, a recipient must meet the following criteria:

- Be Medicaid eligible;
- Be medically fragile or technologically dependent;
- Be age 20 or under;
- Be medically stable; and
- Must require short or long-term health care supervision due to medically-complex condition or the need for acute care.

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

CMAT Referrals
If the primary care provider has not ordered PPEC services at the time of a CMAT staffing, the CMAT may recommend PPEC services. The recipient's case manger will communicate the CMAT recommendation to the primary care provider and request an order for PPEC services.

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

Under appropriate statute and administrative authorities, CMAT is charged with determining whether medical necessity has been adequately established and AHCA must assess whether the Medicaid reimbursement criteria have been met. While the

mother argued that medical necessity standards were met in the current situation and sustaining that would be prudent, substantive evidence did not support such a contention. The evidence submitted did support the determination made by the agency as to appropriateness of transition to an equally effective, less restrictive and more conservative or less costly alternative.

Based upon the evidence it is concluded that the plan to authorize skilled nursing services at a PPEC for five days a week is a reasonable determination. Thus, it is concluded the agency action has been justified.

DECISION

The appeal is denied and the agency action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 27th day of July, 2006, in Tallahassee, Florida.

J W Alper

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

Copies Furnished To:

Lisa Broward, Area 4 Medicaid Adm.

William Roberts, Esq.

FILED

JUL 2 1 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-02875

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 04 Duval
UNIT: APD

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 17, 2006, at 3:15 p.m., in Jacksonville, Florida. The petitioner was present and represented by Pete Brewer, waiver support coordinator. Ernestine Brewer, waiver support coordinator, appeared as a witness. The agency was represented by Joy Tootle, Assistant Attorney General. Appearing as witnesses for the agency were Ora Way, Agency for Persons with Disabilities, Dorothy Rowe, APS, Inc. and Pamela Chamberlynn, APS, Inc. Ms. Rowe and Ms. Chamberlynn participated in the hearing by telephone.

ISSUE

The petitioner is appealing the agency's action of March 27, 2006, to reduce supported living coach service from 25 hours per month to two hours weekly, under the Agency for Persons with Disabilities Medicaid Waiver Program. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a developmentally disabled adult who is approved to receive services in the Agency for Persons with Disabilities Medicaid Waiver Program. The petitioner has a diagnosis of mental retardation. Other health concerns include edema for which she is currently taking medication for. The petitioner had vein surgery in February 2005 and she has sickle cell anemia for which she is also taking medication.

The petitioner attends doctor appointments quarterly for lab work and follow up. According the support plan the supported living coach assists the petitioner in scheduling and attending doctor and dental appointments. The petitioner currently resides in her own apartment in the community. The petitioner is able to perform activities of daily living independently. The petitioner is also able to clean her own apartment, cook and shop with assistance. The petitioner currently attends an Adult Day Training Program Monday through Friday. The supported living coach assists with money management activities as well as other social activities. The waiver support coordinator explained that the petitioner prefers to have the supported living coach accompany her to some of the social activities she enjoys (Respondent's Exhibit 3).

A support plan with an effective date of March 1, 2006 was submitted requesting supported living coach, support coordination services, adult day training, adult dental,

transportation and medication review. The agency evaluated the request for five hours weekly of support living coach services and determined that the request was excessive and exceeded what would be considered medically necessary.

The agency instead approved two hours a week of supported living coach services. The petitioner was mailed notification of the agency's decision on March 27, 2006.

The rationale for the APS unit decision states in part:

> "Supported Living Coach is requested in the amount of 1200 quarter hours, or 25 hours a month at a unit cost of $8.29 and an allocated amount of $9,948.00 for BT, an adult residing in her own apartment. Supported Living Coach service began in 2003. Documentation submitted demonstrates that the supported living coach assists with budgeting and meal preparation. Additional documentation from the waiver support coordinator states BT has a difficult time walking and has to be accompanied by her Supported Living Coach and prefers her Supported Living Coach to medical and dental appointments, shopping, pharmacy, recreation and leisure. The Supported Living Coach also assists BT with Banking and Money Management.
>
> In accordance with the June 23, 2005 Developmental Disabilities DD Waiver Services Coverage and Limitations Handbook page 2-4, defines the set of conditions for determining medical necessity for each requested service which states in part that services must; 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; be furnished in a manner not primarily intended for the 'convenience' of the recipient or the provider, and be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide.
>
> Medical necessity is not demonstrated for 1456 quarter hours of supported living coaching. The recommendation is made to approve two hours per week at a unit cost of $8.29 and an allocated amount of $3,448.64. This represents a reduction in service delivery for the recipient. Supported living coach is not the more conservative or less costly service to provide a recipient with physical support when walking, escort service, transportation, leisure or recreational activities. Support and cost plan

amendments may be submitted for other, more appropriate services for BT.

A request for reconsideration (Form #4) may be submitted if desired, and should be accompanied by documentation that clearly demonstrates BT's needs. Please refer to the letter accompanying this notice for a description of BT's rights for reconsideration."

A reconsideration was requested and additional documentation was provided. The additional information provided for reconsideration consisted of a letter of justification indicating the petitioner needed the service. The APS Unit in evaluating the additional information, upheld the original decision upon reconsideration. Additional documentation was provided after the reconsideration period was completed. This documentation however, further supported the decision already made. The APS witness identified other waiver services which would be more appropriate to meet the needs of the petitioner in a more cost efficient manner.

CONCLUSIONS OF LAW

Fla. Admin. Code 59.G-13.080, Home and Community-Based Services Waivers, states in part:

"(1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness... (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, July

2002, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent."

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

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

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook dated June 23, 2005, states in part:

"Description Supported living coaching services provide training and assistance, in a variety of activities, to support recipient's who live in their own homes or apartments. These services may include assistance with

> locating appropriate housing; the acquisition, retention or improvement of skills related to activities of daily living such as personal hygiene and grooming; household chores; meal preparation; shopping; personal finances and the social and adaptive skills necessary to enable recipient's to reside on their own. Supported living services mean the provision of supports necessary for an adult who has a developmental disability to establish, live in and maintain a household of his choosing in the community. This includes supported living coaching and other supports…"

In a support plan the petitioner requested that the agency pay for 25 hours monthly of supported living coach services. In evaluating this request for services it was noted that the petitioner can independently perform all activities of daily living. The petitioner is involved in meaningful day activity and she enjoy a number of social activities. The evidence shows the petitioner prefers the accompaniment of the supported living coach in such engagements. The agency's medical expert witnesses determined that supported living coach services was not the appropriate service for all of the activities it was being used for. Instead it recommended that the petitioner consider requesting services such as in home supports and companion services for physical support when walking, escort services, transportation, leisure and recreational activities. These services are less expensive and more consistent with the medical necessity criteria.

The petitioner asserted that it takes more than two hours to attend scheduled medical appointments. However, there was no evidence to show that the petitioner was required to attend weekly medical appointments. In fact the evidence showed the petitioner is scheduled medical appointments on a quarterly basis for lab work and follow up.

In making a determination of what a word means, the normal and ordinary meaning for the word is typically used. However, by rule, the term "medical necessity" has special meaning. The rule specifically defines matters that have to be taken into consideration in determining medically necessary.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in referring to medically necessary determinations states: "An appropriate, qualified professional shall make the determination that the standards for medical necessity set forth in 59G-1.010 (166)(a)(c), F.A.C., are met, and that the requested item meets the service definition, as contained in the approved DD waiver." This statement recognizes that it takes a qualified professional to apply the concepts included in the rule definition of medically necessary.

The agency notification states the reason for the reduction in services is "The request exceeds medical necessity or there is no determination that the service(s) is medically necessary." The petitioner provided no medical evidence to justify that the amount of service requested was medically necessary.

Based on the evidence presented, it is determined that two hours of supported living coach services weekly is sufficient to meet the petitioner's needs and 25 hours monthly of supported living coach services is in excess of the petitioner's needs and is not considered to be medically necessary, as defined in the rule. Therefore, it is concluded that the respondent's action to reduce supported living coach services to two hours weekly is an action that is consistent with the applicable authorities.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 21st day of July, 2006,

in Tallahassee, Florida.

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:
District 4 APD: Gayle Granger
Joy Tootle, Esq.
Ernestine Brewer, Esq.

FILED
JUL 0 7 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs. APPEAL NO. 06F-2553

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 03 Alachua
UNIT: APD

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 19, 2006, at 10:30 a.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was David Kanya, People Systems. Present as witnesses for the petitioner were Jimmy Daniels and Joyce Daniels of F s Group Home. The respondent was represented by Lucy Goddard-Teel, District 3 legal counsel with the Department of Children and Families. Present testifying by telephone on behalf of the respondent was Dr. Bob Roberts of Maximus.

ISSUE

The petitioner is appealing the respondent's action of April 5, 2006, to decrease his residential habilitation services at the behavior focus level from 11 hours of direct care staff per day to seven hours per day, under the Developmental Services Home and Community Based Services Medicaid Waiver Program.

FINDINGS OF FACT

The petitioner is developmentally disabled and is eligible to receive services from the respondent's Developmental Services Home and Community-Based Services Waiver Program. He is 25 years old and lives at the 's Group Home. The petitioner attends an adult day training program five days per week for six to eight hours per day. The petitioner is independent of most of his activities of daily living and self help skills. The petitioner does not have problems sleeping at night. The petitioner assumes responsibility for some household chores. The petitioner has good expressive and receptive language skills. He is friendly, energetic, outgoing and social. He is in good health and is physically fit. The petitioner likes to play basketball, likes to go swimming and likes to spend time with friends.

The petitioner has a history of many behaviors that threaten his safety and the safety of others around him. He has difficulty controlling his anger, has inappropriate outbursts, has a history of attacking others, causing property damage, stealing, suicidal behaviors and inappropriate sexual behaviors. The petitioner's behaviors have been stable during the last year, he has not had any inappropriate sexual behaviors in the past year and there was no documentation to show that he has had any recent suicidal behaviors.

The petitioner's waiver support coordinator submitted a support plan which was to be effective March 1, 2006. In the support plan, the waiver support coordinator requested to continue 11 hours per day of residential habilitation at the behavior focus level.

The respondent's Developmental Disabilities Program has contracted with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels. Maximus reviewed the petitioner's request to continue his 11 hours per day of residential habilitation services at the behavior focus level. The 11 hours per day of residential habilitation services at the behavior focus level was temporarily approved by Maximus for 150 days to allow more appropriate services to be put in place. The documentation Maximus received showed that the petitioner's behavior was stable, he did not have any inappropriate sexual behaviors during the past year and did not have any recent suicidal behaviors. Additionally, the petitioner was independent of most of his activities of daily living and self help skills, he was not having problems sleeping at night and was home and awake about eight to ten hours per day. Based on the documentation received, Maximus determined that the residential habilitation service at the behavior focus level of 11 hours per day was more intense that what was required and was in excess of the petitioner's needs and not medically necessary. Maximus determined that based on the documentation submitted that seven hours per day of residential habilitation service at the behavior focus level met his needs and was medically necessary.

On April 5, 2006, Maximus notified the petitioner that his residential habilitation services at the behavior focus level was being reduced to seven hours per day, as medical necessity for the continuation of 11 hours per day of residential habilitation services at the behavior focus level was not demonstrated and was in excess of his needs.

CONCLUSIONS OF LAW

Fla. Admin. Code 59.G-13.080, Home and Community-Based Services Waivers, states in part:

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness... (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, July 2002, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent...

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

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

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

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in part states:

Residential habilitation provides specific training activities that assist the beneficiary to acquire maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the beneficiary to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the beneficiary and reflects the beneficiary's goal(s) from their current support plan...

Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office...

<u>Residential Habilitation with a Behavioral Focus</u>

Service characteristics for residential habilitation with a behavioral focus include:

• A Board Certified Behavior Analyst or Associate Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or 491, F.S., provides on-site-oversight for residential services,

• Integration of behavioral services throughout residential and community programs,

• No fewer than 75% of the provider's direct service staff who work with the recipient(s) for whom the residential habilitation with a behavioral focus rate applies have completed at least 20 contact hours of face-to face competency-based instruction with performance-based validation in the following content areas;

_ Introduction to applied behavior analysis – basic principles and functions of behavior.
_ Providing positive consequences, planned ignoring, and stop redirect reinforce techniques.
_ Data collection and charting.

• The service provides for comprehensive monitoring of staff skills and their implementation of required procedures. Monitoring for competence must occur at least once per month for 50% of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each recipient's behavior analysis services plan.

• Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans.

In order for the provider to receive a residential habilitation with a behavioral focus rate for a recipient based on the published rate matrix, the provider must meet the specified staff qualifications for the service, and the recipient must exhibit the characteristics listed below. This rate level shall be approved only when it has been determined through use of the Department approved assessment by a certified behavior analyst, and the support planning process that an individual requires residential habilitation with a behavioral focus services. The need for residential habilitation with a behavioral focus and the rate for the service shall be identified on the individual's support and cost plan and on the authorization for service submitted to the provider by the individual's

support coordinator. Service authorization shall be based on established need and re-evaluated at least every six months while the recipient is receiving the services. The provider must document evidence of continued need as well as evidence that the services are assisting the service provider in meeting the needs of the recipient so that transition to less restrictive services may be possible.

Recipients exhibiting one of the following characteristics may need residential habilitation with a behavioral focus services. Recipients receiving the service have behavioral challenges that fit one or both of the following two categories of behavioral problems, labeled A and B:

A. The person does not engage in an adaptive behavior that, if not performed by the person or taught by a caregiver, would result in a real and present threat of substantial harm to the person's health or safety. This includes not engaging in adaptive behaviors such as following safety rules, responding in acceptable ways to conflict, performing daily living activities safely and maintaining basic health.

B. The person has exhibited a problem with behavior during the past year or currently exhibits a problem with behavior that meets one of the criteria below:

• Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional.
• Is being addressed through the use of behavior analysis services and reviewed by the Local Review Committee (LRC).
• Has lead to the use of restraint or emergency medications within the past year.

Has resulted in one or more of the following:

1. Self-inflicted, detectable, external or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
2. External or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behavior include hitting others, biting others and throwing dangerous objects at others.
3. Arrest and confinement by law enforcement personnel.

4. Major property damage or destruction in excess of $500 for any one intentional incident.
5. A life-threatening situation. These types of behaviors include but are no limited to excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.

Residential habilitation provides specific training activities that assist an individual to acquire, maintain or improve skills related to activities of daily living. The residential habilitation focuses on personal hygiene skills such as bathing and oral hygiene, homemaking skills and on social and adaptive skills that enable the individual to reside in the community. The Findings of Fact show that the petitioner's behavior was stable, he did not have any inappropriate sexual behaviors during the past year and did not have any recent suicidal behaviors. Additionally, the findings showed that the petitioner was independent of most of his activities of daily living and self help skills and he was not having problems sleeping at night.

In making a determination of what a word means, the normal and ordinary meaning for the word is typically used. However, by rule, the term "medical necessity" has special meaning. The rule specifically defines matters that have to be taken into consideration in determining medically necessary.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in referring to medically necessary determinations states: "An appropriate, qualified professional shall make the determination that the standards for medical necessity set forth in 59G-1.010 (166)(a)(c), F.A.C., are met, and that the requested item meets the service definition, as contained in the approved DD waiver."

included in the rule definition of medically necessary. There was no rebuttal evidence presented by the petitioner to prove medical necessity.

The agency cites reasons for the above noted decision for services was based on: "The request exceeds medical necessity or there is no determination that the service(s) is medically necessary."

Based on the evidence presented, it is determined those seven hours of residential habilitation service at the behavioral focus level is sufficient to meet the petitioner's residential habilitation needs as the petitioner's behaviors have been stable and he is independent of his activities of daily living and self help skills. The 11 hours per day of residential habilitation service at the behavioral focus level is considered to be in excess of the petitioner's needs and is not considered to be medically necessary. Therefore, it is concluded that the respondent correctly reduced the petitioner's residential habilitation at the behavior focus level to seven hours per day.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of July, 2006,

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: J[illegible]
District 3 APD: Jim Smith
Lucy Goddard-Teel, Esq.
David Kanya
Shannon Miller

FILED
JUL 14 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03290

PETITIONER,

Vs.

CASE NO.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 07 Orange
UNIT: APD

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 15, 2006, at 11:46 a.m., in Orlando, Florida. The petitioner did not appear. , petitioner's father and representative, appeared on petitioner's behalf. . petitioner's stepmother, appeared as a witness for the petitioner. Linda Cumbie, petitioner's waiver support coordinator, appeared as a witness for the petitioner.

Joseph Robles, assistant attorney general, appeared and represented the agency. Leslie Varhol, human services analyst with the Agency for Persons with Disabilities (APD), appeared as a witness for the agency. Dr. Sandra Jensen, clinical psychologist and consultant reviewer with APS Healthcare, and Pam Chamberlynn, qualified mental retardation professional and consultant reviewer with APS, appeared as witnesses for the agency via telephone. Colette Riehl,

qualified mental retardation professional and consultant reviewer for APS, was present via phone and observed the proceeding.

ISSUE

At issue is the agency's action of April 20, 2006, denying the petitioner's request for an increase in respite care hours from thirty days per year (720 hours) to forty days per year (1,280 hours) due to a service limitation. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

The petitioner is a 24-year old young lady who is developmentally disabled and living with her parents. She is mentally retarded and is currently receiving services through the agency's Developmental Disabilities Home and Community-Based Waiver Services Program. Specifically, she receives the services of personal care assistance and respite care.

The petitioner's paternal grandparents, who live in Miami, became very ill. As a result, the petitioner's father and stepmother were, and still are desperately needed to go and care for them until they can stabilize. This event gave rise to the need for the petitioner's father to request extra hours of respite care for his daughter so that someone could provide her care while he and his wife were absent tending to the family's emergency.

Respite care provides care and supervision to an individual when her primary caregiver is unable to because of a temporary absence or emergency (Developmental Disabilities Waiver Services Coverage and Limitations

Handbook, June 23, 2005, p. 2-79, Respondent's Exhibit 4). The petitioner is receiving the maximum allowed by the agency's handbook.

The agency forwarded the petitioner's request to its prior service authorization agent, APS Healthcare. APS assigned the request to one of its consultant reviewers (Respondent's Exhibit 3). The reviewer discovered that the petitioner is already receiving the maximum allowable amount of days/hours of respite care as set forth in the agency's handbook. Because of this, the request could not be approved (Respondent's Exhibit 2). This decision was affirmed after a reconsideration review. The agency issued a notice informing the petitioner of the denial of increase dated April 20, 2006 (Respondent's Exhibit 1).

The petitioner appeals. She agrees that she is receiving the capped amount of respite hours. However, she seeks an exception to the rule limiting the service. She has not utilized all of the funds in her budget allocation and would like to use them to pay for the extra respite. The agency stated that monies allocated for payment of one service may not be used to pay another.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080 states in relevant part:

> (12) Developmental Services Waiver -- General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities

Waiver Services Provider Rate Table is available from the Medicaid fiscal agent.

The agency is granted authority to administer the waiver program and set its requirements. This is done through the use of the program's handbook.

Developmental Disabilities Waiver Services Coverage and Limitations Handbook, p. 2-79 states in relevant part:

> Respite Care…Description…Respite care is a service that provides supportive care and supervision to a recipient when the primary caregiver is unable to perform these duties due to a planned brief absence, an emergency absence or when the caregiver is available, but temporarily physically unable to care for or supervise the recipient for a brief period…Limitations…Respite care services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan. **The amount of respite services are determined individually and limited to no more than thirty days per year, (720 hours) per recipient.** [emphasis added]

Based on the evidence and testimony presented, the hearing officer concludes that the agency's action denying the increase for respite hours was correct. The agency has established a cap on the amount of hours an individual can receive and the petitioner is currently receiving that amount. The family's crisis does not go unnoticed and there is no dispute as to the urgency of the request, however, the program's rules do not allow any exceptions to the service limitation.

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

DONE and ORDERED this 14th day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:
District 7 APD: Steve Roth
M. Catherine Lannon, Sr. Assistant Attorney General
Shane DeBoard, Esq

FILED

JUL 2 1 2006

OFFICE OF APPEAL HEARING
DEPT. OF CHILDREN & FAMILIE

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

PETITIONER,

Vs.

APPEAL NO.06F-0801

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 23 Pinellas
UNIT: APD

RESPONDENT.

_______________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was schedule before the undersigned hearing officer on March 8, 2006, at 10:45 a.m., in Largo, Florida. The petitioner requested and was granted a continuance to April 18, 2006.

The administrative hearing was not held on April 18, 2006, at 2:15 p.m., in, Florida. Prior request for multiple call-in number had not been made for multiple telephonic witnesses and two of the petitioner's witnesses were unavailable. A prehearing conference was held with counsel both parties present, the petitioner's parents and the respondent's representative. The hearing was rescheduled to May 23, 2006.

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 23, 2006, at 10:03 a.m., in Largo, Florida. The petitioner was not present. The petitioner was represented by co-counsels Gerald Rutberg, Esq. and Ann Rutberg, Esq. The respondent was represented by Joseph

Robles, assistant attorney general. Due to the number of witnesses the hearing was reconvened to June 25, 2006, at 10:15 a.m.

The hearing was reconvened on June 25, 2006, at 10:15 a.m. The petitioner was represented by co-counsels Gerald Rutberg, Esq. and Ann Rutberg, Esq. The respondent was represented by Joseph Robles, assistant attorney general. As the rebuttal witness for the respondent was unavailable, the hearing was reconvened to July 11, 2006.

The hearing was reconvened on July 11, 2006 at 2:00 p.m. The petitioner was represented by co-counsels Gerald Rutberg, Esq. and Ann Rutberg, Esq. The respondent was represented by Joseph Robles, assistant attorney general.

Witnesses for the petitioner were petitioner's mother; , petitioner's father; K ey, petitioner's caretaker at House; Bonnie Jo Hill, owner of Group Homes, Inc.; Christian Gingras, behavior specialist; Steven Parrish Winesett, M.D. and John Viverito, M.D.

Witnesses for the respondent were Cheryl Blackwell-Cox, supervisor; Emma Guilarte, Ph.D., consultant reviewer with Maximus, and Kelli Michels, documentary reviewer for Maximus.

ISSUE

The petitioner is appealing the notice of January 10, 2006 for the respondent's action to reduce residential habilitation services through the Developmental Disabilities Home and Community-Based Services Waiver Program from 14 hours per day to 9 hours per day, for the cost plan of January 1, 2006 through December 31, 2006. As the respondent reduced the services, the respondent has the burden of proof.

FINDINGS OF FACT

The petitioner is Medicaid and Developmental Disabilities eligible adult, 21 years of age as of April 26, 2006. The petitioner's impairments were indicated on the Support Plan as mental retardation and seizure disorder. The petitioner has been diagnosed with Cornelia deLange syndrome, a genetic disorder, with a measured I.Q. of 51. The petitioner is of large frame and weighs between 165 and 170 pounds. His physical symptoms are inability to walk, difficulty with facial expression and nonverbalization. His behavioral issues are self-injurious hand-biting, hyperactivity, aggression and sleep disturbance. The petitioner's hand-biting is continuous without intervention. The hand-biting can result in necrosis. The petitioner is incontinence of bowel and bladder and requires a diaper at all times. He ambulates by wheelchair or a form of crawling by propelling himself on his knees. Due to the petitioner propelling himself using his knees, injury to the knees is present. The petitioner will eat anything. He will eat too much and too fast, causing aspiration. The petitioner is prone to infection and seizures.

As a result of the petitioner's hyperactivity, aggression and sleep disturbance, he sleeps, at most, three hours at a time during the night. During the night if unattended, he will crawl through the home and is destructive. Once awake, the petitioner may wander in the home and pull down items. If he is left alone in his room while awake he will remove the sheets, take down his clothes and create potential choking hazards.

The petitioner is receiving services through the Developmental Disabilities Home and Community-Based Services Waiver Program. The petitioner requested services. The request included14 hours per day of residential habilitation services, for the cost plan of January 1, 2006 through December 31, 2006. The petitioner resides with five other

individuals receiving Developmental Disability services in a group home. The group home is staffed with at least two employees every shift. The petitioner requires two people to assist with bathing, dressing and transfers. The request was for 14 hours of one to one staffing per day for 350 days. The petitioner is away from the group home for school seven hours a day Monday through Friday. On 180 days when the petitioner is in school, he requires grooming, personal hygiene services for two hours in the morning, two hours after school for diapering and bathing and two hours for dinner. The remainder of the request was for supervision during the petitioner's awake hours during the night and for the 185 days the petitioner is not in school.

The respondent reviewed the criteria for prior authorization. The petitioner request met the criteria for prior authorization and the case was referred to Maximus for prior authorization. Maximus, a contract provider of the Department, reviews service requests for medical necessity and cost effectiveness.

The Maximus review for prior authorization is done by a team of three reviewers. The team reviewed the documentation submitted by the support coordinator. The Maximus reviewer determined that the documentation submitted by the support coordinator did not demonstrate medical necessity for the service request for 14 hours per day and did not meet the requirements of the Developmental Services Waiver Services Medicaid Coverage and Limitation Handbook. The residential habilitation was approved for 9 hours per day. A notice was sent to the petitioner

Reconsideration was requested. A team of three additional Maximus reviewers upheld the original decision of Maximus to authorize eight hours per day. The basis for

that decision was that the information submitted for reconsideration did not demonstrate medical necessity for the additional hours requested.

The petitioner's treating physician has been caring for the petitioner for over 16 years. The treating physician stated that the petitioner is a danger to himself and other when he is not supervised. The petitioner's experts' proffered that the petitioner has limited ability to increase his level of skills. There have been no conclusive sleep studies. A sleep observation indicated that the petitioner did not sleep more than three hours. The physician indicated that everything except the mattress has to be removed for the petitioner's safety.

The behavioral services had recently been added. The behavior analyst indicated the each time the petitioner is ill, which is frequently, she has to restart the training from the beginning. However, she has made some progress. Prior to the implementation of this new training the staff at the petitioner's home would give the petitioner food to coax him back to his room and or spend time with him. The behavioral analyst is working with redirection of the petitioner and training the staff, while maintaining the petitioner's safety, to not engage in conversation, not give food as a bribe and redirect the petitioner to sleep.

The petitioner's parent cared for the petitioner until he went to the group home. When the petitioner lived at home, his door was locked to prevent the petitioner for wandering during the night.

CONCLUSIONS OF LAW

Florida Statutes at Fl. Stat. 393.13, Personal treatment of persons who are developmentally disabled, states in part:

> (3)(c) Persons who are developmentally disabled shall receive services, within available resources...
> (d) Persons who are developmentally disabled shall have a right to participate in an appropriate program of quality education and training services, within available resources...

Florida Statutes at Fl. Stat. 393.066, Community services and treatment for persons who are developmentally disabled, states in relevant part:

> (1) The Department of Children and Families shall plan, develop, organize, and implement its programs of services and treatment for persons who are developmentally disabled along district lines. The goal of such programs shall be to allow clients to live as independently as possible in their own homes or communities and to achieve productive lives as close to normal as possible...

Florida Administrative Code at Fl. Admin Code 59.G-8.200, Home and Community-Based Services Waivers, states in part:

> (1)Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting...

Florida Administrative Code at Fl. 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 Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, June 23, 2005, pages 2-66 through 76 set forth the description of limitations, place of service, documentation requirements, and special considerations for Residential Habilitation. The handbook states on page 2-66 for "Description":

> Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the recipient and reflects the recipient's goal(s) from their current support plan.

The evidence set forth that the petitioner is in need of direct care at all times. Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain or improve skills related to activities of daily living. It is apparent that the petitioner needs the residential rehabilitation to maintain the skills that he has acquired. Attempts at redirection and behavior modification by the staff during the

eight hours the petitioner is not asleep at night would be consistent with the concept of specific training activities.

The hearing officer concludes that at this time 14 hours residential habilitation is medically necessary with behavioral services. The petitioner should, in addition, request all other services recommended by the respondent to augment the goals. The undersigned is mindful of the comments made by the respondent's experts as to the possibility that other services may be of assistance to the petitioner. In light of those comments, all parties are encouraged to discuss these options while being mindful of safety concerns, in future support plans.

DECISION

This appeal is granted.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 21st day of July, 2006,

in Tallahassee, Florida.

L. J. Nicholson
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: E
Suncoast APD: Carl Littlefield
Gerald and Ann Rutberg, co-counsel for the petitioner
Joseph Robles, counsel for the respondent
Jennifer Lima, Suncoast District Legal

FILED
JUL 2 1 2006
OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03015

PETITIONER,

Vs.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 11 Dade
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 2, 2006, at 8:45 a.m., in Miami, Florida. The petitioner was not present. Representing the petitioner was Christopher Mazzarella, administrator, [illegible] Group Home. Present, on behalf of the petitioner was Judith Rodriguez, support coordinator, Life Plus. Representing the agency was Kathleen M. Savor, assistant attorney general, Office of the Attorney General. Appearing as a witness for the agency was Jane Fiskind, nurse consultant with Maximus. Ms. Fiskind appeared via telephone.

ISSUE

At issue is the agency's action of April 7, 2006, to deny Adult Dental Services, terminate Physical Therapy, and to approve with change Residential Habilitation-Standard and Consumable Medical Supplies in the Home and Community-Based Waiver Services Program, due to the request exceeds medical necessity or there is no determination that

the service(s) is medically necessary, and due to the request does not meet the Developmental Services Home and Community-Based Services Medicaid Waiver service limitations/exclusions or requirements.

The petitioner carries the burden of proof for the denial. The agency carries the burden of proof for the termination and for the reduction of services.

FINDINGS OF FACT

The petitioner is a 32 year-old developmentally disabled adult, approved to receive authorized services through the Home and Community-Based Services Medicaid Waiver Program. He currently resides in a licensed group home in Miami Dade County.

As part of the eligibility determination process, the support coordinator must submit a support plan, a cost plan, and an implementation plan for review. Maximus is the private agency that is contracted by the agency to perform Prior Service Authorizations (PSA) and reviews of the submitted plans.

Maximus' process for completing the reviews is to have a lead reviewer make a preliminary decision for each review. A peer reviewer reviews this decision and agrees or not. Finally, a physician reviews this action and makes the decision if the action on the review is correct or not. This process occurred for the case at hand.

Maximus reviewed the petitioner's request for Adult Dental Service in the amount of $2,136 to provide Mr. a gross scale, irrigation, anesthesia and filings for various teeth. Maximus sent a request for missing information on November 3, 2005 and the respond received was that Mr was no longer seeking the service. During the

reconsideration process no additional information was submitted so the initial determination was upheld.

In addition, Maximus reviewed the petitioner's request for two boxes of gloves per month and a case of wipes per month. The agency approved the wipes, but not the gloves because they are payable items for the Medicaid State Plan.

This decision was upheld during the reconsideration determination because no additional information was submitted. The evidence shows that the petitioner has Medicare and Medicaid coverage, and Medicare only pays for gloves when a patient is undergoing dialysis. In the process to bill Medicaid for gloves, the petitioner has to bill Medicare first and when he receives a denial he should send Medicaid a copy of that denial for Medicaid to pay for those gloves. The petitioner's representative stated that they are having problems with the providers because they refuse to follow this process on a monthly basis.

The petitioner requested Physical Therapy in the amount of 48 quarter hours per year. Documentation provided by the petitioner indicates that a physical therapy assessment had not been performed since 2005, despite the fact that Mr. had received Physical Therapy in the last cost plan. Maximus requested a current physical therapy assessment, but this information was not submitted within the timeframe allotted. The reconsideration request did not include Physical Therapy; therefore, the initial determination was upheld.

The petitioner requested Residential Habilitation-Standard in the amount of 350 days, at the intensity of 13 direct care staff hours per day to assist the petitioner with using

the dishwasher, folding and putting away clothing, doing his own banking and cleaning his bathroom sink. The information provided to Maximus indicates he is independent in much of his self care activities and there is no indication of any change in the petitioner's health or functional status from the last cost plan year.

Ms. Fiskind, explained that given the information submitted for review, medical necessity was demonstrated for Residential Habilitation with behavior focus service at an intensity of seven hours of direct care staff per day to assist the petitioner with his self-care and living skills. Ms. Fiskind noted that this was a documentary review, and that she based her decision on the information submitted to her. The information indicates that Mr. performs basic self-care activities including tooth brushing, dressing and undressing with minimal prompts; he eats independently and is able to communicate. Mr. ses a walker and is able to maneuver a wheelchair for mobility, but requires assistance with transfers and to use the bathroom. In the submitted documentation there is no sleep data to indicate if he requires overnight supervision.

The agency determined that medical necessity was demonstrated for Residential Habilitation at the intensity of seven direct care staff hours.

The petitioner's representative purported that Mr. has significant limitation in self care and in all his activities of daily living, and needs constant staff assistance. He claims that in the previous cost plan the petitioner was approved for 13 direct care staff hours per day. The petitioner's representative argues that there is no change in Mr. health status or functional status that justifies a reduction of services.

Ms. Fiskind responded that their records show that in the previous support plan the petitioner requested ten hours and was approved for seven. She stated that she does not have any personal knowledge as to what happened in the middle of the year that prompted the agency to increase the services from seven to thirteen hours for a period of six months. Ms. Fiskind asserted that according to the last documentation provided to Maximus medical necessity was demonstrated for Residential Habilitation at the intensity of seven direct care staff hours per day, and that is what was approved.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010(166) defines medically necessary as follows:

> (a) "Medically necessary" or "medical necessity" means that medical *or* allied care, goods or services furnished or ordered must 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 defined by the Medicaid program and not be experimental or investigational;
> 4. Be reflective of the level of service that can safely be furnished; 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 beneficiary, the beneficiary's caretaker, or the provider.

Developmental Disabilities Waiver Services Florida Coverage and Limitations Handbook, updated October 2003 with implementation of June 23, 2005, Chapter 2 Covered Services, Limitations and Exclusions states in part:

> **Description**
> Consumable medical supplies are those non-durable supplies and items that enable recipients to increase their ability to perform activities of daily living. Consumable medical supplies are of limited usage and must be replaced on

frequent basis. Supplies covered under the Developmental Disabilities Home and Community-Based Services waiver must meet all of the following conditions: a) be related to a recipient's specific medical condition, b) not be provided by any other program, c) be the most cost-beneficial means of meeting the recipient's need, and d) not primarily for the convenience of the recipient, caregiver, or family. Consumable medical supplies covered by the DD waiver are listed under Limitations.

Limitations
Consumable medical supplies will not duplicate supplies provided by the Medicaid State Plan...

Description
Adult dental services cover dental treatments and procedures that are not otherwise covered by Medicaid State Plan services. Adult dental services include diagnostic, preventive and restorative treatment, extractions; and endodontics, periodontal and surgical procedures. Adult dental benefits also include medically necessary emergency dental procedures to alleviate pain and or infection. Emergency dental care consists of oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess. The services strive to prevent or remedy dental problems that, if left untreated, could compromise a recipient's health, by increasing the risk of infection or disease, or reducing food options, resulting in restrictive nutritional intake.

Limitations
Adult dental services are limited to recipient's 21 years of age or older. Adult dental services will not duplicate dental services provided to adults by the Medicaid State Plan...

Description
Residential habilitation provides supervision and specific training activities that assist the recipient to acquire, maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the recipient to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the recipient and reflects the recipient's goal(s) from their current support plan. Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the

recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office.

Limitations

Residential habilitation services are provided to adults, 18 years of age and older, living in their own home or family home, or living in a licensed facility...

Description

Physical therapy is a service prescribed by a physician that is necessary to produce specific functional outcomes in ambulation, muscle control, and postural development, and to prevent or reduce further physical disability. The service may also include a physical therapy assessment, which does not require a physician's prescription. In addition, this service may include training and monitoring direct care staff and caregivers to ensure they are carrying out therapy goals correctly.

Limitations

Physical therapy and assessment services are available through Medicaid State Plan services to recipients under the age of 21...

These rules established guidelines for the definitions and authorization of services under the Waiver Services Program.

The Findings of Fact show that the agency has reviewed the petitioner's eligibility for Adult Dental Services and Physical Therapy under these rules and determined that there was insufficient information to complete the eligibility process, and as a result medical necessity could not be demonstrated for the requested services. Concerning the Consumable Medical Supplies the agency determined that the Waiver cannot replace a benefit available through the Medicaid State Plan; therefore, the request for gloves was not approved.

Lastly, the Findings of Fact show that given the information provided, medical necessity was demonstrated for Residential Habilitation Services, but not at the intensity

requested. This service was approved for seven hours of direct care staff per day for 350 days.

After considering the evidence, the Florida Administrative Code and all of the appropriate authorities set forth in the findings above, the hearing officer concludes that the agency's action to deny Adult Dental Services and terminate Physical Therapy was correct. Additionally, the hearing officer concludes that the agency's action to reduce Consumable Medical Supplies and Residential Habilitation Services was also correct.

DECISION

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

JUDICIAL REVIEW

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, 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 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 July, 2006,

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:

District 11 APD: Evelyn Alvarez
James Murdock
Hilda Fluriach, Esq.
M. Catherine Lannon, Esq.
Judith Rodriguez

FILED
JUL 2 1 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs.

APPEAL NO. 06F-2801

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 03 Alachua
UNIT: APD

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 21, 2006, at 1:05 p.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was David Kanya, People Systems. Present as witnesses for the petitioner were [illegible] roup Home. The respondent was represented by Lucy Goddard-Teel, Department of Children and Families District 3 legal counsel. Present testifying by telephone on behalf of the respondent was Kelli Michaels of Maximus.

ISSUE

The petitioner is appealing the respondent's action of May 1, 2006, to decrease his residential habilitation services at the behavior focus level from eleven hours of direct care staff per day to seven hours per day, under the Developmental Services Home and Community-Based Services Medicaid Waiver Program.

FINDINGS OF FACT

The petitioner is a resident of Alachua, County, Florida. He is 36 years old and resides at the s Group Home in Gainesville, Florida. The petitioner is developmentally disabled and is eligible to receive services from the respondent's Developmental Services Home and Community-Based Services Medicaid Waiver Program. The petitioner works at at night and works seven hours per day. The petitioner's employment is his meaningful day activity.

The petitioner is independent of most of his activities of daily living and self help skills. He takes care of his personal hygiene needs with occasional prompts from the group home staff. The petitioner is able to get along with the group home staff and with his peers. The petitioner cleans, cooks and is able to operate a washing machine, dryer, can opener, coffee maker, food mixer, oven and microwave. The petitioner is able to sort and fold his laundry, make his bed, and self-administer his medications. The petitioner has been receiving behavior analysis services due to agitation, physical and verbal aggression and inappropriate sexual behavior. There have been no recent incidents of property destruction or sexually inappropriate behavior. However, on May 28, 2006, the petitioner was arrested for aggravated assault on his manager at where he was previously employed. The petitioner does have an average of one episode of agitation per month. There were no other reports of inappropriate behaviors.

The petitioner's waiver support coordinator submitted a support plan which was to be effective April 1, 2006. In the support plan, the waiver support coordinator requested the continuation of eleven hours per day of residential habilitation at the

behavior focus level to provide the petitioner with training and supervision to learn to read, manage his money, obtain a driver's license and cook.

The respondent's Developmental Disabilities Program has contracted with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels. Maximus reviewed the petitioner's request to continue his eleven hours per day of residential habilitation services at the behavior focus level. The eleven hours per day of residential habilitation services at the behavior focus level was temporarily approved by Maximus for 204 days to allow more appropriate services to be put in place. The documentation Maximus received showed that the petitioner's behavior was stable, he did not have any recent inappropriate sexual behaviors or recent incidents of property destruction. Additionally, the petitioner was considered a high functioning individual, was independent of most of his activities of daily living and self help skills. Based on the documentation received, Maximus determined that the residential habilitation service at the behavior focus level of eleven hours per day was more intense than what was required and was in excess of the petitioner's needs and not medically necessary. Maximus determined that based on the documentation submitted that seven hours per day of residential habilitation service at the behavior focus level met his needs and was medically necessary.

On May 1, 2006, Maximus notified the petitioner that his residential habilitation services at the behavior focus level was reduced to seven hours per day, as medical necessity for the continuation of eleven hours per day of residential habilitation services at the behavior focus level was not demonstrated and was in excess of his needs.

CONCLUSIONS OF LAW

Fla. Admin. Code 59.G-13.080, Home and Community-Based Services Waivers, states in part:

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness...(12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, July 2002, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent...

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

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

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

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in part states:

Residential habilitation provides specific training activities that assist the beneficiary to acquire maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the beneficiary to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the beneficiary and reflects the beneficiary's goal(s) from their current support plan...

Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office...

<u>Residential Habilitation with a Behavioral Focus</u>

Service characteristics for residential habilitation with a behavioral focus include:

• A Board Certified Behavior Analyst or Associate Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or 491, F.S., provides on-site-oversight for residential services,

• Integration of behavioral services throughout residential and community programs,

• No fewer than 75% of the provider's direct service staff who work with the recipient(s) for whom the residential habilitation with a behavioral focus rate applies have completed at least 20 contact hours of face-to face competency-based instruction with performance-based validation in the following content areas;

_ Introduction to applied behavior analysis – basic principles and functions of behavior.
_ Providing positive consequences, planned ignoring, and stop redirect reinforce techniques.
_ Data collection and charting.

• The service provides for comprehensive monitoring of staff skills and their implementation of required procedures. Monitoring for competence must occur at least once per month for 50% of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each recipient's behavior analysis services plan.

• Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans.

In order for the provider to receive a residential habilitation with a behavioral focus rate for a recipient based on the published rate matrix, the provider must meet the specified staff qualifications for the service, and the recipient must exhibit the characteristics listed below. This rate level shall be approved only when it has been determined through use of the Department approved assessment by a certified behavior analyst, and the support planning process that an individual requires residential habilitation with a behavioral focus services. The need for residential habilitation with a behavioral focus and the rate for the service shall be identified on the individual's support and cost plan and on the authorization for service submitted to the provider by the individual's

support coordinator. Service authorization shall be based on established need and re-evaluated at least every six months while the recipient is receiving the services. The provider must document evidence of continued need as well as evidence that the services are assisting the service provider in meeting the needs of the recipient so that transition to less restrictive services may be possible.

Recipients exhibiting one of the following characteristics may need residential habilitation with a behavioral focus services. Recipients receiving the service have behavioral challenges that fit one or both of the following two categories of behavioral problems, labeled A and B:

A. The person does not engage in an adaptive behavior that, if not performed by the person or taught by a caregiver, would result in a real and present threat of substantial harm to the person's health or safety. This includes not engaging in adaptive behaviors such as following safety rules, responding in acceptable ways to conflict, performing daily living activities safely and maintaining basic health.

B. The person has exhibited a problem with behavior during the past year or currently exhibits a problem with behavior that meets one of the criteria below:

- Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional.
- Is being addressed through the use of behavior analysis services and reviewed by the Local Review Committee (LRC).
- Has lead to the use of restraint or emergency medications within the past year.

Has resulted in one or more of the following:

1. Self-inflicted, detectable, external or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
2. External or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behavior include hitting others, biting others and throwing dangerous objects at others.
3. Arrest and confinement by law enforcement personnel.

4. Major property damage or destruction in excess of $500 for any one intentional incident.
5. A life-threatening situation. These types of behaviors include but are no limited to excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.

Residential habilitation provides specific training activities that assist an individual to acquire, maintain or improve skills related to activities of daily living. The residential habilitation focuses on personal hygiene skills such as bathing and oral hygiene, homemaking skills and on social and adaptive skills that enable the individual to reside in the community. The Findings of Fact show that the petitioner's behavior was stable, he did not have any recent inappropriate sexual behaviors or recent incidents of property destruction. Additionally, the findings showed that the petitioner was independent of most of his activities of daily living and self help skills.

In making a determination of what a word means, the normal and ordinary meaning for the word is typically used. However, by rule, the term "medical necessity" has special meaning. The rule specifically defines matters that have to be taken into consideration in determining medically necessary.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in referring to medically necessary determinations states: "An appropriate, qualified professional shall make the determination that the standards for medical necessity set forth in 59G-1.010 (166)(a)(c), F.A.C., are met, and that the requested item meets the service definition, as contained in the approved DD waiver." This statement recognizes that it takes a qualified professional to apply the concepts included in the rule definition of medically necessary.

The agency cites reasons for the above noted decision for services was based on: "The request exceeds medical necessity or there is no determination that the service(s) is medically necessary."

Based on the evidence presented, it is determined those seven hours of residential habilitation service at the behavioral focus level is sufficient to meet the petitioner's residential habilitation needs as the petitioner's behaviors have been stable and he is independent of his activities of daily living and self help skills. Eleven hours per day of residential habilitation service at the behavioral focus level is considered to be in excess of the petitioner's needs and is not considered to be medically necessary. Therefore, it is concluded that the respondent correctly reduced the petitioner's residential habilitation at the behavior focus level to seven hours per day.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21st day of July, 2006,

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:
District 3 APD: Jim Smith
Lucy Goddard-Teel, Esq.
David Kanya

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

FILED

JUL 03 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

PETITIONER,

Vs.

APPEAL NO. 06F-2424

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 03 Alachua
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 19, 2006, at 8:45 a.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was David Kanya, People Systems. Present as witnesses for the petitioner were J [illegible] es Group Home; Martina Young, waiver support coordinator, People Systems and Nita Pierre, waiver support coordinator, People Systems. The respondent was represented by Lucy Goddard-Teel, Department of Children and Families' District 3 legal counsel. Present testifying by telephone on behalf of the respondent was Dr. Emma Guilarte of Maximus.

ISSUE

The petitioner is appealing the respondent's action of February 8, 2006, to decrease his residential habilitation services from fourteen hours per day to nine hours

per day and to decrease his behavioral analysis services from 384 quarter hours to 128 quarter hours.

The petitioner stated in his hearing request that he was also appealing the reduction of adult day training and the denial of behavior assistant services. However, at the hearing, he withdrew the hearing request related to those two services.

FINDINGS OF FACT

The petitioner is developmentally disabled and is eligible to receive services from the respondent's Developmental Services Home and Community-Based Services Medicaid Waiver Program. He is 31 years old and lives at the ; Group Home where he has been living for approximately five years.

The petitioner was court ordered into a group home as a result of battery charges, physical aggression and inappropriate sexual behavior. It was determined that he could live in the group home with 24 hour per day awake staff. The petitioner is independent, is capable of taking care of his own personal needs, he does not need assistance in eating, walking or transferring. The petitioner needs minimal assistance in his activities of daily living. The petitioner's primary problem is his behavior. The petitioner's behavior has been stable during the past year and there was no significant relapse in his activities of daily living. However, during February 2006, the petitioner was arrested for pulling a knife on a resident in the group home.

The petitioner, through his waiver support coordinator, submitted a support plan which was to be effective November 1, 2005. In the support plan, the waiver support coordinator request fourteen hours per day of residential habilitation at the behavior

focus level. Additionally, the petitioner's waiver support coordinator requested 384 quarter hours of behavior analysis services.

The respondent's Developmental Disabilities Program has contracted with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels. Maximus reviewed the petitioner's request to continue his fourteen hours per day of residential habilitation services at the behavior focus level. The fourteen hours per day of residential habilitation services at the behavior focus level was approved for 120 days to allow more appropriate services to be put in place. Maximus did not receive documentation that supported the continuation of the fourteen hours per day of residential habilitation services at the behavior focus level. The documentation received showed that the petitioner's behavior was more stable, he was able to complete his personal care and he needed minimal support with his activities of daily living. Therefore, Maximus reduced the residential habilitation services at the behavior focus level to nine hours per day for the remaining 230 days of the support plan period. On February 8, 2006, Maximus notified the petitioner that his residential habilitation services at the behavior focus level was being reduced to nine hours per day, as medical necessity for the continuation of fourteen hours of residential habilitation services at the behavior focus level was not demonstrated.

During the petitioner's previous support plan period, Maximus approved 384 quarter hours of behavior analysis services. To determine whether the level of service that the petitioner was receiving was correct and medically necessary, Maximus requested an updated behavior intervention plan and data that showed how the

behavior analysis services had affected the petitioner's behavior, during the previous support plan period. Maximus did not receive the updated behavior intervention plan or data related to how the service affected the petitioner's behavior and could not determine that the 384 quarter hours of behavior analysis was medically necessary. However, Maximus determined that medical necessity was demonstrated for behavior analysis services as the petitioner had behavioral problems but not at the amount requested. Therefore, Maximus approved 128 quarter hours for behavior analysis services to ensure that a behavior intervention plan was prepared for the petitioner, by a provider with expertise in working with individuals who have similar needs.

On February 8, 2006, Maximus notified the petitioner that his behavior analysis service was being reduced to 128 quarter hours, as medical necessity for 384 quarter hours was not demonstrated.

CONCLUSIONS OF LAW

Fla. Admin. Code 59.G-13.080, Home and Community-Based Services Waivers, states in part:

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness... (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, July

2002, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent...

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

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

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in part states:

Residential habilitation provides specific training activities that assist the beneficiary to acquire maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as

bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the beneficiary to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the beneficiary and reflects the beneficiary's goal(s) from their current support plan.

Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office...

Residential Habilitation with a Behavioral Focus

Service characteristics for residential habilitation with a behavioral focus include:

• A Board Certified Behavior Analyst or Associate Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or 491, F.S., provides on-site-oversight for residential services,

• Integration of behavioral services throughout residential and community programs,

• No fewer than 75% of the provider's direct service staff who work with the recipient(s) for whom the residential habilitation with a behavioral focus rate applies have completed at least 20 contact hours of face-to face competency-based instruction with performance-based validation in the following content areas;

_ Introduction to applied behavior analysis – basic principles and functions of behavior.
_ Providing positive consequences, planned ignoring, and stop redirect reinforce techniques.
_ Data collection and charting.

• The service provides for comprehensive monitoring of staff skills and their implementation of required procedures. Monitoring for competence

must occur at least once per month for 50% of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each recipient's behavior analysis services plan.

• Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans.

In order for the provider to receive a residential habilitation with a behavioral focus rate for a recipient based on the published rate matrix, the provider must meet the specified staff qualifications for the service, and the recipient must exhibit the characteristics listed below. This rate level shall be approved only when it has been determined through use of the Department approved assessment by a certified behavior analyst, and the support planning process that an individual requires residential habilitation with a behavioral focus services. The need for residential habilitation with a behavioral focus and the rate for the service shall be identified on the individual's support and cost plan and on the authorization for service submitted to the provider by the individual's support coordinator. Service authorization shall be based on established need and re-evaluated at least every six months while the recipient is receiving the services. The provider must document evidence of continued need as well as evidence that the services are assisting the service provider in meeting the needs of the recipient so that transition to less restrictive services may be possible.

Recipients exhibiting one of the following characteristics may need residential habilitation with a behavioral focus services. Recipients receiving the service have behavioral challenges that fit one or both of the following two categories of behavioral problems, labeled A and B:

A. The person does not engage in an adaptive behavior that, if not performed by the person or taught by a caregiver, would result in a real and present threat of substantial harm to the person's health or safety. This includes not engaging in adaptive behaviors such as following safety rules, responding in acceptable ways to conflict, performing daily living activities safely and maintaining basic health.

B. The person has exhibited a problem with behavior during the past year or currently exhibits a problem with behavior that meets one of the criteria below:

• Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional.
• Is being addressed through the use of behavior analysis services and reviewed by the Local Review Committee (LRC).
• Has lead to the use of restraint or emergency medications within the past year.

Has resulted in one or more of the following:

1. Self-inflicted, detectable, external or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
2. External or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behavior include hitting others, biting others and throwing dangerous objects at others.
3. Arrest and confinement by law enforcement personnel.
4. Major property damage or destruction in excess of $500 for any one intentional incident.
5. A life-threatening situation. These types of behaviors include but are no limited to excessive eating or drinking, vomiting, ruminating, eating non-nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in part states:

Behavior analysis services are provided to assist a person or persons to learn new behavior, to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. The term "behavior analysis services" includes the terms "behavior programming" and "behavioral programs." Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. It includes the identification of functional relationships between behavior and environment. It uses direct observation and measurement of behavior and environment. Contextual factors, establishing operations,

antecedent stimuli, positive reinforcers and other consequences are used, based on identified functional relationships between behavior and environment, in order to produce practical behavior change.

Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to engineer environmental modifications including ongoing styles of interactions, and contingencies maintained by significant others in the recipient's life. Training for parents, caregivers and staff is also part of the services when these persons are integral to the implementation or monitoring of a behavior analysis services plan. Services should be provided for a limited time and discontinued as the significant others gain skills and abilities to assist the recipient to function in more independent and less challenging ways.

Documentation of services must comply with Chapter 65B-4.030(9) and (10), F.A.C. Reimbursement* and monitoring documentation to be maintained by the provider includes:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Copy of assessment report;
4. *Monthly summary of monitoring including the who, what, when and where of the monitoring events;
5. *Behavior analysis service plan and services provided including graphic display of acquisition and reduction behaviors related to implementation of the service plan;
6. *Annual report; and
7. *If the targeted reduction behaviors meet the requirements identified in Chapter 65B-4.030(9)(10), F.A.C., the LRC review date and recommendations made specific to the plan, a review schedule for the plan must be included.

Documentation to be submitted to the waiver support coordinator by the provider:

1. *Copy of service log, monthly;
2. *Copy of assessment report within 30 days of initially providing services;
3. *A copy of the provider's behavior analysis service plan within 90 days of initially providing services;
4. *Monthly updates of the intervention plan as it is modified;
5. *Graphic displays of acquisition and reduction behaviors related to implementation of the service updated monthly, with baseline data to

allow evaluation of progress; and
6. Annual report prior to the annual support plan update.

Residential habilitation provides specific training activities that assist an individual to acquire, maintain or improve skills related to activities of daily living. The residential habilitation focuses on personal hygiene skills such as bathing and oral hygiene, homemaking skills and on social and adaptive skills that enable the individual to reside in the community. The Findings of Fact show that the petitioner is independent in all areas of personal care and other activities of daily living. Additionally, the findings show that the petitioner's behavior has been stable.

In making a determination of what a word means, the normal and ordinary meaning for the word is typically used. However, by rule, the term "medical necessity" has special meaning. The rule specifically defines matters that have to be taken into consideration in determining medically necessary.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in referring to medically necessary determinations states: "An appropriate, qualified professional shall make the determination that the standards for medical necessity set forth in 59G-1.010 (166)(a)(c), F.A.C., are met, and that the requested item meets the service definition, as contained in the approved DD waiver." This statement recognizes that it takes a qualified professional to apply the concepts included in the rule definition of medically necessary.

The agency cites reasons for the above noted decision for services was based on: "The request exceeds medical necessity or there is no determination that the service(s) is medically necessary."

Based on the evidence presented, it is determined that nine hours of residential habilitation at the behavioral focus level is sufficient to meet the petitioner's residential habilitation needs and fourteen hours per day of residential habilitation is in excess of the petitioner's needs and is not considered to be medically necessary, as defined in the rule. Therefore, it is concluded that the respondent correctly reduced the petitioner's residential habilitation at the behavior focus level to nine hours per day.

The Findings of Fact show that, during the petitioner's previous support plan period, he was receiving 384 quarter hours of behavior analysis services. In order to determine whether the level of service could be continued, the respondent requested information that showed the effect the behavior analysis services was having on the petitioner's behavior. The Findings of Fact showed that the respondent did not receive the information. Therefore, only 128 quarter hours of behavior analysis services was approved so that behavior intervention plan could be prepared. Based on a lack of medical necessity evidence to the contrary, it is concluded that the respondent correctly reduced the behavior analysis services to 128 quarter hours and that 384 quarter hours was in excess of the petitioner's needs and not medically necessary.

DECISION

The appeal is denied on both issues. The respondent's actions are affirmed.

NOTICE OF RIGHT TO APPEAL

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

the court fees required by law or seek an order of indigency to waive those fees. The respondent has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 3rd day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:
District 3 APD: Jim Smith
Lucy Goddard-Teel

FILED

JUL 14 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03320

PETITIONER,

Vs.

CASE NO.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 07 Orange
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 15, 2006, at 9:58 a.m., in Orlando, Florida. The petitioner appeared. s, petitioner's mother and representative, appeared on petitioner's behalf. t, petitioner's companion, appeared as a witness for the petitioner. Joseph Robles, assistant attorney general, appeared and represented the agency. Leslie Varhol, human services consultant, appeared as a witness for the agency. Pam Chamberlynn, APS consultant reviewer, appeared as a witness for the agency via telephone. Colette Riehl, APS consultant reviewer, observed the proceeding via telephone. Jim Mitchell, notary, appeared to verify the identity of the parties appearing by phone.

ISSUE

At issue is the agency's action of May 1, 2006, denying the petitioner's request to increase companion services from eight hours per week to ten hours per week due to lack of medical necessity. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

The petitioner is a developmentally disabled young lady currently receiving services through the agency's Developmental Disabilities Home and Community-Based Waiver Services Program. Recently, she submitted her renewal request for the upcoming year's services to the agency for approval. The services requested included support coordination, adult dental, adult day training, transportation, and companion (Respondent's Exhibit 2). The petitioner's request for companion services included a request to increase the hours from eight per week to ten per week.

Companion services are non-medical in nature. They provide supervision and socialization activities on a one-on-one basis (Developmental Disabilities Waiver Services Coverage and Limitations Handbook, June 23, 2005, p. 2-27, Respondent's Exhibit 4). Consumers utilizing this service must justify their use of such. Generally the goal of the service is to enable consumers to become more outgoing and social and to function in the public. This goal is not all inclusive.

The agency forwarded the petitioner's cost plan request to its prior service authorization agent, APS Healthcare. One of APS' consultant reviewers examined the cost plan. Each request was approved except the increase in

companion services. Companion services were to be continued at the current level of eight hours per week. The reviewer found that the service appeared to be meeting its goal and that based on the information provided the petitioner was not suffering from "socialization deficit." Socialization deficit is evident where there is no level of progress in social skills, etc. The petitioner's support plan indicated that the petitioner was doing well in the area of socialization. As a result, there was no justification present to warrant an increase in companion service hours (Respondent's Exhibit 5).

APS notified the agency that the request was denied. APS also issued the petitioner a notice informing of such. The notice, dated May 1, 2006, informed that the request did not meet medical necessity (Respondent's Exhibit 1).

At the hearing, the petitioner's representative stated that because her daughter has benefited from the companion service, she feels an increase would continue to foster her growth in having a positive attitude, being able to relate to people more favorably, learning proper mannerisms, and handling herself appropriately in public. The companion currently serving the petitioner is doing a wonderful job and is like a second mother to the petitioner.

The agency stated that there has been a tremendous amount of growth and improvement in the petitioner's social ability. Because of the level of progress, there is no lack of or decrease in this skill area. No specific goal, other than the general goal (socialization) was listed in the cost plan request to serve

as justification for an increase to be medically needed. Justification was deemed sufficient to continue the service at the current level.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080(12) establishes:

> Developmental Services Waiver—General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All DS Waiver Services providers enrolled in the Medicaid program must comply with the DS Waiver Services Florida Medicaid Coverage and Limitations handbook, October 2003, incorporated by reference, and the Florida Medicaid Providers Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent...

Developmental Disabilities Waiver Services Coverage and Limitations Handbook, June 23, 2005, p. 2-27 states in relevant part:

> Companion Services...Description...Companion services consist of non-medical care, supervision and socialization activities provided to an adult on a one-on-one basis. This service must be provided in direct relation to the achievement of the recipient's goals per his support plan. A companion provider may also assist the recipient with such tasks as meal preparation, laundry and shopping; however, these activities shall not be performed as discrete services. This service does not entail hands-on medical care. Providers may also perform light housekeeping tasks, incidental to the care and supervision of the recipient. Companion services may be scheduled on a regular, long-term basis. Companion services are not merely diversional in nature but are related to a specific outcome or goal of the recipient. An acceptable companion activity could include going to the library, getting a library card, learning how to use the library and checking out books or videos for personal use, shopping for groceries, or going to an animal shelter to learn about animals, perhaps volunteering or assisting at the animal shelter.

Medical Services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Fla. Admin. Code Rule 59G-1.010(166)(a)(c), as follows:

> (a) “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must 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, a covered service."

Based on the evidence and testimony presented, the hearing officer finds that the agency’s action to deny the increase was correct. In reviewing the petitioner’s support plan, it is apparent that the petitioner has undoubtedly benefited from and continues to improve in her social and adaptive skills. The testimony of the petitioner’s mother substantiates this. However, because no other specific goal was provided or skill deficiency shown, no medical necessity exists to support an increase from eight hours to ten hours per week. Until such can be demonstrated, eight hours is sufficient to meet the petitioner’s needs.

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

DONE and ORDERED this 14th day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:
District 7 APD: Steve Roth
Joseph Robles
M. Catherine Lannon, Sr. Assistant Attorney General
Shane DeBoard, Esq

FILED

JUL 14 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03123

PETITIONER,

Vs.

CASE NO.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 07 Orange
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 19, 2006, at 11:00 a.m., in Orlando, Florida. The petitioner did not appear. petitioner's legal guardian and authorized representative, appeared on petitioner's behalf. Evelyn Rivera, petitioner's waiver support coordinator, appeared as a witness for the petitioner. Joseph Robles, assistant attorney general, appeared and represented the agency. Yolanda Rivera, government operations consultant, appeared as a witness for the agency. Karen Henderson, consultant reviewer for APS Healthcare, appeared as a witness via telephone for the agency.

ISSUE

At issue is the agency's action of February 24, 2006, denying the petitioner's request for durable medical equipment. The petitioner bears the burden of proof in this appeal.

FINDINGS OF FACT

The petitioner is a developmentally disabled young man currently receiving services through the agency's Home and Community-Based Services Waiver Program. His waiver support coordinator submitted an amended cost plan request to the agency seeking certain medical equipment to assist the petitioner with his needs.

The specific items requested included a CindyLift (a lifting/transporting device), a positioning wedge (a device designed to assist with engaging in multiple positions), and an Easystand 5000 Youth (a device which allows a person otherwise unable, to successfully stand) (Petitioner's Composite Exhibit 1 & Respondent's Composite Exhibit 4). The total cost for these items amounted to $5,800 (Respondent's Exhibit 2). The agency forwarded the request to its prior service authorization agent, APS Healthcare.

APS completes reviews of requests for services or supplies which exceed a certain dollar amount. In this case, the request exceeded that amount thereby invoking a required assessment by APS. The consultant reviewer for APS determined that the three pieces of equipment listed on the request could be covered under State Plan Medicaid. Because the waiver program is the last

funding source to pay for any service or supply, other resources must be first exhausted before payment from the waiver can be rendered (Respondent's Exhibits 3 & 6, Developmental Disabilities Waiver Services Coverage and Limitations Handbook, June 23, 2005, p. 2-6).

Because of this limitation under waiver requirements, APS denied the request for the equipment. APS notified the agency of this decision. Additionally, APS issued a notice of such on February 24, 2006, informing the petitioner of the denial (Respondent's Exhibit 1).

The petitioner appeals. The petitioner's guardian and also waiver support coordinator have both made efforts to have the equipment covered through State Plan Medicaid. These efforts consist of going to the actual equipment dealers and setting up a sale through Medicaid. These dealers, without actually submitting the paper documentation required for payment via the State Medicaid Plan, told them that Medicaid would not cover the specific equipment requested and that they "needed to seek payment through the waiver." As a result, no documentation showing a denial from Medicaid was given to the agency.

The agency's witness from APS rebutted this information by stating that the petitioner must submit, in writing, the request through the dealer to Medicaid for payment. In order for the waiver to even consider payment for the request, an official letter of denial from Medicaid must first be submitted to APD/APS. Only then can APS determine medical necessity for the equipment and other factors essential to authorizing the request.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080(12) establishes:

> Developmental Services Waiver—General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All DS Waiver Services providers enrolled in the Medicaid program must comply with the DS Waiver Services Florida Medicaid Coverage and Limitations handbook, October 2003, incorporated by reference, and the Florida Medicaid Providers Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent...

The Developmental Disabilities Waiver Services Coverage and Limitations Handbook, June 23, 2005, p.2-6 states in relevant part:

> ...Requirements to Receive Services, continued...Availability of Other Coverage Sources, continued...When a service must be purchased, those available under the Medicaid State Plan must be utilized before accessing services through the waiver. The waiver cannot supplant or replace a benefit available through Medicaid State Plan services. It is a federal requirement to access state plan coverage before the provision of waiver services. As stated in section 4442.3, State Medicaid Manual: "No service may be provided under the waiver if it is already provided under the State plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State plan..."

Developmental Disabilities Waiver Services Coverage and Limitations Handbook, June 23, 2005, p. 2-34 establishes:

> Durable Medical Equipment and Supplies...Limitations...Durable medical equipment and supplies will not duplicate DME and supplies provided through the Medicaid State Plan...Supplies not available under the Medicaid State Plan, or available in insufficient

quantity to meet the needs of the recipient, may be purchased by the waiver...

Based on the evidence and testimony presented, the hearing officer concludes that the agency's action to deny the equipment request was correct. The above cited authorities demonstrate that requests for services and supplies must be sought through Medicaid first. The petitioner is required to follow through in the actual documentary process of attempting to obtain the needed item. If denied by Medicaid, then the petitioner must present a copy of that written denial to the agency so that the request may be considered for payment through the waiver.

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

responsibility.

DONE and ORDERED this 14th day of July, 2006,

in Tallahassee, Florida.

Jeannette Estes

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

Copies Furnished To:
District 7 APD: Steve Roth
Shane DeBoard, Esq
M. Catherine Lannon, Esq.

F I L E D
JUL 2 6 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs. APPEAL NO. 06F-02944

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 03 Alachua
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 21, 2006, at 2:40 p.m., in Gainesville, Florida. The petitioner was present. Present representing the petitioner was David Kanya, People Systems. Present as witnesses for the petitioner were [illegible] Group Home; Martina Young, waiver support coordinator, People Systems and Nita Pierre, waiver support coordinator, People Systems. The respondent was represented by Lucy Goddard-Teel, Department of Children and Families' District 3 legal counsel. Present testifying by telephone on behalf of the respondent was Dr. Emma Guilarte of Maximus.

ISSUE

The petitioner is appealing the respondent's actions of May 1, 2006, to decrease his residential habilitation services at the behavior focus level from eleven hours per day to seven hours per day, to deny his request for an increase in behavioral analysis

services from 100 quarter hours to 384 quarter hours, to terminate his supported employment and also to terminate his transportation.

FINDINGS OF FACT

The petitioner is developmentally disabled and is eligible to receive services from the respondent's Developmental Services Home and Community-Based Services Medicaid Waiver Program. He is 54 years old and lives at the F Group Home. The petitioner works in a cafeteria at the [illegible]. He is physically fit and independent in daily living skills, including some food preparation and many household chores. The petitioner is independent in mobility and has good expressive and receptive language skills. The petitioner attends an adult day training service program. The petitioner has a history of sexual offences. However, there had not been any recent sexual offences. The petitioner, at times, goes home to his family and there was no indication that he had any problems when visiting his family or that there were precautions taken when he goes to visit his family.

The petitioner, through his waiver support coordinator, submitted a support plan which was to be effective April 1, 2006. In the support plan, the waiver support coordinator request eleven hours per day of residential habilitation at the behavior focus level, 384 quarter hours of behavior analysis services, supported employment and transportation.

The respondent's Developmental Disabilities Program has contracted with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services or when costs of a support plan exceed certain levels. Prior to the action under appeal, the petitioner was receiving 11 hours per day of residential habilitation at the

behavior focus level which was approved for 145 days. The approval was based on a memorandum of October 7, 2005, which explained that a behavior analysis provider had recently been identified and that the petitioner's home was going through transitional issues that required that he have additional residential habilitation support at the time. Maximus reviewed the petitioner's request to continue his eleven hours per day of residential habilitation services at the behavior focus level. The information received was incomplete and not clear regarding residential habilitation and other services requested. Maximus requested clarification as to the progress towards providing the petitioner with a more stable residential habilitation environment. However, the information was not provided and the information received did not indicate how the petitioner had responded to interventions through the residential habilitation service. Based in the information provided, Maximus determined that there was the medical necessity for residential habilitation services at the behavior focus level with the intensity of seven hours per day and that eleven hours per day was not medically necessary and in excess of his needs.

The petitioner was receiving 100 quarter hours of behavior analysis services. The petitioner through his waiver support requested 384 quarter hours of behavior analysis services in the support plan that was to be effective April 1, 2006. The information submitted to Maximus contained data that was from May 2005 and had no explanation or analysis of the effects of the intervention of the behavior analysis services. Maximus determined that it was not clear as to how some information fit into the interventions and appeared not to be personalized to the petitioner. Therefore, Maximus requested that the petitioner, through his waiver support coordinator, submit

the last twelve months of data, analysis and explanations regarding the effect of interventions. Maximus also requested a behavior plan and current assessment as the assessment they had was from 2004. Maximus did not receive the information requested. Therefore, Maximus denied the petitioner's request for an increase in behavior analysis services as medical necessity for 384 quarter hours was not demonstrated. However, Maximus approved the continuation of the 100 quarter hours of behavior analysis services.

The petitioner, through his waiver support coordinator, requested 208 quarter hours of supported employment. The petitioner submitted an implementation plan, however, did not submit an annual summary. Maximus requested that the petitioner provide clarification of the schedule for the supported employment and how the 208 quarter hours are provided. Maximus did not receive the information requested and could not determine the medical necessity for the supported employment based in the information submitted. Therefore, they terminated the petitioner's supported employment.

The petitioner, through his waiver support coordinator, requested transportation for 520 one way trips. Transportation services were used to provide rides to and from the petitioner's home and his community-based waiver services. Once supported employment was terminated, there was no community based waiver service that would require transportation identified on the petitioner's cost plan. Therefore, Maximus terminated the transportation due to a service limitation of the waiver.

CONCLUSIONS OF LAW

Fla. Admin. Code 59.G-13.080, Home and Community-Based

Services Waivers, states in part:

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness... (12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, July 2002, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent...

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

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

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

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in part states:

Residential habilitation provides specific training activities that assist the beneficiary to acquire maintain or improve skills related to activities of daily living. The service focuses on personal hygiene skills such as bathing and oral hygiene; homemaking skills such as food preparation, vacuuming and laundry; and on social and adaptive skills that enable the beneficiary to reside in the community. This training is provided in accordance with a formal implementation plan, developed with direction from the beneficiary and reflects the beneficiary's goal(s) from their current support plan.

Recipients with challenging behavioral disorders may require more intense levels of residential habilitation services described as behavioral residential habilitation, or intensive behavioral residential habilitation. The necessity for these services is determined by specific recipient behavioral characteristics that impact the immediate safety, health, progress and quality of life for the recipient, and the determination that less intensive services have not been sufficient to alter these behaviors. The need for more intense levels of residential habilitation, behavioral residential or intensive behavioral residential habilitation will be verified by the Developmental Disabilities Program Office...

<u>Residential Habilitation with a Behavioral Focus</u>

Service characteristics for residential habilitation with a behavioral focus include:

• A Board Certified Behavior Analyst or Associate Analyst, or Florida Certified Behavior Analyst with a bachelor's degree, or a person licensed under Chapter 490 or 491, F.S., provides on-site-oversight for residential services,

• Integration of behavioral services throughout residential and community programs,

• No fewer than 75% of the provider's direct service staff who work with the recipient(s) for whom the residential habilitation with a behavioral focus rate applies have completed at least 20 contact hours of face-to face competency-based instruction with performance-based validation in the following content areas;

_ Introduction to applied behavior analysis – basic principles and functions of behavior.
_ Providing positive consequences, planned ignoring, and stop redirect reinforce techniques.
_ Data collection and charting.

• The service provides for comprehensive monitoring of staff skills and their implementation of required procedures. Monitoring for competence must occur at least once per month for 50% of direct service staff that have completed the training described above. Staff must be recertified in the training requirements yearly. The provider has a system that demonstrates and measures continuing staff competencies on the use of procedures that are included in each recipient's behavior analysis services plan.

• Provides for the eventual transitioning of behavioral improvement of the recipient, to a less intense service alternative, through formalized procedures incorporated into implementation plans.

In order for the provider to receive a residential habilitation with a behavioral focus rate for a recipient based on the published rate matrix, the provider must meet the specified staff qualifications for the service, and the recipient must exhibit the characteristics listed below. This rate level shall be approved only when it has been determined through use of the Department approved assessment by a certified behavior analyst, and the support planning process that an individual requires residential habilitation with a behavioral focus services. The need for residential habilitation with a behavioral focus and the rate for the service shall be identified on the individual's support and cost plan and on the authorization for service submitted to the provider by the individual's support coordinator. Service authorization shall be based on established need and re-evaluated at least every six months while the recipient is receiving the services. The provider must document evidence of continued need as well as evidence that the services are assisting the service

provider in meeting the needs of the recipient so that transition to less restrictive services may be possible.

Recipients exhibiting one of the following characteristics may need residential habilitation with a behavioral focus services. Recipients receiving the service have behavioral challenges that fit one or both of the following two categories of behavioral problems, labeled A and B:

A. The person does not engage in an adaptive behavior that, if not performed by the person or taught by a caregiver, would result in a real and present threat of substantial harm to the person's health or safety. This includes not engaging in adaptive behaviors such as following safety rules, responding in acceptable ways to conflict, performing daily living activities safely and maintaining basic health.

B. The person has exhibited a problem with behavior during the past year or currently exhibits a problem with behavior that meets one of the criteria below:

• Requires visual supervision during all waking hours and intervention as determined by a certified behavior analyst or licensed behavior analysis professional.
• Is being addressed through the use of behavior analysis services and reviewed by the Local Review Committee (LRC).
• Has lead to the use of restraint or emergency medications within the past year.

Has resulted in one or more of the following:

1. Self-inflicted, detectable, external or internal damage requiring medical attention or the behavior is expected to increase in frequency, duration, or intensity resulting in self-inflicted, external or internal damage requiring medical attention. These types of behaviors include head banging, hand biting, and regurgitation.
2. External or internal damage to other persons that requires medical attention or the behavior is expected to increase in frequency, duration or intensity resulting in external or internal damage to other persons that requires medical attention. These types of behavior include hitting others, biting others and throwing dangerous objects at others.
3. Arrest and confinement by law enforcement personnel.
4. Major property damage or destruction in excess of $500 for any one intentional incident.
5. A life-threatening situation. These types of behaviors include but are no limited to excessive eating or drinking, vomiting, ruminating, eating non-

nutritive substances, refusing to eat, swallowing excessive amounts of air, or severe insomnia.

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in part states:

Behavior analysis services are provided to assist a person or persons to learn new behavior, to increase existing behavior, to reduce existing behavior, and to emit behavior under precise environmental conditions. The term "behavior analysis services" includes the terms "behavior programming" and "behavioral programs." Behavior analysis includes the design, implementation and evaluation of systematic environmental modifications for the purposes of producing socially significant improvements in and understanding of human behavior based on the principles of behavior identified through the experimental analysis of behavior. It includes the identification of functional relationships between behavior and environment. It uses direct observation and measurement of behavior and environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers and other consequences are used, based on identified functional relationships between behavior and environment, in order to produce practical behavior change.

Behavioral services must include procedures to insure generalization and maintenance of behaviors. The services are designed to engineer environmental modifications including ongoing styles of interactions, and contingencies maintained by significant others in the recipient's life. Training for parents, caregivers and staff is also part of the services when these persons are integral to the implementation or monitoring of a behavior analysis services plan. Services should be provided for a limited time and discontinued as the significant others gain skills and abilities to assist the recipient to function in more independent and less challenging ways.

Documentation of services must comply with Chapter 65B-4.030(9) and (10), F.A.C. Reimbursement* and monitoring documentation to be maintained by the provider includes:

1. *Copy of claim(s) submitted for payment;
2. *Copy of service log;
3. *Copy of assessment report;
4. *Monthly summary of monitoring including the who, what, when and where of the monitoring events;
5. *Behavior analysis service plan and services provided including graphic

display of acquisition and reduction behaviors related to implementation of the service plan;
6. *Annual report; and
7. *If the targeted reduction behaviors meet the requirements identified in Chapter 65B-4.030(9)(10), F.A.C., the LRC review date and recommendations made specific to the plan, a review schedule for the plan must be included.

Documentation to be submitted to the waiver support coordinator by the provider:

1. *Copy of service log, monthly;
2. *Copy of assessment report within 30 days of initially providing services;
3. *A copy of the provider's behavior analysis service plan within 90 days of initially providing services;
4. *Monthly updates of the intervention plan as it is modified;
5. *Graphic displays of acquisition and reduction behaviors related to implementation of the service updated monthly, with baseline data to allow evaluation of progress; and
6. Annual report prior to the annual support plan update.

Developmental Services Waiver Service Florida Medicaid Coverage and Limitations Handbook in part states:

Supported employment services provide training and assistance in a variety of activities to support recipients in sustaining paid employment at or above minimum wage unless the recipient is operating a small business. The supported employment provider assists with the acquisition, retention or improvement of skills related to accessing and maintaining such employment or developing and operating a small business. With the assistance of the supported employment provider, the recipient is assisted in securing employment according to their desired outcomes, including the type of work environment, activities, hours of work, level of pay and supports needed. Supported employment is conducted in a variety of settings, to include work sites in which individuals, without disabilities, are employed.

Supported employment includes activities needed to sustain paid work at or above minimum wage for recipients receiving waiver services, including supervision and training. This training can focus on both the recipient's needs, as well as providing consultation to the employer to enhance

> supports natural to the workplace rather than imposing paid supports. Supported employment providers will immediately notify the recipient's waiver support coordinator of any changes affecting the recipient's income. The service provider shall work with both the recipient and the respective support coordinator to maintain eligibility under the HCBS waiver, as well as health and income benefits through the Social Security Administration and other resources.

Developmental Services Waiver Service Florida Medicaid Coverage and Limitations Handbook in part states:

> Transportation services are the provision of rides to and from the recipient's home and their community-based waiver services, enabling the recipient to receive the supports and services identified on both their support plan and approved cost plan, when such services cannot be accessed through natural (i.e., unpaid) supports.

Residential habilitation provides specific training activities that assist an individual to acquire, maintain or improve skills related to activities of daily living. The residential habilitation focuses on personal hygiene skills such as bathing and oral hygiene, homemaking skills and on social and adaptive skills that enable the individual to reside in the community. The Findings of Fact show that the petitioner is independent in all areas of personal care and other activities of daily living. Additionally, the findings show that the petitioner's behavior has been stable.

In making a determination of what a word means, the normal and ordinary meaning for the word is typically used. However, by rule, the term "medical necessity" has special meaning. The rule specifically defines matters that have to be taken into consideration in determining medically necessary.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in referring to medically necessary determinations states: "An

appropriate, qualified professional shall make the determination that the standards for medical necessity set forth in 59G-1.010 (166)(a)(c), F.A.C., are met, and that the requested item meets the service definition, as contained in the approved DD waiver." This statement recognizes that it takes a qualified professional to apply the concepts included in the rule definition of medically necessary.

The agency cites reasons for the above noted decision for services was based on: "The request exceeds medical necessity or there is no determination that the service(s) is medically necessary."

Based on the evidence presented, it is determined that seven hours of residential habilitation at the behavioral focus level is sufficient to meet the petitioner's residential habilitation needs and eleven hours per day of residential habilitation is in excess of the petitioner's needs and is not considered to be medically necessary, as defined in the rule. Therefore, it is concluded that the respondent correctly reduced the petitioner's residential habilitation at the behavior focus level to seven hours per day.

The Findings of Fact show that, during the petitioner's previous support plan period, he was receiving 100 quarter hours of behavior analysis services and that the petitioner request 384 quarter hours of behavior analysis services. In order to determine whether the level of service could be increased, the respondent requested that the petitioner, through his waiver support coordinator, submit the last twelve months of data, analysis, explanations regarding the effect of interventions, a behavior plan and current assessment. The Findings of Fact showed that the respondent did not receive the information requested. Therefore, only 100 quarter hours of behavior analysis services was approved. Based on a lack of medical necessity evidence to the contrary,

it is concluded that the respondent correctly approved 100 quarter hours of behavior analysis services and that 384 quarter hours was in excess of the petitioner's needs and not medically necessary.

The Findings of Fact show that the respondent requested that the petitioner provide clarification of the schedule for the supported employment and how the 208 quarter hours are provided. The respondent did not receive the information requested and could not determine the medical necessity for the supported employment based in the information submitted. Therefore, it is concluded that the respondent's action to terminate the petitioner's supported employment was correct at the time it was taken because they did not have the information requested.

The Findings of Fact show that supported employment was terminated and there was no community based waiver services that would require transportation identified on the petitioner's cost plan. Therefore, it is determined that the respondent correctly terminated the petitioner's transportation.

DECISION

The appeal is denied on all issue. The respondent's actions are affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 26th day of July, 2006,

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:
District 3 APD: Jim Smith
Lucy Goddard-Teel, Esq.
David Kanya

FILED
JUL 2 1 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-03121

PETITIONER,

Vs.

CASE NO.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 07 Orange
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 6, 2006, at 12:34 p.m., in Orlando, Florida. The petitioner appeared but did not remain during the proceeding. The petitioner's mother, ., appeared and represented her daughter. Gerda Mothersil, Consumer-Directed Care Program consultant, appeared as a witness for the petitioner.

Joseph Robles, assistant attorney general, appeared and represented the agency. Yolanda Rivera, government operations consultant with the Agency for Persons with Disabilities (APD), appeared as a witness for the agency. Gary Reavis, registered nurse and consultant reviewer for Maximus, appeared as a witness for the agency via telephone. Laura Gebert, legal intern, and Stacy

Robinson Pierce, senior attorney for the Department of Children and Families, observed the proceeding.

ISSUE

At issue is the agency's action of April 26, 2006, reducing the petitioner's number of service hours of respite care from twenty hours per week to fifteen hours per week due to a reduced level of medical necessity and a policy change. Additionally at issue is the agency's denial of the petitioner's request for an increase in the number of personal care assistance service hours from six hours per day to fifteen hours per day due to lack of medical necessity. There is a shared burden of proof in this appeal. The agency bears the burden of proof regarding the service reduction. The petitioner bears the burden regarding the service increase.

FINDINGS OF FACT

The petitioner is a fifteen-year old young lady whose primary diagnoses include mental retardation and dysautonomia (condition affecting the nervous system). She currently receives medical and other-related services through the agency's Consumer-Directed Care Program. This program is administered by the agency through the Home and Community-Based Services Waiver Program.

The petitioner's waiver support coordinator submitted a cost plan for the upcoming fiscal year (June 2006 through May 2007) to request services for continued provision of her needs. On this particular cost plan, the following services were requested: consumable medical supplies, personal care assistance, respite care, and support coordination (Respondent's Exhibit 2).

Consumable medical supplies and support coordination were approved without changes. However, the other two services were not and serve as the issues in this appeal.

Because the petitioner is a participant in the Consumer-Directed Care (CDC) program, she is given the flexibility of using both Medicaid and non-Medicaid providers to meet her needs. She is given a monthly budget in order to facilitate receipt of and payment for her services. However, whenever she requests services over a standard dollar amount, the agency must forward the request to its contracted provider Maximus. Maximus performs prior service authorizations for the agency by reviewing the appropriateness of high-dollar service requests. Maximus examines several factors in deciding whether or not to approve a request. These factors include whether the service is allowable under the program, whether it is medically necessary, whether it is appropriate, and whether it is cost-effective.

The petitioner had been receiving respite care in the amount of twenty hours per week. Respite provides consumers with care while their primary caregiver must be away for a planned, brief absence, an emergency absence, or when the caregiver is temporarily physically unable to care for or supervise the consumer (Developmental Disabilities Waiver Services Coverage and Limitations Handbook, June 23, 2005, p. 2-79, Respondent's Exhibit 3). The petitioner requested this service to be continued at the same weekly rate.

When this service was reviewed, Maximus' consultant discovered that there was a newly implemented limitation on the number of respite care hours

that an individual could receive regardless of their level of need. This change occurred with the agency's updated waiver handbook. The agency placed a cap on respite by limiting it to fifteen hours per week per consumer (Respondent's Exhibit 3). As a result, the agency reduced the petitioner's respite hours from twenty to fifteen. Even though the handbook policy change became effective June 23, 2005, the petitioner continued to receive twenty hours per week because the change occurred in the middle of her cost plan period. All participants receiving more than fifteen hours have been allowed to finish their current cost plans. Upon renewal, each individual may no longer receive more than fifteen hours per week.

The petitioner also received six hours of personal care assistance per day. Personal care assistance (PCA) is a service designed to help individuals with activities of daily living. Activities of daily living include bathing, grooming, hygiene, toileting, transferring, meal preparation, and other self-care areas (Developmental Disabilities Waiver Coverage and Limitations Handbook, June 23, 2005, p. 2-57, Respondent's Exhibit 4). Because the petitioner is no longer attending school due to her medical conditions, more hours of personal care were requested.

The petitioner resides at home with her mother. No one else lives in the household. Her mother provides the majority of her care. The petitioner's other diagnoses include congenital heart disease with pacemaker, Down syndrome, Addison's disease (deterioration of the adrenal system), hypothyroidism (slow-metabolism), and cyanosis (oxygen deficiency) (Petitioner's Exhibit 1). She

receives oxygen constantly and takes approximately twelve maintenance medications per day (Petitioner's Exhibit 2).

The consultant reviewer for Maximus considered all of this information in the service request review. He was concerned about the petitioner's level of medical complexity and generated a referral to the agency to inform Children's Medical Services (CMS) that the medical case management should do a home assessment of the petitioner's situation and health (Respondent's Exhibit 6). He felt that other services may be more appropriate to supply the petitioner's needs including nursing services. The petitioner had an assessment over a year ago completed by the Children's Multidisciplinary Assessment Team (CMAT) from CMS. The petitioner's mother informed that nursing services were denied. Shortly thereafter, her daughter became eligible for the CDC waiver program and she opted to receive only the respite and personal care assistance services offered through CDC.

Maximus' consultant decided that because other services would likely be more appropriate, the request for an increase to fifteen hours per day in personal care assistance was medically excessive. As a result, the request for the increase was denied. Maximus issued its notice of decision regarding both the respite and the personal care assistance in its letter dated April 26, 2006 (Respondent's Exhibit 1).

Upon receipt of this notice, the petitioner requested reconsideration. The reconsideration is completed by Maximus and is assigned to a different consultant reviewer to determine whether the initial decision was correct. The

reconsideration consultant agreed with the original determination that the request was medically excessive. The original decision was therefore upheld (Respondent's Exhibit 7).

At the hearing, the agency's witness from Maximus emphasized that other services may be more appropriate to serve this young lady. He stated that nursing services can be paid for under the State Medicaid Plan through CMS. He also stated that the waiver program is the payor of last resort. This means that an individual must seek appropriate services through CMS first. Once a denial is generated, then the waiver can be considered as the payment source for the service. Regarding respite, the handbook specifically limits the number of hours a consumer can receive. Regarding personal care assistance, the petitioner is a fifteen –year old child and because her mother primarily provides her care, she needs only supplementation for activities of daily living with this service. Thus, six hours per day is sufficient. Fifteen hours is medically excessive because other more appropriate services (i.e. nursing) should be in place to help provide her care.

The petitioner's mother stated that she is basically the only individual who can manage her daughter's difficult behaviors and medical conditions. Personal care assistance is less costly than nursing services and the agency would actually be saving money if the request for an increase in personal care assistance was approved. Even her pediatrician recommends twenty-four hour, one-on-one care to meet her needs. This can best be met with the services and hours she requested.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080 establishes:

Purpose. Under authority of Section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness.

Fla. Admin. Code 59G-13.080 states in relevant part:

(12) Developmental Services Waiver -- General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent.

The waiver and its sub-programs are governed by the agency's handbook.

Developmental Services Florida Consumer-Directed Care Plus (CDC+)

Waiver Operational Protocol establishes:

A. Organization and Structural Administration...Consumers participating in this program will direct their own care and manage the budget allocated for their care needs. The state will provide two distinct support services to assist consumers in assuming their

> management responsibilities: consultant services and fiscal/employer agent (FEA) services...The consultant will train, coach, and provide technical assistance to consumers, as needed. The training and technical assistance will help consumers to use the budget correctly and avoid overspending...Establishing the Budget Amount...The consumer's budget amount is based on the value of the HCBS waiver services authorized in the care plan/support plan and available in the community...Developing the Purchasing Plan...Consumers develop a purchasing plan to specify how the monthly budget will be used to meet the consumer's care needs...Changes to the Budget Amount...The Consumer-Directed Care Plus Program offers consumers the opportunity to adjust the level of support provided (either temporarily or permanently) in response to significant changes in needs. Consumers may inform the consultant of significant changes in needs such as changes in health or functional status or the loss of an unpaid caregiver. Additionally, a consultant may identify changes in need that would warrant an adjustment to the monthly budget amount, either upward or downward. Changes to the budget amount will be made only after completion of the 3-step purchasing plan development process. The care plan/support plan will be used to determine the increased level of funds that would be provided to consumers receiving HCBS 1915(c) waiver support...

The petitioner is a consumer participating in the CDC program. She is entitled to seek waiver services as part of her care plan. These steps were complied with by the submission of the cost plan at issue in this appeal.

Developmental Disabilities Waiver Services Coverage and Limitations Handbook, p. 2-79 states in relevant part:

> Respite Care...Description...Respite care is a service that provides supportive care and supervision to a recipient when the primary caregiver is unable to perform these duties due to a planned brief absence, an emergency absence or when the caregiver is available, but temporarily physically unable to care for or supervise the recipient for a brief period...Limitations...Respite care services are limited to the amount, duration, and scope of the service described on the recipient's support plan and current approved cost plan. **The amount of respite services are determined**

> **individually and limited to no more than thirty days per year, (720 hours) per recipient.** [emphasis added]

The evidence shows that the petitioner is receiving the maximum number of hours allowed per week – fifteen. She previously received twenty hours per week. The agency reduced this amount with the beginning of the new cost plan so that the service would follow the service limitation set forth in the handbook. The agency has followed its rules in reducing the number of respite care hours and its action is supported.

Developmental Disabilities Waiver Services Coverage and Limitations Handbook, p. 2-57 states in relevant part:

> Description...Personal care assistance is a service that assists a recipient with eating and meal preparation, bathing, dressing, personal hygiene, and other self care activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health, safety and welfare of the recipient and when no one else is available to perform them. This service is provided on a one-on-one basis. Personal care assistance may not be used solely for supervision...Limitations...Personal care assistance is limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan. A recipient shall receive no more than 64 units of this service per day, when the quarter-hour unit pays the provider. Should the recipient need more than 64 units of this service a day, the additional units shall be approved by the Department's prior service authorization process.

The service requested exceeds the maximum number of hours per day. It is therefore, appropriate for the agency, through its contracted provider Maximus, review the request for prior service authorization.

Medical Services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Fla. Admin. Code Rule 59G-1.010(166)(a)(c), as follows:

> (a) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must 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, a covered service."

Personal care services for children is limited as states on 2-60

Personal care assistance in the family home should be provided only to assist the parent or primary caregiver of children in meeting the personal care needs of the child. Recipient's who live in their own home or adults that live in a family home may require personal care assistance to assist them with meeting their own personal care needs.

Things to consider when approving this service for children include: 1) physical limitations or abilities of the parent or caregiver; 2) number of other recipient's the parent or caregiver is attempting to provide assistance to; 3) gender of recipient, compared to that of the parent or caregiver; and 4) complexity of the recipient's personal care routine.

> For recipient's living in their own home, consider their own physical limitations
> or abilities to meet their own daily personal care assistance needs.

Parents are expected to provide some personal care for their children. This is taken into account. The agency does not dispute the petitioner's need for personal care assistance. The evidence shows that the petitioner is justified in receiving personal care assistance. The specific issue on appeal is the number of hours. While the petitioner has demonstrated there is a definite need for some level of personal care assistance, she has failed to show that fifteen hours per day is justified. Personal care assistance may not be used as a method of supervision. The number of hours requested borders on the appearance of such.

The agency has pointed to the strong possibility that the petitioner's needs would be more appropriately served by the placement of skilled nursing services into the home. The agency appropriately referred the petitioner to CMS for an assessment of the need for nursing. The agency also stated that this service could be paid for by the State Medicaid Plan and that a consumer must use the waiver as a last resort for payment.

Developmental Disabilities Waiver Services Coverage and Limitations Handbook, June 23, 2005, p.2-6 states in relevant part:

> ...Requirements to Receive Services, continued...Availability of Other Coverage Sources, continued...When a service must be purchased, those available under the Medicaid State Plan must be utilized before accessing services through the waiver. The waiver cannot supplant or replace a benefit available through Medicaid State Plan services. It is a federal requirement to access state plan coverage before the provision of waiver services. As stated in section 4442.3, State Medicaid Manual: "No service may be provided under the waiver if it is already provided under the State

plan unless the nature or the amount of the service, when provided under the waiver, would not be covered if provided under the State plan..."

The handbook specifically requires any service which can be covered through State Plan Medicaid to be sought by consumers. The agency has shown through its evidence that the petitioner is likely to benefit from services besides personal care assistance. Fifteen hours per day of personal care assistance is excessive when other care, such as nursing, etc., could very well be implemented.

It is admirable how the petitioner's mother has taken on the role of primary caregiver in her daughter's life. However, the agency has carried its burden in proving that the service request for the increase in personal care assistance is medically excessive. The petitioner is strongly encouraged to exhaust all possibilities of obtaining coverage under State Plan Medicaid by having CMS conduct a home-based assessment of what services to place in the home. If a denial is generated, the petitioner may provide evidence of this denial and seek to obtain her nursing or other appropriate services through the CDC program.

DECISION

The appeal is denied. The agency's actions are affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, 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 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 July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:
District 7 APD: Steve Roth
Shane DeBoard, Esq.
M. Catherine Lannon, Esq.

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

FILED
JUL 18 2006
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

APPEAL NO. 06F-02706

PETITIONER,

Vs.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 11 Dade
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on June 1, 2006, at 8:50 a.m., in Miami, Florida. The petitioner was not present but was represented by his parents, [illegible] Representing the agency was James D. Murdock, attorney with the Office of Attorney General (OAG). Appearing as a witness for the agency was Caroline Hunter, supervisor with the Agency for Disabled Persons (ADP).

ISSUE

The petitioner is appealing the agency's determination of March 30, 2006, where he has not been determined to be "in crisis" and continued placement on a waiting list, for services through the Developmental Disabilities Home and Community-Based Services Waiver Program.

FINDINGS OF FACT

The petitioner is five years old and on January 5, 2006, applied for the Waiver Program. On February 10, 2006, the petitioner was found to have a diagnosis (autism) that would make him eligible for Developmental Disabilities HCBS Medicaid Waiver Services. However, when funding is not available the petitioner is placed on a waiting list for services, which he was placed on February 10, 2006. The agency explains that due to funding limitations, there are limited slots (30 per month) that are available each month for individuals found to be "in crisis." The petitioner is a Medicaid recipient, currently receiving some therapy.

On February 24, 2006, a "Crisis Identification Tool" from the Developmental Disabilities Program was submitted on behalf of the petitioner. The purpose of the submission of the form was to assess if the petitioner was considered to be in crisis and therefore, possibly eligible for immediate services under the Developmental Disabilities HCBS Waiver Program. The crisis tool was reviewed by the local crisis committee, which is comprised of a registered nurse, an administrator for the program, and a behavior analyst. The committee makes their determination whether the petitioner, given the information provided, was considered to be "in crisis" according to program guidelines.

The Crisis Identification Tool evaluates an individual under three criterias, (1) homeless, (2) danger to self or others, and (3) caregiver unable to give care. The crisis request indicated that the petitioner was a danger to "self or others."

The petitioner's parents listed certified behavior analysis, speech therapy and occupational therapy as potential services needed to alleviate the crisis situation. The

petitioner has received occupational therapy and speech therapy in the past, either through Medicaid or privately paid and Medicaid eligibility is off and on, according to the household's income.

The petitioner's parents submitted letters from treating specialists; his teacher; a neighbor; and the petitioner's mother where they state, among other things, that the petitioner has demonstrated, "severe behavioral disorder during his temper tantrums he is dangerous to himself and others as he is unable to comprehend the situation." The petitioner must be watched at all times. The agency considered the petitioner's age (five years old); the fact that there have been no police incidents; and no hospitalizations as a result of the petitioner's behavior.

On March 13, 2006, the agency's local committee reviewed all documentation that was provided by the petitioner's parents. The agency determines through the crisis tool, where the most critical need is and given the information provided with the February 24, 2006 crisis tool, Peter's situation, although difficult, did not rise to the level of crisis. On March 30, 2006, the agency issued a notice to the petitioner's parents informing them that Peter, according to Program guidelines, had not been determined to be in crisis.

CONCLUSIONS OF LAW

Fla. Stat. 393.13, Personal treatment of persons who are developmentally disabled, states in part:

> (3)(c) Persons with developmental disabilities shall receive services, *within available resources*...(d) Persons who are developmentally disabled shall have a right to participate in an appropriate program of quality education and training services, within available resources...

Fla. Stat. 393.066, Community services and treatment for persons who are developmentally disabled, states in relevant part:

> (1) The Department of Children and Families shall plan, develop, organize, and implement its programs of services and treatment for persons who are developmentally disabled along district lines. The goal of such programs shall be to allow clients to live as independently as possible in their own homes or communities and to achieve productive lives as close to normal as possible...(5) Provided it is consistent with the intent of the Legislature, the *Department shall prioritize* increased appropriations provided for community-based supports and services for consumers and their families...

Fla. Admin. Code 59G-8.200, Home and Community-Based Services Waivers, states in part:

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. ...

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, July 2002, Appendix F, Consumer Wait List, 2. Waiting List states in part:

> B. The waiting list is composed of two tiers with those in crisis at the top of the list. Once the preliminary determination of eligibility for the waiver is made but no vacancy or funding is available to serve the applicant, the applicant will receive prompt written notification of their placement on the waiting list for the waiver...

The general rule is, that as in court proceedings, the burden of proof, apart from statute, is on the party asserting the affirmative of an issue before an administrative tribunal, America Balino et al., v. Dept of Health and Rehab. Services, 348 So.2d 349 (Fla.

1st DCA 1977). This case involved Medicaid recipients whose level of care had been reduced by the department. As the department was asserting the affirmative, that the level needed to be reduced, the court held that the department had the burden of proof. Subsequent to that decision, the department promulgated Fla. Admin. Code 65-2.060. Evidence, which states in part:

> (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.

In the matter under review, the petitioner has applied for and is asserting eligibility for benefits under a Medicaid waiver. The respondent denied that request. Therefore the petitioner has the burden to establish the eligibility for benefits under the program.

The respondent agrees that the petitioner meets the basic eligibility requirements for the program, however the respondent argues that because of a lack of funding, only a limited number of new individuals are approved to receive benefits. The process used to decide if a new individual can be added to the waiver is called a crisis determination in accordance with Appendix F of the Handbook. The state is allowed to limit participation in waivers based on available funding. Both the Florida Constitution and Florida Statutes prohibit agencies from contracting or agreeing to spend any moneys in excess of the amount appropriated to them unless authorized by law. *See* Art. VII, Sec. 1(c), Fla. Const.; § 216.311(1), Fla. Stat. (2002). Applicants are entitled to receive services only within available resources, and the respondent has discretion to prioritize how it will

distribute funds. § 393.13(3)(c)-(d), Fla. Stat. (2002); *see also* Dep't of Health & Rehab. Servs. v. Brooke, 573 So.2d 363 (Fla. 1st DCA 1991) (holding budgetary decision-making was within agency head's executive discretion).

In Bridget Ellingham v. Dept. of Children and Family Services, 896 So.2d 926 (Fla. 1st DCA 2005) the court concluded that lack of funding is an affirmative defense to a claim for developmental disabilities services, analogous to the defense of impossibility of performance in a contract action. The party seeking to assert the affirmative defense has the burden of proof as to that defense.

This case involves the petitioner's assertion of eligibility for waiver services. The respondent is asserting that the petitioner must be placed on a waiting list because he was not determined in crisis and based on the lack of funding, only individuals in crisis can currently be added to the waiver to receive services. The respondent has the burden to show that there is insufficient funding for the petitioner to receive benefits.

The Developmental Disabilities Waiver Services and Coverage Limitations Handbook, Appendix F sets forth by rule the method of determining an individual's entitlement to waiver services. This appendix states in part:

> (2) If the Individual is Determined Eligible: When an individual is determined to be eligible for waiver services, the District should consult with the Central Office to determine whether a vacancy and funding are available to serve the individual.
> (i) If vacancy and funding are available to serve the individual, the procedures outlined in the section on "Waiver Enrollment" shall be followed.
> (ii) If no vacancy or funding are available to serve the individual:
> I. The District will assess whether an assessment for crisis, using the Crisis Identification Tool (page 3 of this appendix) is needed. The District will complete the Crisis Identification Tool when it appears that the individual requires immediate placement into an Intermediate Care Facility for Developmental Disabilities (ICF/DD), absent the provision of waiver services

> or the individual, family or legal guardian makes a request for a crisis determination. If the Crisis Identification Tool is to be completed, the procedures outlined in Section 3 (page 3 of this appendix) shall be followed.

Based on the evidence presented, the hearing officer concludes that a limited funding situation exists where the agency only adds a limited number of individuals to the waiver each year in accordance with a process promulgated in rule. Therefore, the agency has met its burden of the affirmative defense for using the process included in the rule.

The burden is now on the petitioner to establish that he is eligible under Appendix F, in order to receive benefits. The Appendix states in part:

> 3. Crisis
> ...The District will conduct a preliminary review of the documentation to determine whether sufficient information exists to recommend review by the Central Office. The District program administrator will complete the initial crisis assessment, sign the request and transmit the assessment to the Central Office for final determination. The Crisis Identification Tool, along with relevant documentation to support the crisis request, and a copy of the Wait List Form shall be submitted to the Central Office. It is the Central Office's responsibility to determine whether or not an individual's situation constitutes a crisis.

The Findings of Fact shows that the petitioner applied for services with the Developmental Disabilities HCBS Waiver Program on January 5, 2006. A preliminary determination of eligibility was made and the petitioner was placed on the waiting list on February 10, 2006 for possible future eligibility of services, when a slot and funding becomes available. The agency serves their clients according to spending limitations based on legislative appropriations.

The petitioner on February 24, 2006 submitted a "Crisis Identification Tool", alleging the situation was that of being in "crisis" and listed the services needed in order to alleviate the crisis situation. The agency determined on March 30, 2006, that according to the documentation provided, he did not meet the criteria of being in "crisis".

The petitioner's parents expressed concern on how the agency could determine that their son was not in crisis, when he could hurt himself and others, by throwing objects; spitting; and aggressive physical behavior. The agency had initially recommended that the petitioner receive the services requested through the public school system. The petitioner's state that not all therapies are provided by the school such as behavior therapy. Speech therapy is provided in a group setting and they state that the doctor recommends a one on one session.

The petitioner's parents state that the doctor has recommended medications for

The petitioner is not taking any medications at present, because the parents feel that they do not know what effects the medication can have on in the future. The parents state their son is getting older, he is weighing 60 pounds and he is getting more difficult to control. They would like to see their son have the services that have been requested, in order to "have an active member of society and not a burden to society."

According to evidence received, the petitioner is in need of supervision, due to his age, his behavior towards himself and others. The petitioner is five years old and attends school full-time. The petitioner's parents believe that in crisis due to his behavior.

Therefore, considering the rules, evidence and testimony, the hearing officer concludes that the agency was correct in placing the petitioner on the waiting list.

Although, the petitioner's current situation is of concern to all, especially his family, it does not rise to the level of crisis as required by the handbook to be eligible to receive services.

DECISION

The appeal is denied. The agency's action to place the petitioner on the waiting list, as he was not in crisis, 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, 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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 18th day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To: F r
District 11 APD: Evelyn Alvarez
James Murdock, OAG
Hilda Fluriach, Esq.

FILED

JUL 28 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

PETITIONER,

Vs. APPEAL NO. 06F-03057

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 13 Marion
UNIT: APD
RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 20, 2006, at 2:10 p.m., in Ocala, Florida. The petitioner was present. Present representing the petitioner was his mother, . Present as a witness for the petitioner was Peggy Rasch, waiver support coordinator. The respondent was represented by Diana Esposito, assistant attorney general. Present as a witness for the respondent was David Hogg, Agency For Persons with Disabilities. Testifying by telephone on behalf of the respondent was Kim Watson of APS Healthcare.

ISSUE

The petitioner is appealing the respondent's action of April 27, 2006, to reduce the number of hours of companion services to be funded through the Developmental Services Home and Community-Based Services Waiver because medical necessity was not demonstrated.

FINDINGS OF FACT

The petitioner is developmentally disabled. He is 26 years old and has a diagnosis of spastic diaparesis, cerebral palsy, mental retardation, cortical blindness and seizure disorder. The petitioner is eligible to receive services from the respondent's Developmental Services Home and Community-Based Services Waiver Program. The petitioner lives with his mother, step-father and 14-year old brother.

Prior to the action under appeal, the petitioner was receiving 35 hours per week of companion services. On April 27, 2006, the respondent notified the petitioner that his companion services were being reduced from 35 hours per week to 14 hours per week.

The petitioner through his waiver support coordinator, submitted a support plan dated December 1, 2005 in which he requested companion services of 35 hours per week. The goals as listed in the support plan for companion services were: to socialize with peers, develop skills to get along with others, participate in outings in the community and access the community. The support plan did not state that there were any safety issues. The support plan stated that the petitioner likes to be alone and have quiet time, likes to swing in his back yard swing and sings as he swings. The petitioner likes to listen to classic rock music and watch television. The petitioner is close to his family and spends time with his grandparents. The petitioner's companion provider takes the petitioner to the park daily, helps him with toileting as the petitioner is incontinent of bowel, prepares his lunch, helps with feeding, helps with brushing his teeth and at times takes the petitioner to fast food restaurants. The petitioner's companion provider also supervises the petitioner during his quite time and when he is

listening to audio tapes. The companion provider was arriving at the petitioner's home at 8:30 a.m. and leaving at 3:30 p.m.

The respondent's Developmental Disabilities Program has contracted with APS Healthcare to perform Prior Service Authorization (PSA) reviews. APS Healthcare reviewed the petitioner's request for 35 hours per week of companion services and determined that the number of hours requested was not supported by the documentation provided, as the companion services is based on the goals listed in the support plan. According to APS Healthcare, the four goals listed on the support plan did not require 35 hours of companion services per week and the goals of the companion services could be met with 14 hours per week of companion services as there were no safety issues listed in the support plan. Therefore, APS Healthcare approved 14 hours per week of companion services, as 35 hours per week was in excess of the petitioner's needs and not medically necessary. During the hearing, APS Healthcare indicated that based on the petitioner's goals, he could benefit from other services including behavior assessment, behavior analyst and non-residential support services.

CONCLUSIONS OF LAW

Fla. Admin. Code 59.G-13.080, Home and Community-Based Services Waivers, states in part:

> (1) Purpose. Under authority of section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must

demonstrate each waiver's cost-effectiveness...(12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent.

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

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

Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in part states:

> Companion services consist of non-medical care, supervision and socialization activities provided to an adult on a one-on-one basis. This service must be provided in direct relation to the achievement of the beneficiary's goals per his or her support plan. A companion provider may also assist the beneficiary with such tasks as meal preparation, laundry and shopping; however, these activities shall not be performed as discrete services. This service does not entail hands-on medical care. Providers may also perform light housekeeping tasks, incidental to the care and supervision of the beneficiary. Companion services may be scheduled on a regular, long-term basis.
>
> Companion services are not merely diversional in nature but are related to a specific outcome or goal of the beneficiary. An acceptable companion activity could include going to the library, getting a library card, learning how to use the library and checking out books or videos for personal use, shopping for groceries, or going to an animal shelter, to learn about animals, perhaps volunteering or assisting at the animal shelter.

Companion services consist of non-medical care, supervision and socialization activities provided to an adult on a one-on-one basis. This service must be provided in direct relation to the achievement of the individual's goals per his or her support plan.

In making a determination of what a word means, the normal and ordinary meaning for the word is typically used. However, by rule, the term "medical necessity" has special meaning. The rule specifically defines matters that have to be taken into consideration in determining medically necessary.

The Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook in referring to medically necessary determinations states: "An appropriate, qualified professional shall make the determination that the standards for medical necessity set forth in 59G-1.010 (166)(a)(c), F.A.C., are met, and that the

requested item meets the service definition, as contained in the approved DD waiver." This statement recognizes that it takes a qualified professional to apply the concepts included in the rule definition of medically necessary.

The agency cites reasons for the above noted decision for services was based on: "The request exceeds medical necessity or there is no determination that the service(s) is medically necessary."

The Findings of Fact showed that the petitioner requested 35 hours per week of companion services to meet his goals which included socializing with peers, develop skills to get along with others, to participate in outings in the community and access the community. The support plan did not state that there were safety issue related to the petitioner's care and did not document the need for 35 hours per week of companion services. Based on the evidence presented, the goals listed in the support plan for companion services do not support the 35 hours per week of companion services requested and are considered to be in excess of the petitioner's needs and not medically necessary. Therefore, it is determined that the respondent correctly reduced the petitioner's companion services to 14 hours per week.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

the court fees required by law or seek an order of indigency to waive those fees. The respondent has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 28th day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:
District 13 APD: John Pridham
Diana Esposito, Esq.

FILED

JUL 14 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-02714

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 04 Duval
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on July 12, 2006, at 9:25 a.m., in Jacksonville, Florida. The petitioner was present and represented by her father r. Appearing as witnesses for the petitioner were r, mother; Nancy Decker, Program Manager; Sarah Knight, personal care assistant and Candice Buerger, waiver support coordinator. The agency was represented by Ann Cocheu, assistant attorney general. Appearing as witnesses for the agency were Alethea Oliphant, Agency for Persons with Disabilities and Gary Reavis, Maximus Inc. Mr. Reavis participated in the hearing by telephone.

ISSUE

At issue is the agency's action of April 10, 2006 to terminate Personal Care Assistant Services due to the lack of medical necessity, under the Developmental Services Home and Community Based Medicaid Waiver Program. Since this was a termination of services, the agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a recipient of Developmental Services Home and Community Based Medicaid Waiver services. The petitioner has a diagnosis of cerebral palsy. The petitioner lives in a group home with other residents. The petitioner has no functional arm, leg, head or postural control. The petitioner requires assistance with all activities of daily living. The petitioner has occasional incontinence and requires consumable medical supplies in the form of pull ups and wipes. The petitioner is employed as a volunteer at a local school wherein she provides children stories which are recited out loud by a specialized computer mechanism. The petitioner is able to use a knee switch that allows her to type the stories onto her computer. These stories are later read by a computer voice module to elementary school children. This process was demonstrated at the hearing.

The petitioner was previously approved to receive Personal Care Assistance Services. The Personal Care Assistant accompanies the petitioner to the school, assists with setting up the computer and trouble shooting any computer glitches that may arise. The Personal Care Assistant also assists with feeding, toileting and other needs while the petitioner is out in the community. The Personal Care Assistant also accompanies the petitioner to her therapy sessions.

A cost plan was submitted with an effective date of April 2006. This cost plan requested 4160 quarter hours of Personal Care Assistance for the upcoming cost plan year. The Maximus Unit evaluated the request and determined that the petitioner was not eligible for this service because she is residing in a group home. The Maximus Unit representative referenced the Developmental Disabilities Waiver Services Coverage and Limitations Handbook as providing the criteria for making this decision. The petitioner did not meet the criteria for making an exception to this policy. On April 10, 2006 the petitioner was notified of the termination of Personal Care Assistance Services. The petitioner submitted a request for reconsideration and the original decision was upheld.

At the hearing the petitioner's witness acknowledged an awareness of the policy that limited authorization of personal care assistance when an individual is living in a group home. However, the petitioner's representative disagreed with this policy and requested that an exception be made based the special circumstance of this case. Neither party presented any policy, law, statute or regulation that would justify the hearing officer making such an action.

CONCLUSIONS OF LAW

42 C.F.R. §440.180 **Home or community-based services** states in part:

"(a) Description and requirements for services. Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter."

Florida Administrative Code 59G-13.080, **Home and Community-Based Services Waivers** states in part:

"(5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs:

(a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.

(b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient.

(6) Program Requirements – General.... (f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish each service...

(12) Developmental Services Waiver – General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent."

Florida Administrative 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; 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."

Developmental Disabilities Waiver Services Florida Coverage and Limitations

Handbook dated June 23, 2005, states in part:

"Personal care assistance is a service that assists a recipient with eating and meal preparation, bathing, dressing, personal hygiene, and other self care activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health, safety and welfare of the recipient and when no one else is available to perform them. This service is provided on a one-on-one basis. Personal care assistance may not be used solely for supervision...Personal care assistance shall be provided in the recipient's own home or family home or while the recipient who lives in one of those arrangements is engaged in a community activity. No service may be provided or received in the provider's home or in a hospital, ICF/DD or other institutional environment...
Recipient's living in foster or group homes are not eligible to receive this service, except:

• During an overnight visit with family or friends away from the foster or group home, to facilitate the visit; or
• When a group home resident is recovering from surgery, does not require the care of a nurse and the group home operator is unable to provide the personal attention required to insure the recipient's personal care needs are being met. Under these circumstances it would be considered reasonable to provide this service to a group home resident only on a time limited basis. Once the recipient has recovered, the service must be discontinued."

In the case at hand the petitioner had previously been approved to receive Personal Care Assistant Services. In a cost plan effective April 2006 this service was again requested. The Maximus Unit evaluated the request and determined that because the petitioner is residing in a group home she is not eligible for the service. Policy from the Developmental Disabilities Services Florida Coverage and Limitations Handbook was provided to support the decision. The petitioner did not meet the criteria for making an exception to this policy. Neither party presented any other policy, law, rule or regulation that could be used to justify making an exception to the stated policy in the Developmental Disabilities Services Florida Coverage and Limitations Handbook. Upon a careful evaluation of the evidence presented, the hearing officer concludes that the agency met its burden of proof. As such, the agency's action to deny Personal Care Assistant Services is a justified action that is consistent with the applicable authorities.

DECISION

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

DONE and ORDERED this 14th day of July, 2006,

in Tallahassee, Florida.

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:

District 4 APD: Gayle Granger
Ann Cocheu, Esq.

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

APPEAL NO. 06F-02551

PETITIONER,

Vs.

AGENCY FOR PERSONS
WITH DISABILITIES
DISTRICT: 03 Putnam
UNIT: APD

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 20, 2006 at 2:35 p.m., in Palatka, Florida. The petitioner was not present. However, he was represented by David Kanya, Waiver Support Coordinator with People Systems, Aleksandra Suslov, support coordinator, ..., .esidential Director Homes and Lisa Renninger, LPN --, appeared as witnesses for the petitioner. Lucy Goodard-Teel, attorney, represented the agency. Jane Siskind, Maximus Inc. appeared as a witness for the agency. Ms. Siskind participated in the hearing by telephone.

ISSUE

The petitioner is appealing the agency's action of March 10, 2006 to reduce residential nursing services from 520 quarter hours to 208 quarter hours due to the lack of medical necessity. The agency has the burden of proof.

FINDINGS OF FACT

The petitioner is a participant in the Developmental Services Home and Community Based Services Medicaid Waiver Program. The petitioner has diagnosis of mental retardation and is currently living in a residential group home setting with six other housemates. The petitioner is ambulatory, verbal and is capable of feeding himself. He requires some physical assistance with bathing and he is able to brush his teeth. The petitioner has diabetes and must have his blood sugar monitored on a daily basis. The petitioner also has gingivitis which requires that he receive assistance with making sure all his dental hygiene needs are being met.

A support plan was submitted requesting adult day training, adult dental services, support coordination services, behavior analysis , behavioral evaluation, non residential support services, residential habilitation-standard, residential nursing services and transportation services. All of the requested services were approved as requested except residential nursing services, which was terminated. The agency notified the petitioner of its action on March 10, 2006.

The request for residential nursing services was terminated due the lack of medical necessity. The justification for the agency's denial of this service states in part:

> " Residential Nursing Service is being requested in the amount of 520 quarter hours for Mr. . The support plan indicates the service is needed in order to monitor Mr. blood sugar due to

diabetes. No other information was submitted regarding the services provided by the nurse. A Notification of Missing Information (Form #2) was issued on 2/21/06 requesting the required documentation for this service as indicated on Form # 1, A-6; however, the information submitted in response only included Residential Habilitation Service goals and multiple copies of the annual report.

According to form #1, A-6, documentation required in order to determine medical necessity includes a prescription, a nursing assessment, the location (s) where nursing services are to be provided, a list of specific duties to be performed by the nurse, and the nursing care plan. Therefore, since none of this information was submitted, medical necessity could not be demonstrated and Residential Nursing Service is terminated."

The petitioner requested a reconsideration. In evaluating the reconsideration request, the Maximus justification for the decision states in part:

"Documentation received includes a nursing assessment, nursing care plan, an updated support plan, medication list and medical consultation form. A prescription for this service places a limitation on it, it states "Nurse to give Diabetes teaching to ALF staff for food preparation for 1800 ADA diet." According to the Florida Medicaid Developmental Disabilities, Coverage and Limitations Handbook on page 2-4, the medical necessity conditions require that a service not be in excess of the individuals needs and be reflective of the level that can safely be furnished. Medical necessity is not demonstrated for residential nursing at the amount requested. 520 quarter hours is in excess of what Mr. [illegible] physician has ordered. To perform teaching and supervision of staff for Mr. [illegible] diet should require 208 quarter hours per year. This is an approval with changes in the amount of 208 quarter hours. The original determination is overturned to the extent of 208 quarter hours per year."

The agency's action was largely based on the physician's prescription which limited the nursing services to teaching diabetes training to the group staff. The agency determined that this request was in excess of the needs of the petitioner and not medically necessary. The agency witness explained that the approval of residential nursing services was based on the number of hours needed for the nurse to teach the

group home staff diabetes training because that is what the doctor ordered in the prescription. It was noted that even though the evidence submitted indicated the nurse would be performing other duties, the agency is required to make a decision based on the doctor's orders.

CONCLUSIONS OF LAW

42 C.F.R. §440.180 **Home or community-based services** states in part:

"(a) Description and requirements for services. Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter."

Florida Administrative Code 59G-13.080 **Home and Community-Based Services Waivers** states in part:

"(5) Service Limitations – General. The following general limitations and restrictions apply to all home and community-based services waiver programs:

(a) Covered services are available to eligible waiver program participants only if the services are part of a waiver plan of care ("care plan", "individual support plan", or "family support plan"). Care plan requirements are outlined in subsections (6) and (8) of this rule.

(b) The agency or its designee shall approve plans of care based on budgetary restrictions, the recipient's necessity for the services, and appropriateness of the service in relation to the recipient, prior to their implementation for any waiver recipient.

(6) Program Requirements – General.... (f) The plan of care will identify the type of services to be provided, the amount, frequency, and duration of each service, and the type provider to furnish each service."

Florida Administrative 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; 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 Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook dated June 23, 2005, states in part:

"**RESIDENTIAL NURSING SERVICES**
Description
Residential nursing services are services prescribed by a physician that consist of continuous nursing care provided by registered or licensed practical nurses, in accordance with Chapter 464, F.S. within the scope of Florida's Nurse Practice Act for recipients who require ongoing nursing intervention in a licensed residential facility, group or foster home."

The Findings of Fact show that 520 quarter hours of residential nursing services was requested in a support plan dated March 1, 2006. In reviewing this plan the agency determined that the evidence submitted to support the request for 520 hours of residential nursing services, was insufficient to meet the medically necessary criteria. This decision was largely based on the doctor's prescription which limited the nurse's intervention to diabetes training for the group home staff.

In carefully reviewing the evidence presented, the hearing officer concludes that the petitioner did not provide sufficient evidence to substantiate that 520 quarter hours of residential nursing services is a medically necessary service required to meet the needs of the petitioner. As such, the agency's action to approve 208 quarter hours of residential nursing services instead of the 520 quarter hours requested due to not meeting the medically necessary criteria, is a justified action that is consistent with the above cited authorities.

DECISION

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

DONE and ORDERED this 5th day of July, 2006,

in Tallahassee, Florida.

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:
District 3 APD: Jim Smith
Lucy Goddard-Teel, Esq.

F I L E D

JUL 2 1 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 05F-03870

PETITIONER,

Vs.

CASE NO.

AGENCY FOR PERSONS WITH DISABILITIES
DISTRICT: 14 Highlands
UNIT: APD

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 14, 2006, at 11:14 a.m., in Sebring, Florida. The petitioner was present. He was represented his attorney, Loretta Thompson. The agency was represented by Joseph Robles, assistant attorney general. Present as a witness for the petitioner was . mother; . .ss, father; Johanna Souther, support coordinator with Gulf Coast Community Care; , grandmother; Barbara Cook, executive director of Vision, ADT. Present as a witness for the agency was Connie Miller, program administrator; and George Gill, consultant reviewer with Maximus.

The hearing was reconvened on April 14, 2006, at 10:47 a.m., in Sebring, Florida. The petitioner was present. He was represented by his attorney, Loretta Thompson. The agency was represented by Joseph Robles, assistant attorney general. Present as witnesses for the petitioner were ; ... ;, mother; [.... grandmother; .

teacher; Suzanne Ather, certified behavior analyst; Johanna Souther, support coordinator; and Keisha Cooper, program coordinator with Gulf Coast Community Care. Present as a witness for the agency was Connie Miller, program administrator, and George Gill, consultant reviewer with Maximus.

The department was allowed 10 days for the agency to provide information. Information was received from the agency on April 20, 2006. It was accepted as Agency Exhibit 9. The petitioner filed an objection to accepting Agency Exhibit 9 into evidence for being an ex parte communication. This information was requested at the end of the hearing allowing 10 days for the information thus was not an ex parte communication. The exhibit was received by the hearing officer on April 20, 2006 within the request 10 day period from the date of the hearing. The petitioner's objection to the acceptance of Department Exhibit 9 is overruled.

ISSUE

At issue is the agency's action reducing the petitioner's ratio for the Adult Training Program from 1:1 to 1:3 effective with the cost plan for April 1, 2005 through March 31, 2006.

FINDINGS OF FACT

The petitioner is a recipient of benefits through the Developmental Disabilities Home and Community-Based Services Waiver Program (DD-HCBS). His support coordinator submitted a proposed cost plan to the agency for the time period of April 1, 2005 through March 31, 2006. The Agency contracts with Maximus to perform Prior Service Authorization (PSA) reviews on certain requested services, or when costs of a support plan exceed certain levels. The PSA unit reviews these requests to determine if

the service(s) meets the established criteria for medical necessity. The petitioner has been in the Consumer Directed Care (CDC) Project since 2001. Maximus treats the review of a cost plan for the traditional DD-HCBS Waiver in the same way as for the Consumer Directed Care Plus Program.

The petitioner is 26 years old and lives in the home with his parents. He began attending Adult Day Training in October 2004 where his staff ratio was 1:1. He has a gastostomy tube and wears adult protective garments. If the tube comes loose, it must be replaced within two hours.

He uses a Dynavox augmentative communication device during the day program hours. The petitioner requires visual supervision at all times. There are been a few incidents of self-injurious behaviors. The petitioner is sensitive to discussions regarding his behavior. The documentation submitted did not reveal any significant behavioral issues.

Maximus reviewed the petitioner's cost plan on June 6, 2005. The documentation submitted with the cost plan indicated that the petitioner does not have a behavioral analysis plan. Maximus determined that the 1:1 staffing ratio required the petitioner to have a behavioral services plan that is implemented by the day program provider. The Area APD Local Review Committee Chair (LRC) must verify the need for the 1:1 staffing ratio in writing.

Maximus determined that the petitioner did not establish the "medical necessity" for the 1:1 staffing ratio. He established the need for a 1:3 staff ratio due to his need for trained staff to assist him with eating, and to keep him dry and comfortable in his wheelchair throughout the day. They approved the plan with changes. The district was

notified of their decision on June 23, 2005. On June 28, 2005, the district mailed a notice explaining the changes to the petitioner.

The petitioner filed a request for a reconsideration of the proposed reduction in the staff ratio for the Adult Day Training. On July 17, 2005, Maximus conducted a reconsideration. The reviewer found that the petitioner did not have a behavioral services plan in action. The reviewer upheld the prior reduction stating that an approved behavioral services plan must be in place to medically justify the 1:1 ratio. On July 19, 2005 Maximus denied authorization of a 1:1 ratio and upheld the approval of a 1:3 ration of staffing for Adult Day Training.

Maximus received a second request for reconsideration and a packet of information in November 2005. Maximus requested information to clarify the request. They informed the support coordinator that a second reconsideration is not permitted within the same cost plan year. Therefore, they would consider this a new request for services. The information from the petitioner contained an LRC Service Recommendation Form approving hours 480 quarter hours for a Behavioral Assessment based on an October 28, 2005 Behavioral Assessment.

In response, Maximus issued a Form 2a requesting that the support coordinator complete an initial request form, identify the service or services requested, the amount of each service, and the unit cost for each service. They set a deadline of December 28, 2005 for the return of the information. Maximus did not receive the requested information. On March 16, 2006, Maximus issued a Notification of Closed Review Form #6 informing the petitioner that the request filed in November 2005 was denied as requested information was not provided within 60 days.

Suzanne Ather, certified behavior analyst, conducted a Behavioral Assessment for the petitioner on October 28, 2005. She submitted a temporary behavior plan to the LRC for their review. She trained the Adult Day Training Staff on data collection to monitor the plan. However, the plan was never implemented and data was not collected. Ms. Ather did not recommend 1:1 staffing for the petitioner as she did not consider his behaviors severe enough. However, she determined that the petitioner would benefit from the smaller staff ratio to help him in other areas such as communication.

The support coordinator denies receiving the request for information in December 2005. She submitted the information to Maximus with a form requesting a reconsideration. She considered the submission to be a continuation of the reduction in staffing issue. The support coordinator never submitted a behavior services plan to Maximus or the other information requested in December 2005.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-13.080 establishes:

Purpose. Under authority of Section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting. To meet federal requirements, Medicaid must demonstrate each waiver's cost-effectiveness.

Fla. Admin. Code 59G-13.080 states in relevant part:

(12) Developmental Services Waiver -- General. This rule applies to all Developmental Services Waiver Services providers enrolled in the Medicaid

> program. All Developmental Services Waiver Services providers enrolled in the Medicaid program must comply with the Developmental Services Waiver Services Florida Medicaid Coverage and Limitations Handbook, October 2003, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, Non-Institutional 081, October 2003. Both handbooks are available from the Medicaid fiscal agent. The Developmental Disabilities Waiver Services Provider Rate Table, November 2003, is incorporated by reference. The Developmental Disabilities Waiver Services Provider Rate Table is available from the Medicaid fiscal agent.
> The waiver and its sub-programs are governed by the agency's handbook.

Developmental Services Florida Consumer-Directed Care Plus (CDC+) Waiver Operational Protocol establishes:

> A. Organization and Structural Administration...Consumers participating in this program will direct their own care and manage the budget allocated for their care needs. The state will provide two distinct support services to assist consumers in assuming their management responsibilities: consultant services and fiscal/employer agent (FEA) services...The consultant will train, coach, and provide technical assistance to consumers, as needed. The training and technical assistance will help consumers to use the budget correctly and avoid overspending...Establishing the Budget Amount...The consumer's budget amount is based on the value of the HCBS waiver services authorized in the care plan/support plan and available in the community...Developing the Purchasing Plan...Consumers develop a purchasing plan to specify how the monthly budget will be used to meet the consumer's care needs...Changes to the Budget Amount...The Consumer-Directed Care Plus Program offers consumers the opportunity to adjust the level of support provided (either temporarily or permanently) in response to significant changes in needs. Consumers may inform the consultant of significant changes in needs such as changes in health or functional status or the loss of an unpaid caregiver. Additionally, a consultant may identify changes in need that would warrant an adjustment to the monthly budget amount, either upward or downward. Changes to the budget amount will be made only after completion of the 3-step purchasing plan development process. The care plan/support plan will be used to determine the increased level of funds that would be provided to consumers receiving HCBS 1915(c) waiver support...

The Florida Administrative Code at 59G-1.010 (166) defines medically necessary as follows:

"(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."

The DS/HCBS Waiver Service Limitation and Rate Consideration Checklist dated July 10, 2003 discusses the ratio of staff to customers and states in relevant part:

"Adult Day Training is a service which presumes that there is a standard ratio between the number of staff and the number of clients that is typical in the community of providers of this service. This differs from other stepped rates wherein there is an assumption that the likelihood of any of the staff to client ratios is the same. For Adult Day Training, the standard rate is that for any ratio between 1 – 6 and 1 – 10.

The items of information that will be needed to select the appropriate rate for the client are the following:

- Will the service be performed in a zip code that would make it eligible for a geographic factor differential?
- Will the client be attending for a full day (six hours) or for a portion of the day?
- How many clients are simultaneously receiving the service from the same staff person (ratio)?

1 staff to 5 consumers:

- A moderate level of *personal care support services(to include such areas as specialized eating techniques and positioning needs) as

indicated on a department approved assessment; OR

- A recipient who is on a behavioral services plan that is implemented by the Adult Day Training provider, and who requires consistent visual supervision hours and occasional intervention as determined by a Certified Behavioral Analyst. The individual does not exhibit the characteristics required for a behavioral residential habilitation service. (The recipient does not have to live in a licensed residential facility.)

1 staff to 3 consumers:

- An intense level of *personal care support services (to include such areas as specialized eating techniques and positioning needs) as indicated on a department approved assessment; OR
- A recipient who is on a behavioral services plan that is implemented by the Adult Day Training provider, and who exhibits the characteristics required for behavioral residential habilitation services as determined by a Certified behavioral Analyst, (The recipient does not have to live in a licensed residential facility.)"

1 staff to 1 consumer:

- A recipient who is on a behavioral services plan that is implemented by the Adult Day Training provider, and who exhibits the characteristics required for behavioral residential habilitation services or intensive behavioral residential habilitation services as determined by a Cerfified Behavior Analyst. The need for this level of supervision must be verified in writing by the district Local Review Committee Chair. (The recipient does not have to live in a licensed residential facility.)

The Findings of Fact show that the petitioner requested that the staffing ratio for the Adult Training Program remain at 1:1 for the cost plan at issue. The cost plan was reviewed by Maximus as was the common practice of the agency. The petitioner argues that he was part of the Consumer Directed Care Plus Program and therefore, should not have been subjected to this review. He further argues that Maximus should only review new services and this was a continued services. This argument is not supported by any policy or rule prohibiting this review. Therefore, the review was accepted.

It is not in dispute that the petitioner failed to submit proof of a behavioral services plan that was approved by the LRC justifying an intensive 1:1 staff ratio. In fact, the certified behavioral analyst testified that the petitioner did not need a 1:1 ratio due to behavioral problems. It is clear that the petitioner would benefit from a 1:1 ratio for other reasons. The petitioner argues that the 1:1 ratio is not prohibited for other reasons. However, the above-cited guidelines make it clear that the criteria established as a guideline for this service relates to behavioral issues. Therefore, the hearing officer concludes that the agency correctly established the staffing ratio at 1:3 based on the documented medical necessity.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, 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 21st day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:
District 14 APD: Eric Olsen
Loretta Thompson, Esq.
Shane Deboard, Esq.
Joseph Robles, Esq.

FILED

JUL 2 7 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06N-00121

PETITIONER,

Vs.

Administrator

RESPONDENT.

_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 13, 2006, at 3:10 p.m., at the Center Nursing Facility in St. Augustine, Florida. The petitioner was not present. However, he was represented by his son, n, at the hearing. The nursing facility was represented by Patti King, Licensed Practical Nurse and Dannette Korfhage, Social Services Director.

ISSUE

At issue is whether or not the nursing home's action of May 4, 2006 to discharge the petitioner is an appropriate action based on the federal regulations found at

42 C.F.R. §483.12. The nursing facility has the burden of proof to establish that the discharge action is consistent with the federal regulations.

FINDINGS OF FACT

The petitioner has been a resident of the facility since August 2005. The petitioner frequently exhibits combative behavior and he is resistant to care, lab treatments and medical intervention. The nursing record showed the petitioner refuses medicine and on occasion displays an array of hostile, irrational and angry behaviors. The nursing record reflected that such behaviors have limited the nursing facility's ability to provide necessary care. The nursing home representatives referred to the petitioner's refusal to have dressing changes performed, which has resulted in infection and an inability to properly treat a melanoma of the petitioner's arm.

The discharge was implemented to transfer the petitioner to a facility with a secure unit that would be better able to handle the petitioner's behaviors. The facility where the petitioner currently resides does not have a secure unit and is unable to properly meet the petitioner's needs related to his dementia. The nursing facility submitted documentation to show that several of the petitioner's doctors have recommended that the petitioner be discharged to a facility with a secure unit to better serve his needs. On May 4, 2006 the petitioner was notified that effective June 3, 2006 he was being discharged to the ' in Jacksonville, Florida because his needs could no longer be met at the facility.

The petitioner's representative acknowledged that the petitioner's behaviors are problematic. However, he was concerned that in an Alzheimer's unit, the petitioner's

capacities would rapidly diminish. The petitioner's representative also noted that visitation would be more inconvenient if he is moved to a facility in Jacksonville.

CONCLUSIONS OF LAW

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

In the case hand, the discharge notice specifies reasons that appear at 42 C.F.R. §483.12 **Admission, transfer and discharge rights**, which state in part:

> "*(2) Transfer and discharge requirements.* The facility must permit each resident to remain in the facility unless...(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility...(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section."

The petitioner was provided with a Notice of Discharge on May 4, 2006. The reason given on the Discharge Notice was, "Your needs cannot be met in this facility." The record shows the petitioner frequently demonstrates combative, uncooperative and irrational behaviors that prevent the nursing facility from providing necessary care. Several of the petitioner's physicians wrote statements that indicate the petitioner's needs could be better served at a facility with a secure unit due to his uncooperative behaviors.

Based upon a careful analysis of the evidence presented, the hearing officer concludes that the [redacted] Nursing Facility has met its burden of proof in substantiating that the discharge action is a justified action that is consistent with the federal regulations.

DECISION

This appeal is denied. The nursing facility is authorized to proceed with the discharge action.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the 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 27th day of July, 2006, in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

FINAL ORDER (Cont.)
06N-00121
PAGE-5

Copies Furnished To:

CENTER, Respondent

Ms. Karen Swann,
Agency for Health Care Administration

FILED

JUL 17 2006

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06N-0080

PETITIONER,

CASE NO.

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on June 19, 2006, at 2:25 p.m., in Orlando, Florida. The petitioner appeared. , petitioner's sister and authorized representative, appeared. Betty Bairley, ombudsman, appeared as a witness for the petitioner. Shelby Parker, facility administrator, appeared to represent the facility. Sally Uva, business office manager, appeared as a witness for the facility.

ISSUE

At issue is the facility's action of April 14, 2006, intending to discharge the petitioner due to non-payment of services. The facility bears the burden of proof in this appeal.

FINDINGS OF FACT

The facility admitted the petitioner on August 12, 2004. Medicare paid the facility for the petitioner's initial 100 days of care. The petitioner applied for Medicaid and in November 2004 began receiving such.

The petitioner's sister placed the petitioner's home up for sale. The house was sold in December 2004 for $69,330, thereby resulting in the petitioner not being eligible for Medicaid for that month. This caused the petitioner to be placed into private payment status. This status means that an individual pays for her care directly out-of-pocket. The petitioner's sister used the proceeds from the sale of the home to pay for her nursing home care.

The petitioner was in private pay status until her funds were exhausted. The facility continued to receive payments through February 2006. In February 2006, the petitioner's representative re-applied for Medicaid. The application was approved beginning April 2006 and for future months. No retroactive eligibility for March 2006 was approved due to excessive assets.

The parties discussed options to resolve the matter. The petitioner's representative was unable to pay the $7,427.71 for services rendered for March 2006 (Respondent's Exhibit 2). As a result, the facility issued a Nursing Home Transfer and Discharge Notice, dated April 14, 2006, to the petitioner due to non-payment. The facility listed the discharge location as a facility in Florida. The effective date of the discharge was listed as May 15, 2006 (Respondent's Exhibit 1).

At the hearing, the petitioner's representative stated that she does not want her sister moved as she is very pleased with the quality of care received at the current facility. The facility stated that it must pursue the monies owed it. The facility affirmed that discharge planning and orientation were conducted with the petitioner and her representative.

CONCLUSIONS OF LAW

Jurisdictional boundaries to conduct this hearing have been assigned to the department by Federal Regulations appearing at 42 C.F.R. § 431.200. Regarding transfer and discharge rights from a facility, 42 C.F.R. § 483.12 states in relevant part:

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

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

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

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

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

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

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

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

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

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

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

Based on all evidence and testimony presented, the hearing officer concludes that the facility has followed the requirements of the law in its intent to discharge the petitioner. It is highly unfortunate that the petitioner has been unable to secure payment for March 2006; nevertheless, the petitioner's account still carries an arrearage to which the facility is due.

In reference to the location listed on this discharge notice, the facility has complied with the federal regulation cited above. Complaints about the appropriateness of an intended discharge/transfer location are not within the

jurisdiction of this hearing officer. These issues lie under the purview of the Agency for Health Care Administration (AHCA) and should be addressed with the agency accordingly.

DECISION

The appeal is denied. The facility's action is affirmed. The facility may proceed with its discharge accordingly.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 17th day of July, 2006,

in Tallahassee, Florida.

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

Copies Furnished To:

Respondent

Mr. Joel Libby
Agency for Health Care Administration