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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 08F-00106

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Clay
UNIT: 88250

CASE NO. 1271900408

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on January 31, 2008, at 4:00 p.m., in Orange Park, Florida. The petitioner was not present. Present representing the petitioner was her son, [redacted]. The Department was represented by Mary Kay Dacey, ACCESS supervisor. Present as a witness for the Department was Selena Simpkins, economic self-sufficiency specialist. Present observing was Leslie Green with the Office of Appeal Hearings.

ISSUE

The petitioner is appealing the Department's action of January 14, 2004, to deny Institutional Care Program (ICP) benefits for the months of October 2007, November 2007 and December 2007 due to an alleged improper transfer of assets. The petitioner had the burden of proof.

FINDINGS OF FACT

1. On October 9, 2007, the petitioner filed an application for Institutional Care Program (ICP) benefits. Prior to the application, the petitioner was living with her son and his wife who were taking care of her. Additionally, the son would have a neighbor who was a nurse bathe the petitioner when his wife was not available or at work. However, the petitioner's health deteriorated and they could no longer take care of her in their home. Therefore, on October 23, 2007, the petitioner was admitted into a skilled nursing facility. The petitioner was seeking ICP benefits from October 23, 2007 and ongoing.

2. The petitioner was born on D. and was 86 years old at the time of the application. On July 28, 2006, the petitioner was involved in a motor vehicle accident and lost her left eye and broke her neck. Prior to the accident, the petitioner had also been diagnosed with emphysema. At the time of the accident, the petitioner was 85 years old. Subsequent to the accident, the petitioner underwent three months of rehabilitation in a skilled nursing facility and later went to live with her son and his wife as she could not live alone because of her poor health.

3. At the time of the application, the petitioner had a burial contract in the amount of $10,590 which was for cost of her burial expenses. The contract was originally revocable. However, the burial contact was subsequently made irrevocable.

4. On July 7, 2007, the petitioner received an insurance settlement of $20,000. On September 15, 2007, the petitioner's son, as the petitioner's power of attorney, gave two of the petitioner's grandsons $6,500 each. On September 16, 2007, he gave a third grandson $7,000. The above funds came from the insurance settlement. The

Department presumed that the above transfers of funds were made to become Medicaid eligible.

5. On November 2, 2007, the Department mailed the petitioner a Notice of Determination of Resource/Income Transfer which gave the petitioner the opportunity to rebut the presumption that the transfers of the funds were made to obtain Medicaid eligibility. In response to the above notice, the petitioner's son in a letter dated November 9, 2007 (Petitioner's Exhibit 3) stated that he distributed the funds to the three grandsons because in previous conversations with the petitioner she had expressed her desire to give her grandsons money as she had never really done anything for them. The Department determined that the petitioner had not successfully rebutted the presumption that the transfers were made to obtain Medicaid eligibility and determined that the petitioner was not eligible to receive ICP benefits for four months from the date of the transfers (September 2007 through December 2007). The ineligibility period was determined by dividing the total amount transferred of $20,000 by $5,000 which was the average private nursing home rate.

6. On November 28, 2007, the Department denied ICP benefits for the months of October 2007, November 2007 and December 2007 as it was determined that the petitioner improperly transferred funds to become eligible to obtain Medicaid eligibility. ICP benefits were approved effective January 2008.

CONCLUSIONS OF LAW

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

> (3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing facility care services, institutional hospice or HCBS waiver services. The department will mail a notice to individuals who report a transfer for less than fair market value (Form CF-ES 2264, Feb 2007, Notice of Determination of Assets (Or Income) Transfer, incorporated herein by reference), advising of the opportunity to rebut the presumption and of the opportunity to request and support a claim of undue hardship per subparagraph (c)5. below. If the department determines the individual is eligible for Medicaid on all other factors of eligibility except the transfer, the individual will be approved for general Medicaid services (not long-term care services) and advised of their penalty period (Form 2358, Feb 2007, Medicaid Transfer Disposition Notice, incorporated herein by reference.) The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.
> (a) The department follows the policy for transfer of assets mandated by 42 U.S.C. §§ 1396p and 1396r-5. Transfer policies apply to the transfer of income and resources...
> (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 paragraph (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 medical care such that their life or health would be endangered. Undue hardship also exists when imposing a period of ineligibility would deprive the individual of food, clothing, shelter or other necessities of life. All efforts to access the resources or income must be exhausted before this exception applies. The facility in which the institutionalized individual is residing may request an undue hardship waiver on behalf of the individual with the consent of the individual or their designated representative.
(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...
(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. 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 or if the individual's total countable resources (including the transferred resources) are below the program limits.
(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) For transfers prior to November 1, 2007, periods of ineligibility are calculated beginning with the month in which the transfer occurred and shall be equal to the actual computed period of ineligibility, rounded down to the nearest whole number. For transfers made on or after November 1, 2007, periods of ineligibility begin with the later of the following dates: (1) the day the individual is eligible for medical assistance under the state

plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period; or (2) the first day of the month in which the individual transfers the asset; or (3) the first day following the end of an existing penalty period. The department shall not round down, or otherwise disregard, any fractional period of ineligibility of the penalty period but will calculate the period down to the day. There is no limit on the period of ineligibility. Once the penalty period is imposed, it will continue although the individual may no longer meet all factors of eligibility and may no longer qualify for Medicaid long-term care benefits.
1. Monthly periods of ineligibility due to transferred resources or income are determined by dividing the total cumulative uncompensated value of all transferred resources or income computed in accordance with paragraph 65A-1.712(3)(f), F.A.C., by the average monthly private pay nursing facility rate at the time of application as determined by the department (refer to paragraph 65A-1.716(5)(d), F.A.C.
a. For transfers prior to November 1, 2007, where resources or income have been transferred in amounts or frequency or both that would make the calculated penalty periods overlap, the value of all transferred resources or income is added together and divided by the average cost of private nursing home care.
b. For transfers prior to November 1, 2007, where multiple transfers are made in such a way that the penalty periods for each would not overlap, each transfer is treated as a separate event with its own penalty period.
c. For transfers after November 1, 2007, the uncompensated value of all transfers will be added together to arrive at one total value with a penalty period assigned...
3. Individuals who are ineligible due solely to the uncompensated value of a transferred resource or income are ineligible for nursing home, institutional hospice or HCBS waiver services payment, but are eligible for other Medicaid benefits.

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

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that -
(A) the assets transferred were a home
(B) the assets
(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,
(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or
(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);
(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual;...

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

Period of Ineligibility (MSSI)
When the presumption is not successfully rebutted, the Economic Self-Sufficiency Specialist must determine the period of ineligibility.
The penalty period depends on:
1. the amount of the total UV,
2. when the transfer occurred, and
3. the average private nursing home cost at the time of application or discovery of the transfer.
The following basic formula is used to determine the period of ineligibility on all applicable cases:
Total UV (divided by) the average private nursing home rate = Number of months of ineligibility (rounded down to the nearest whole number).
Where assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, the values of all assets transferred are added together and divided by the average cost of private nursing home care.
Where multiple transfers are made in such a way that the penalty periods for each would not overlap, each transfer is treated as a separate event with its own penalty period.
If an institutionalized individual is ineligible for assistance due to a transfer of assets or income by the community spouse and the community spouse becomes eligible for ICP, HCBS, or PACE, any remaining period of ineligibility must be apportioned between spouses. This will be done by dividing any new or remaining penalty periods by two and attributing to each spouse. Any odd months may be attributed to the spouse that caused the penalty or attributed according to the couple's (or their representative's) wishes.

> The current average private nursing home rate ($5,000) is used for all transfers, regardless of when the transfer occurred. There is no limit on the number of months of ineligibility.

The petitioner's son, in rebutting the presumption that the transfers were made to become Medicaid eligible, argued that the transfers of the funds from the insurance settlement were made because the petitioner wanted to give her grandsons money as she had never really done anything for them and at the time of the transfers she had no plans on being placed in a nursing facility.

The evidence presented showed that on July 28, 2006, the petitioner, who was 85 years old, lost an eye and broke her neck in a motor vehicle accident. The petitioner was living with her son and daughter-in-law who were taking care of her as she could not live alone because of her poor health. Therefore, the petitioner and/or her son should have anticipated that the petitioner would need medical care and the petitioner would need the funds from the insurance settlement to pay for the cost of her medical care.

The Florida Administrative Code Rule 65A-1.712(3) states if a transfer is not specifically excluded, then the Department must presume the transfer occurred to become Medicaid eligible, unless the individual can provide sufficient evidence to prove otherwise. The transfers in this case are not specifically excluded as set forth in the above authorities. Additionally, it is determined that the petitioner's argument is not sufficient to rebut the presumption that the transfer was made to become Medicaid eligible. Therefore, the Department correctly determined that the petitioner was not

eligible to receive ICP benefits for four months from the date of transfer (September 2007 through December 2007).

The petitioner's son argued that the transfer penalty should not be imposed as it would result in undue hardship as set forth in Rule 65A-1.712(3)(c)5, Florida Administrative Code. However, the evidence presented did not show that without nursing home care, the petitioner would be deprived of food, clothing, shelter or medical care such that her life or health would be endangered. Therefore, the hearing officer cannot conclude that the transfer penalty would result in undue hardship.

DECISION

The appeal is denied. The Department's action to deny the petitioner ICP benefits for October 2007, November 2007 and December 2007 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 26th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
4 DPOES: Theola Henderson
[redacted]

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

[redacted]

PETITIONER,

APPEAL NO. 07N-00224

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice and postponement requests by both the petitioner and the respondent, an administrative hearing was convened at 9:00 a.m. on February 19, 2008. The petitioner was not present but was represented by her daughter, [redacted] who holds durable power of attorney. The respondent was represented by [redacted] administrator, with testimony available from [redacted] licensed practical nurse (LPN) unit manager; [redacted] LPN; and [redacted] business office manager.

ISSUE

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

FINDINGS OF FACT

1. The petitioner was admitted from a hospital to the nursing facility on February 8, 2007. Adequate payments for services rendered were achieved from Medicare, insurance and private payments until November 2007.

2. On December 20, 2007, with balance forward of $5612.72, plus the month of December at $5425 and $61.86 for supplies, billing statement showed "balance due $11,099.58." At time of hearing balance due was shown as $16,174.58, with no payments made since November 6, 2007 (Respondent's Exhibit 2).

3. Between November 2007 and January 2008, facility staff was unaware of any means by which payment would be forthcoming and no payment arrangements had been made.

4. On December 20, 2007, notice of intent to discharge the petitioner to her own home was issued (Respondent's Exhibit 1). Reason was "bill for services at this facility has not been paid after reasonable and appropriate notice to pay."

5. Intent to discharge was appealed (Petitioner's Exhibit 1).

6. The petitioner holds farm assets in addition to her home (Respondent's Exhibit 3) and allegedly needs family compliance to liquidate the assets, and that has not occurred. Her daughter also has allegedly engaged counsel to assist with a Medicaid application.

7. An existing Medicaid application would not remedy the nonpayment problem, according to nursing facility administrative staff. The petitioner receives Social Security benefits, but that money is not being paid to the facility.

8. The petitioner's daughter, who is presently staying at the [redacted] home, allegedly cannot provide sufficient care on her own for the petitioner at the home. The daughter has serious health problems of her own. She needs to get back to her own home from which she has been gone for an extended period.

9. Facility staff will not discharge the petitioner to an unsafe location. The petitioner needs total care for all aspects of living. She cannot feed, bathe or dress herself.

CONCLUSIONS OF LAW

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

> **Admission, transfer and discharge rights.**
>
> (a) Transfer and discharge--
> ...
> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-- ...
> (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.
> ...
> (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--
> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
> ...
> (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: ...
> (iii) The location to which the resident is transferred or discharged;
> (iv) A statement that the resident has the right to appeal the action to the State....

The petitioner's daughter argued that insurance should have covered more of the petitioner's expenses and that the facility should pursue such. Facility staff argued that was not a serious option for any length of time and that even if insurance coverage were achieved for a few weeks, significant other payment efforts would need to be arranged, and that had not occurred. The petitioner's daughter argued that a Medicaid application was pending, might be approved retroactively, and a trust was created and funded. Facility staff argued that possible Medicaid eligibility did not satisfactorily demonstrate a secure payment source, and that intent to discharge to a safe location remained the facility plan.

It is concluded that the facility appropriately issued billing statements and notified proper parties of charges. Inadequate payment has occurred following reasonable and appropriate notice to pay. Despite the preference of the petitioner, and the difficulties of the situation, burden of proof has been met by the respondent. Intent to discharge has been justified.

DECISION

The appeal is denied and discharge intent is upheld.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The party must either pay the court fees required by law or seek an order of indigency

to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 17th day of March, 2008, in Tallahassee, Florida.

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

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

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

[redacted]

APPEAL NO. 07F-07575

PETITIONER,

Vs.

CASE NO. 1272755819

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 09 Palm Beach
UNIT: 88626

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 4, 2008, at 10:25 a.m., in Lake Worth, Florida. The petitioner was not present. Representing the petitioner was [redacted], Medicaid representative, [redacted] Nursing facility. Appearing as a witness was [redacted] registered nurse (RN), [redacted]. Representing the respondent was Martha Stollberg, specialist supervisor.

ISSUE

At issue is whether the respondent was correct in denying Institutional Care Program (ICP) Medicaid benefits due to the petitioner failing to meet a required Level of care (LOC). The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a fifty year old (DOB [redacted]) resident of the [redacted] Nursing facility. An application for Institutional Care Program (ICP) Medicaid benefits was submitted, on her behalf, October 22, 2007.
2. The petitioner, who has cerebral palsy and is mentally retarded, was hospitalized September 25, 2007, following an incident at her home. The hospital sought appropriate placement including a group home but was unsuccessful.
3. [redacted] accepted the petitioner based upon pending acceptance of ICP Medicaid. The application was denied December 28, 2007, due to a failure to pass a required LOC. Determination was made by the CARES unit of the Department of Elder Affairs.
4. [redacted] presents that the petitioner requires supervision with her activities of daily living (ADL) such as bathing, eating, dressing, and toileting.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.701 **Definitions** states in part:

(2) Appropriate Placement: Placement of an individual into a Medicaid-participating nursing facility that provides the type and level of care the department determines the individual requires; or the receipt of approved HCBS waiver services by an individual in accordance with an approved plan; or receipt of hospice services provided by a Medicaid-participating hospice provider by an individual in accordance with Title 42 U.S.C. § 1396d.

65A-1.711 **SSI-Related Medicaid Non-Financial Eligibility Criteria** states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F, with the

exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate:

(2) For ICP benefits, an individual must be:

(a) Living in a licensed nursing facility, or confined to a hospital swing bed or to a hospital-based skilled nursing facility bed, or in an ICF/DD facility that is certified as a Medicaid provider and provides the level of care that the client needs as determined by the department; or living in a Florida state mental hospital and be age 65 or over; and

(b) Determined to be in medical need of institutional care services according to Rules 59G-4.180 and 59G-4.290, F.A.C., for nursing facility, hospital swing bed placements and placements in a hospital-based skilled nursing facility bed according to Chapter 65B-38, F.A.C., for ICF/DD facilities or according to Rule 59G-4.165, F.A.C., for state mental hospitals.

Fla. Admin. Code 59G-1.001 **Purpose** states in part:

The agency adopts these rules to comply with the requirements of Chapter 409, Florida Statutes. All rules in Chapter 59G, F.A.C., must be read in conjunction with the statutes, federal regulations, and all other rules and regulations pertaining to the Medicaid program.

59G-4.180 **Intermediate Care Services** states in part:

(1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitation services to qualify as intermediate care services and clarifies the criteria that must be met in order for such services to qualify as an intermediate level I or intermediate level II service under Medicaid.

(2) Definitions as used in this section.

(a) Intermediate care nursing home resident. A Medicaid nursing home applicant or recipient who requires intermediate care services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and treatment provided in a hospital or that which meets the criteria for skilled nursing services.

59G-4.290 **Skilled Services** states in part:

(1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitative services to qualify as skilled services under Medicaid.

(2) Definitions as used in this section.

(a) Continuous. The need for 24-hour care in a skilled nursing facility with professional nursing services available.

(10) To qualify for placement in a nursing facility, the applicant or recipient must require 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital.

(11) When determining whether nursing facility services are required, consideration shall be given to the individual's physical and mental condition, excluding individuals with functional psychoses, acute psychiatric illness or individuals requiring or receiving active psychiatric treatment, or who require 24-hour care for diagnostic evaluation and psychiatric treatment.

Pursuant to regulation and code, the respondent, through its CARES unit, reviewed the petitioner's medical condition to determine a LOC requirement. The petitioner, at the time of the assessment, did not meet an LOC. There was no need for 24-hour supervision even though she requires some supervision with ADLs. Therefore, CARES determined it was inappropriate to authorize an LOC to meet ICP Medicaid.

Fla. Admin. Code allows the respondent to make that determination. The respondent's requirements have been met.

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 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 10th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
9 DPOES Martha Prock
[redacted]

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

[redacted]

APPEAL NO. 07F-07034

PETITIONER,

Vs.

CASE NO. 1270499629

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 13 Lake
UNIT: 88006

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on January 23, 2008, at 2:48 p.m., in Tavares, Florida. The petitioner was not present but was represented by [redacted] certified senior adviser with [redacted] Senior Services. [redacted] also testified. Sandra Maxwell, supervisor in Adult Payments, represented the respondent by telephone and testified. Joan Petrone, caseworker, also appeared by phone as a respondent witness. Ralph Coleman, senior eligibility worker, physically appeared as a witness for the respondent.

ISSUE

At issue is the respondent's action of November 8, 2007, to deny the petitioner's application for Institutional Care Program and Medicaid benefits (ICP), for August and September 2007 due to excess assets. The respondent

believes the countable bank account values caused the petitioner to be ineligible in these months. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner applied for ICP benefits on September 14, 2007. The respondent approved ICP benefits for the petitioner on November 8, 2007 for the months of October 2007 and ongoing. ICP benefits for August and September 2007 were denied due to excess assets.
2. The petitioner owned a money market account with a balance of $19.253.61 in July 2007. In July 2007, $5,000 was spent down to leave a balance of $14.253.61. The remaining funds from the money market account was transferred into a checking account effective August 2007. The respondent counted $8.518.12 as the lowest available balance in the checking account in August 2007. The petitioner does not dispute that the balance of the account was any lower than this amount in August 2007.
3. In September 2007, the respondent determined the lowest countable balance of the checking account to be $4,993.10. The petitioner does not dispute that the balance was any lower than $4,993.10 for September 2007.
4. The petitioner retained funds in the money market or checking accounts to await a decision on Medicare reimbursement. The petitioner paid medical expenses in August and September 2007.

The respondent considered all checks presented for medical expenses in August and September as an amount spent down to determine the countable asset balances listed above.

CONCLUSIONS OF LAW

Florida Administrative Code Rule 65A-1.716(5)(a)1. sets forth a $2,000 countable asset limit in the ICP Program. If the correctly countable amount of the checking account exceeded this asset limit, then the petitioner is ineligible for ICP benefits in August and September 2007.

The respondent's interpretive FLORIDA on-line manual at section 1640.0407 defines the countable value of an included asset, such as a checking account, as its value minus indebtedness. Section 1640.0408 shows that outstanding checks that have not yet cleared the bank are considered as a legal indebtedness. Findings show that the respondent considered the value of outstanding checks in computing the countable asset value.

Section 1640.0405 of the respondent's interpretive manual sets forth the following about the time assets are countable:

> Individuals who are eligible on one day of the month are eligible for the whole month.

Findings establish that the lowest countable bank account balances, minus consideration for outstanding check expenses, were above $4,900 in August and September 2007. Section 1640.0514 allows a $2,500 burial exclusion policy from countable assets. Even If the petitioner were to properly designate $2,500 in funds for burial exclusion, the countable checking account

balance would still exceed the maximum of $2,000. No other authority is found that would allow for any additional exclusion of the checking account funds. Since the countable value of this checking account exceeded the maximum $2,000 asset limit in August and September 2007, the respondent is correct to deny ICP benefits due to excess assets in these months.

DECISION

This appeal is denied and the respondent's action 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 4th day of March, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
District 13 ACCESS: Micheal Holder

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

[redacted]

PETITIONER,

APPEAL NO. 07F-07036
07F-07037

Vs.

CASE NO. 1272253597

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 08 Charlotte
UNIT: 88634

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 14, 2008, at 10:15 a.m., in Port Charlotte, Florida. The petitioner was not present. He was represented by his son, [redacted] and [redacted] paralegal. The respondent was represented by Mary Norman, senior economic self-sufficiency specialist.

ISSUE

At issue is the November 27, 2007 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program and Medicaid due to the couple's failure to return requested Information. The burden of proof falls with the petitioner as the applicant for benefits.

FINDINGS OF FACT

1. On October 15, 2007, the petitioner filed a Request for Assistance to apply for benefits through the Institutional Care Program and Medicaid. His household consisted of himself and his spouse. Both the petitioner and his spouse resided in a nursing facility. They were applying for Institutional Care Program benefits and Medicaid for both adults.
2. In a notice dated October 18, 2007, the respondent requested that the petitioner return the following information: bank statements, verification of life insurance policies, proof of interest income, and forms signed for both adults. The petitioner returned the requested items on October 19, 2007, and October 30, 2007.
3. The respondent identified $80,742.99 in funds that were received between July 27, 2007 and October 15, 2007. The $80,742.99 consisted of cash from life insurance policies and closed savings accounts. The respondent identified $34,480.56 in copies of cashed checks. They could not account for another $46,262.42. On November 5, 2007, the respondent issued a second pending notice.
4. In the second notice, the respondent requested copies of the most recent bank statements from two different banks, and verification/receipts showing how the $80,742.99 was used for the needs of the couple. The deadline to return the information was November 15, 2007. A copy of the pending letter was faxed to the nursing facility.

5. Two facsimiles were received from the nursing facility on November 7, 2007 and November 9, 2007. They contained copies of a bank statement, cashed checks, and a nursing home billing ledger. There was no further response from the petitioner. On November 26, 2007, the respondent denied the application for failure to return requested information.

6. The respondent does not dispute the facts as presented by the respondent. The son handled the application process as a representative for his parents. He did not provide the respondent with an accountability of the usage of the funds belonging to his parents. However, he has prepared the records recently.

CONCLUSIONS OF LAW

The Fla. Admin. Code discusses the rights and responsibilities associated with the application for benefits and states in relevant part:

> (d) If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, or that an assistance group member is required to register for employment services, the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated) or 30 days from the date of application whichever is later. In cases where medical information is requested the return due date is 30 calendar days following the request or 30 days from the date of application whichever is later. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day. If the verification or information is difficult for the person to obtain, the eligibility specialist must provide assistance in obtaining the verification or information when requested or when it appears necessary. If the required

verifications and information are not provided by the deadline date, the application is denied, unless a request for extension is made by the applicant or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension based on extenuating circumstances beyond the control of the individual, such as sickness, lack of transportation, etc. When all required information is obtained, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

The respondent's Integrated Online Policy Manual HRSM165-22 section 0610.0401 states in relevant part:

If the department needs **additional information** or verification from the applicant, provide:

1. A written list of items required to complete the application process,
2. The date the items are due in order to process the application timely, and
3. The consequences for not returning additional information by the due date.

The verification/information due date is 10 calendar days from the request date. If the due date falls on a holiday or weekend, the deadline for the requested information is the next working day. At the individual's request, extend the due date.

If the individual does not return the requested verification(s) or additional information necessary to process the case during the specified time frames, take the following action:

1. Deny application the day after the pending period ends, or no later than 30 days from the date of application. If the SFU provides the missing verification within the initial 30-day period, reopen the AG if eligible. Provide food stamps from the date of application.
2. Use the same application form for the denied case if reapplication is after the 30th day, but before the 60th day. The new date of application is the date the client requests a new appointment. The AG loses benefits for the initial 30 days; prorate benefits from the new date of application if eligible.

The Fla. Admin. Code at 65A-1.712 (3) SSI-Related Medicaid Resource Eligibility Criteria and states in relevant part:

> (3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing facility care services, institutional hospice or HCBS waiver services. The department will mail a notice to individuals who report a transfer for less than fair market value (Form CF-ES 2264, Feb 2007, Notice of Determination of Assets (Or Income) Transfer, incorporated herein by reference), advising of the opportunity to rebut the presumption and of the opportunity to request and support a claim of undue hardship per subparagraph (c)5. below. If the department determines the individual is eligible for Medicaid on all other factors of eligibility except the transfer, the individual will be approved for general Medicaid services (not long-term care services) and advised of their penalty period (Form 2358, Feb 2007, Medicaid Transfer Disposition Notice, incorporated herein by reference.) The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.

The petitioner filed an application to apply for Institutional Care Program benefits and Medicaid for himself and his spouse. The respondent issued requests for information. The petitioner does not dispute that he failed to return an accounting of sizeable transfers of funds the preceding three months before the application. Since he recently prepared the accounting, he was urged to reapply for benefits and not wait for the results of his appeal.

The above-cited policy and code requires the respondent to request information in writing to the applicants and establish a deadline to return the

information. The applicant has the responsibility to return the information or to report to the respondent when they have a problem obtaining the requested information. If the information is not returned, the guidelines require that the respondent deny or cancel requested benefits. Therefore, the respondent correctly denied the application.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 5th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
8 DPOES: Roseann Liriano
[redacted]

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

[redacted]

APPEAL NO. 08N-00017

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative Hearing was convened before the undersigned hearing officer on March 11, 2008, at 2:45 p.m., at [redacted] (previously known as [redacted]), in Safety Harbor, Florida. The petitioner was not present. The petitioner was represented by his son, [redacted]. The respondent was represented by [redacted], Esq. Witnesses for the respondent were [redacted] administrator, and [redacted] business office manager.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of January 15, 2008 is in accordance with the requirements of 42 C.F.R. § 483.12(a):

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

FINDINGS OF FACT

On January 15, 2008, the petitioner was given a Nursing Home Transfer and Discharge Notice. The reason listed in the discharge was: "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".

1. The petitioner was admitted to the facility in January 2006. A bill for service was incurred by the petitioner for room, board and service for his stay at the facility. As the bill had not been paid, the respondent filed a Complaint in the Sixth Judicial Circuit, Small Claims Division. The petitioner was noticed on this complaint. The balance due cited in the complaint as of April 30, 2006 was $2,085.28.

2. As of January 15, 2008, the petitioner's unpaid balance due and payable to the facility was $17,000. On January 15, 2008, the respondent sent the petitioner Nursing Home Transfer and Discharge Notice.

3. A judgment was entered in favor of the facility in the amount of $2,085.28. Final Judgment was signed on February 15, 2008. As of March 11, 2008, the petitioner has not made payment on the judgment nor has the balance due been paid.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255 F.S. Matters that are considered at this type of hearing is the decision by the facility to discharge the patient. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing

facility may discharge a patient. In this case, the petitioner was sent notice indicating that she would be discharged from facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a):

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

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

DECISION

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

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

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

DONE and ORDERED this 24th day of March 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO. 08F-0216

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 26, 2008, at 8:16 a.m., in Miami, Florida. The petitioner, [redacted] was present and was represented by her mother, [redacted] The respondent was represented by Monica Otoriola, program specialist with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the agency was Dr. Robert A. Buzzeo, physician reviewer and Teresa Ashey, RN nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez, specialist with AHCA was present for observation.

ISSUE

At issue is the agency's action of December 4, 2007 and December 24, 2007, in denying 252 hours of private duty nursing (PDN) and approving 648 hours. The request was for 900 PDN hours to cover the certification period of December 6, 2007 through February 3, 2008. The agency has the burden of proof.

FINDINGS OF FACT

1. The petitioner is fifteen years old and a Medicaid beneficiary in the state of Florida. The petitioner's medical condition as reported was, "Cerebral lipodoses, Respiratory distress syndrome in newborn, Other convulsions, Battens Disease."

2. On December 3, 2007, the provider (Maxim Healthcare Services, Inc.) requested 900 skilled nursing hours (15 hours daily [4pm-7am], 7 days a week) of skilled nursing hours, for the petitioner for the certification period of December 6, 2007 through February 3, 2008.

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

4. On December 3, 2007, an initial screening of the request was performed by a KēPRO registered nurse reviewer. The nurse consultant at that level of review was unable to approve the request, for the number of hours that had been requested. The request was then referred to a KēPRO physician reviewer that is board-certified in pediatrics, for review of medical necessity for the level of service that was being requested.

5. The KēPRO physician consultant reviewed the request and determined the following: "... 15 YO with Gtube for all meds, feeds, on IV and PO antibiotics for pneumonia, must be repositioned Q2 [every 2 hours] with CPT and O2 PRN. SN [Skilled nursing] is necessary, but 900 hours for this cert period is excessive for this mom that works until 3PM M-F. Would approve 7P-7A M-F and 11P-7A on Sat, Sun." The reviewer considered in addition to the medical condition of the petitioner, that the mother is a single mom that works from 8 a.m. to 3 p.m., there is a teenage sibling in the home, and that the petitioner attends PPEC (Prescribed Pediatric Education Center) 7 a.m. to 3:30 p.m.

7. On December 4, 2007, the provider and the petitioner were informed of the denial of 252 hours and approval of 648 PDN hours for the certification period.

8. On December 6, 2007, the provider submitted a reconsideration request and submitted additional information on the petitioner for a hospital stay for pneumonia. Also, the petitioner's mother had been caring for [redacted] during sleep hours, because of nursing availability issues. The petitioner's request for sleep hours had been originally approved and the petitioner attends PPEC during the day until 3:30 p.m. The information included clarification on the need for 15 hours of PDN on Saturday and Sunday, which was being requested to run errands and work overtime when available. The provider was also requesting that "limitation is not placed on actual times of service..." in order to use the hours as needed.

9. A second KēPRO physician consultant board certified in pediatrics, reviewed the reconsideration request and determined that the original request had approved most of the hours on the weekdays. Nothing had changed in the family situation on the

weekends other than the mother was trying to work hours on Saturdays. The provider was informed that a request for a modification of hours would need to be submitted, along with information on the specific hours that were needed because of work. No modification request had been submitted as of the day of the hearing. The physician reviewer upheld the initial denial.

11. On December 24, 2007, the provider and the petitioner were sent the PDN/PC Recipient Reconsideration-Denial Upheld notice.

CONCLUSIONS OF LAW

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

Fla. Admin. Code 59.G-1.010, "Definitions", states for medical necessity:

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and *not* in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be *reflective of the level of service that can be safely furnished*, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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

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

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

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

The Home Health Services Coverage and Limitation Handbook (July 2007) under Private Duty Nursing Services states in part:

Private Duty Nursing *Requirements*-Private duty nursing services *must* be: ... Documented as medically necessary;... Consistent with the physician approved plan of care; and Prior authorized before services are provided.

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

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

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

> *Authorization* Process-Private duty nursing services are authorized by the Medicaid peer review organization if the services are determined to be medically necessary. Private duty nursing services will be *decreased over time* as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child's condition improves.
>
> *Prior Authorization*-All private duty nursing services *must be prior authorized by the Medicaid peer review organization prior to the delivery of services...*
>
> *Requesting Prior Authorization*-All requests for prior authorization must be submitted to the Medicaid peer review organization via its web-based Internet system. At a minimum, the prior authorization request must include: ... Planned dates and times of service; Units of service requested; ... Other documentation requested by Medicaid such as the caregiver's availability and ability to provide care.

The petitioner's mother states that she works from 8 a.m. to 2:30 p.m. and is attempting to work additional hours on Saturday, when they are available for her to work. She states that in December 2007 she was home for three weeks when her daughter had pneumonia and she did not want to send her to PPEC. She would like to be able to use the approved PDN hours on an "as needed" basis, as she has always done so. The petitioner's mother states that she has no social life and is exhausted.

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. It states that medical necessity must be demonstrated before a requested level of service is approved. In this case, two different board certified physician consultants specializing in pediatrics approved 648 PDN hours (7pm-7am weekdays, and 11pm-7am on weekends) and denied 252 hours (4 pm-7pm weekdays, and 4 pm-11pm on weekends) as medically necessary.

The provider was advised to submit a modification request with specific times of work for the weekend, as Medicaid does not allow for the approved hours to be used on

an "as needed" basis. When service is authorized as medically necessary, they are to be used exactly as was approved by Medicaid. Based on the above cited authorities, the respondent's action is affirmed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of March, 2008,

in Tallahassee, Florida.

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

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

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

[redacted]

APPEAL NO. 08F-00022

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE
ADMINISTRATION (AHCA)
AREA 07 Orange

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned. The petitioner is a minor child and was not present, but his mother, [redacted], duly represented him. Also present on his behalf were his grandparents, [redacted]. Lissette Knott, AHCA human service program specialist, represented the respondent. Present to testify by telephone were Mary Wheeler, RN, manager of review operations with KePRO (an agency contracted with AHCA) and Rakesh Mittal, MD, a board certified pediatrician and pediatric emergency physician with KePRO.

ISSUE

At issue was whether or not AHCA correctly reduced private duty nursing (PDN) services by thirty-six hours for the sixty-day certification period of November 29, 2007 to January 27, 2008. Burden of proof was on the agency.

FINDINGS OF FACT

1. The petitioner is nine years old and has severe health impairments. Under State-plan Medicaid, he had been authorized for PDN skilled services at 22 hours a day Monday-Friday, and 20 hours a day on weekends for the review period ending November 28, 2007. That was an authorization level of 1284 hours.

2. At recertification, the same level was requested by the home health agency, but 36 of the hours were denied and only 1248 were approved. KePRO reduced the hours to sixteen per day for the nine Sundays in certification period November 29, 2007 to January 27, 2008.

3. Reduction (notice dated December 15, 2007) was the issue under challenge and at reconsideration (notice dated December 26, 2007), reduction remained the KePRO decision. Reduction remained the KePRO intent as of hearing.

4. Notice information and Internal Focus Review Findings by KePRO were in Respondent's Exhibit 2 with Statement of Matters and administrative guides in Respondent's Exhibit 1.

5. His mother is his primary caregiver and she has been specially trained to provide necessary skilled services. She has serious health problems including heart disorder, diabetes, and she cannot lift more than five pounds, with the petitioner weighing about ninety pounds. She is unable to provide physical care exceeding her physical limits and she is pursuing federal disability status.

6. According to Focus Review Findings, the petitioner has a sibling in the home, and his mother is additionally responsible for care of several young relatives between ages of 8 and 18 who also live there. Nursing staff significantly assist her in care of the

petitioner (see Petitioner's Exhibit 1) on a daily basis, although she asserted the authorized hours are not always fully received. His grandparents are not capable of caring for him.

7. The petitioner's doctor set forth, August 3, 2007 (in Petitioner's Exhibit 1) his opinion of "24 hour nursing care by a licensed professional is needed to prevent harm..." At some point in the past, nursing had been authorized at that level, but not at the certification immediately preceding the one under challenge.

8. At the time of review in late 2007, his father was living in the home (that has changed), and the KePRO Review showed the father working all day Saturday and half day Sunday, with him available to provide care on the Sunday and that being relevant to the decrease.

9. Through the provider, during December 2007, the family informed "hardship to decrease hrs Sunday." Reconsideration notes of late December 2007 said:

> ...12/23/07...approval of PDN coverage on Sundays while father is working and both parents are sleeping is appropriate. Provider has not submitted any additional social information which suggests that father is unable to assist the pcg [primary caregiver] (mother) with help between 2pm to 10pm. I suggest to UPHOLD THE DENIAL (OF FOUR (4) HOURS ON SUNDAYS, and APPROVE only 16 hours on Sunday, as was originally suggested...
> ...12/25/07...Physician Consultant clarified...PC had approved hours not requested. The requested hours are 8a-6p and 6p-4a on Sundays (PC approved 6A-2P and 10P-6A).*** CLARIFICATION: I suggest to UPHOLD the DENIAL (OF FOUR(4) HOURS ON SUDNAYS (between 2pm and 6pm), and APPROVE only 14 hours on Sunday [corrected calculation is 16 hours approved]. which should be the corrected hours of approval for this day.

10. The earlier December 2007 Focus Review data showed the petitioner's health problems including kidney transplant aftermath and noting in part:

> incontinence...wheelchair...CPT...cup, suction machine, ... VNS...Unable to sit independently, weight bear...functional level is that of an infant with frequent seizure activity...Requires constant supervision. ... Cannot ... assist with any care. ... frequent desaturation and bradycardia...trach, gtube, severely delayed... Mom unable to work or assist with care due to 5 lb weight restriction and medical issues...
> ...Registered Nurse Reviewer (RNR)...recipient achieved a score of 220 points on the Pediatric Home Care Guide for PDN Hourly Utilization. A score of 161-190 points is required to support the number of hours requested...

CONCLUSIONS OF LAW

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

As a practical matter, the family noted on behalf of the petitioner that his father was not trained to provide necessary care, and he has not provided care. Moreover, he is rarely at home and there are some severe personal problems in that arena, and he moved out of the home during the period. The respondent noted that review data came from the provider, such was the method used for service authorization, and if incorrect information appeared, that was the source.

Florida Statute 409.905 addresses **Mandatory Medicaid services** with section (4) informing that HOME HEALTH CARE SERVICES can be covered. Under subsection (b) the following information is relevant:

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

> and a family's and child's schedule regarding work, school, sleep, and care for other family dependents...

Thus, it is concluded that the agency was required to review continuing need for private duty nursing (PDN) service and unique family circumstances would be a review factor.

Florida Statute 409.913 addresses **Oversight of the integrity of the Medicaid program**, with (1)(d) describing "medical necessity or medically necessary" standards. Consistent with statute, Fla. Admin. Code 59G-1.010 (166) defines "medically necessary," informing that such services must:

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

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

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

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

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

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

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

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

Facts, governing standards, and arguments have been carefully considered. Basis of the four hour Sunday PDN reduction was provision of needed service by the father. Evidence did not establish he was either available or capable of providing the skills necessary to accommodate the planned reduction in private duty nursing service hours. While the respondent may have followed acceptable review guidelines, the de novo evidentiary standards and the burden of proof standards for administrative

hearings preclude a conclusion that the reduction has been justified by adequate evidence. Therefore, it is concluded that reduction (or denial as it is described in the notices) has not been justified.

DECISION

The appeal is granted and reduction is not upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 13th day of March 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Judy Jacobs, Area 7 Medicaid Adm.
[redacted]

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

[redacted]

APPEAL NO. 08F-00024

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 January 31, 2008, at 10:36 a.m., at the Opa Locka Service Center, in Opa Locka, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's mother, [redacted] The Agency was represented by Sandy Moss, program administrator, from the Agency For Health Care Administration (AHCA). Present as witness for the Agency, via the telephone, was Dr. Mittel Rakesh, physician reviewer, from KePRO South. Also present via the telephone, as a witness for the Agency was Teresa Ashey, nurse reviewer from KePRO. KePRO is located in Tampa, Florida. Carlos Rodriguez was present as an observer.

ISSUE

At issue is the Agency's action of November 29, 2007 and on reconsideration on January 20, 2008, to reduce the petitioner's request for continued private duty nursing

services a total of 78 hours, for the period of November 16, 2007 through January 14, 2008. The reduction of hours totals three hours a day from 8:00 p.m. to 11:00 p.m., for three days a week (Monday, Wednesday and Friday) of the above service. The Agency has the burden of proof.

FINDINGS OF FACT

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

2. KePRO has been authorized to make Prior (service) Authorization Process decisions for the Agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on November 29, 2007, that the petitioner's request for about 1,224 hours of private duty nursing was going to be denied/reduced by 104 hours for the period of November 16, 2007 through January 14, 2008.

3. The petitioner's representative requested a hearing and benefits were restored. A reconsideration was also requested, but a decision on the reconsideration was not completed until January 20, 2008. The Agency restored 26 hours of the requested service for a total denial/reduction of 78 hours of the service. The hours that were reduced or denied on reconsideration were for three hours a day from 8:00 p.m. to 11:00 p.m., for three days a week (Monday, Wednesday and Friday) of the above service.

4. KePRO's decision was based on the information provided by the petitioner's provider or home health agency as part of the request for the service. KePRO determined

that petitioner's mother and father, though employed, are quite capable of caring for the petitioner for the hours of 8:00 p.m. to 11:00 p.m., three days a week, Monday, Wednesday and Friday. Neither the petitioner's mother nor father are employed on the above noted hours.

The petitioner submitted into evidence, Petitioner Exhibit 1, which contains copies of dates of admission to the hospital for the petitioner, based on bouts of respiratory distress. The Agency was made aware of the above. The petitioner's representative is also six months pregnant at this time. The Agency is also aware of this.

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 first on November 29, 2007 and then on reconsideration to reduce the petitioner's request for continued private duty nursing services by 78 hours of the service. This decision was based (partly) 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 representatives argued that the petitioner is in need of the requested private duty nursing, based on the petitioner having possible respiratory

distress at any time. She argued that, she herself, is now six months pregnant and starting to have pregnancy related complications and is worried that a private duty nurse may not be available at that time.

The respondent argued that their decision was based on the period of service ending on January 14, 2008 and if the petitioner's representative or the petitioner has new situations such as giving birth or complications of the pregnancy, then a new request for services should be made. The Agency argued that their decision remains correct.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer finds that the Agency has met its burden of proof and that the Agency's reconsideration action of January 20, 2008, to reduce the petitioner's request for continued private duty nursing services for the 78 requested hours of the service for the period of November 16, 2007 to January 14, 2008, which was for the three hours a day, three days a week, for Monday, Wednesday and Friday, from 8:00 p.m. to 11:00 p.m., is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Robert Akel

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

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

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

[redacted]

APPEAL NO. 08F-0021

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 12, 2008, at 8:20 a.m., in Miami, Florida. The petitioner, Bryan Louzada, was not present however he was represented by his mother, [redacted] Also present, on behalf of the petitioner was [redacted] RN director of clinical services for [redacted] Health Care Services. The respondent was represented by Monica Otoriola, program specialist with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the agency was Dr. Rakah Miettel, physician reviewer and Teresa Ashey, RN nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez, specialist with AHCA served as translator.

ISSUE

At issue is the agency's action of December 4, 2007, December 15, 2007 and February 4, 2008, in denying 149 hours of private duty nursing (PDN) and approving

1,291 hours. The request was for 1,440 PDN hours (24 hours daily, 7 days a week) to cover the certification period of December 7, 2007 through February 4, 2008. The agency has the burden of proof.

FINDINGS OF FACT

1. The petitioner is sixteen years old and a Medicaid beneficiary in the state of Florida. The petitioner's medical condition as reported was, "Infantile cerebral palsy, unspecified; Other convulsions." Other diagnosis were, "Hemophilia A: has Mediport for Factor A to be given weekly/Cortical blindness, asthma, erosive esophagitis/complete care/bedbound +2 lift to W/C [wheelchair]."

2. On November 30, 2007, the provider (Americare) requested 1,440 (24 hours daily, 7 days a week) of skilled nursing hours, for the petitioner for the certification period.

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

4. An initial screening of the request was performed by a KēPRO registered nurse reviewer. Additional information was requested from the provider, in order to determine medical necessity for the level of service that was being requested. The provider submitted the information requested documenting, "Patient/mom live together/no other

children. Mom works 9a-5p M-F/OT on Sat + travel time. Goes to church Tues, Wed, Sun 8p-11p."

5. The nurse reviewer was unable to approve the request and referred the case to a KēPRO physician reviewer that is board-certified in pediatrics, for review of medical necessity for the level of service that was being requested.

6. The KēPRO physician consultant reviewed the request and considered given the work schedule and social activities that independent care can be provided by the mother during time off work and Sundays. The reviewer denied 477 PDN hours and approved 963 hours for the certification period.

7. On December 4, 2007, the provider and the petitioner were informed of the denial and approval of the PDN hours.

8. On December 7, 2007, the provider submitted a reconsideration request and submitted additional information.

9. A second KēPRO physician consultant reviewed the reconsideration and considered in addition to the petitioner's medical conditions, the social situation of the mother such as, being a single mom; her working hours and no work on Sundays; no other children in the home; and her attending church on Tuesdays, Wednesdays, and Sundays from 8pm-11pm.

10. The physician reviewer determined that on the mother's days off (Sunday 7am-noon) and weekdays when not attending church (Monday, Thursday, Friday from 7pm-11pm), she was able to provide care for those four hours. Each Saturday was approved for 24 hours, even though she does not work every Saturday. The physician reviewer

denied 149 PDN hours, as this was care that can be provided by the mother and approved medically necessary coverage of 1,291 PDN hours. This modified approval was allowing for PDN coverage while mom was at work, sleep and for educational needs.

11. On December 15, 2007, the provider and the petitioner were informed of the Reconsideration-Denial Overturned, of the approval of 1,291 PDN hours and denial of 149 hours.

12. The respondent's record documents that on January 29, 2008, the provider submitted a modification request stating, that emergency 24 hour care through end of this cert period was needed as the petitioner had to go to the emergency room. The record documents that the petitioner was treated in the emergency room and released.

13. On February 3, 2008, a third board certified in pediatrics physician consultant reviewed the request and documents, "No complications since this ER visit. Pt is clinically stable. No reason given for new request. I would deny this request."

14. On February 4, 2008, a PDN/PC Recipient Denial Letter was issued to the petitioner and the provider informing them of previous approval of 1,291 PDN hours and the denial of 149 hours.

CONCLUSIONS OF LAW

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

Statutes, and Chapter 59G, Florida Administrative Code. The Program is administered by the Agency for Health Care Administration.

Fla. Admin. Code 59.G-1.010, "Definitions", states for medical necessity:

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

(a) Meet the following conditions:

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

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

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

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

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

The Home Health Services Coverage and Limitation Handbook (July 2007) under Private Duty Nursing Services states in part:

> Private Duty Nursing *Requirements*-Private duty nursing services *must* be: ... Documented as medically necessary;... Consistent with the physician approved plan of care; and Prior authorized before services are provided.
>
> Parental *Responsibility*-Private duty nursing services are authorized to *supplement* care provided by parents and caregivers. Parents and caregivers *must* participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render.
>
> Medicaid does not reimburse private duty nursing services provided solely for the convenience of the child, the parents or the caregiver.
>
> Medicaid does not reimburse private duty nursing for respite care. *Examples* are parent or caregiver recreation, socialization and volunteer activities.
>
> *Authorization* Process-Private duty nursing services are authorized by the Medicaid peer review organization if the services are determined to be medically necessary. Private duty nursing services will be *decreased over time* as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child's condition improves.
>
> *Prior* Authorization-All private duty nursing services must be prior authorized by the Medicaid peer review organization prior to the delivery of services...
>
> *Prior Authorization* for Private Duty Nursing or Personal Care-Description Prior authorization is the approval process required *prior* to providing certain services to recipients under 21 years of age. Medicaid will not reimburse for these services without prior authorization when it is required.

The petitioner's mother states that her son had been institutionalized but she brought him home, because he had been placed too far from her home. She states that she works weekdays from 11am-7pm and two Saturdays a month. She states that she is under too much stress and needs the 24 hour, 7 days a week nursing care for her son.

The petitioner's mother states that she does volunteer work at the church that she attends on Wednesdays, Fridays and Sundays. The petitioner needs repositioning every two hours and the mother states that she is under medication for depression.

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. It states that medical necessity must be demonstrated before a requested level of service is approved. In this case, three different board certified physician consultants specializing in pediatrics denied the request for 1,440 hours (24 hours daily, 7 days a week) of PDN, but did ultimately approve 1,291 PDN hours as medically necessary.

Based on the above cited authorities, the respondent's ultimate action to deny 149 PDN hours for the certification period of December 7, 2007 through February 4, 2008 is affirmed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19th day of March, 2008,

in Tallahassee, Florida.

A. G. Littman

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

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

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

[redacted]

APPEAL NO. 08F-00215

PETITIONER,

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 12:20 p.m. on February 13, 2008. The petitioner was present with his mother, [redacted] who represented him. They were assisted by [redacted] with the [redacted], and present to testify on his behalf were his licensed practical nurses, [redacted] and [redacted] The respondent was represented by Cynthia Barge, RN specialist, with telephone testimony available from AHCA-contracted KePRO staff, Board-certified Pediatrician Robert Anthony Buzzeo, MD, and Review Operation Supervisor Theresa Ashey, RN. Hearing Officer Leslie Green observed.

ISSUE

At issue was whether or not AHCA action correctly reduced private duty nursing (PDN) hours from 1320 to 856 hours for sixty-day certification period December 22, 2007 to February 19, 2008. The respondent had the burden of proof.

FINDINGS OF FACT

1. Prior to review under challenge, the petitioner received 1320 hours (22 hours per day) PDN services. That 1320 level was again requested for the new certification period. On December 20, 2007, KePRO review was conducted and 582 hours were approved. Reconsideration occurred on December 27, 2007 and 856 hours were approved. Notices of reduction intent were issued to the petitioner.

2. Either number of hours (582 or 856) was less than the petitioner's mother and care giving staff thought necessary. Hearing was requested.

3. Care, need, family circumstance and schedule information was developed during the hearing. The respondent's witnesses learned more complete information about care and circumstances. Result was that AHCA-KePRO staff determined the situation did not justify the reduction to 856 hours.

4. KePRO staff noted that reversal of reduction was appropriate. Twenty-two hours daily PDN for Monday through Sunday were determined necessary by KePRO for the review period.

CONCLUSIONS OF LAW

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

Fla. Admin. Code 65-2.060, regarding evidence, informs as follows:

> (1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce

> or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

Because of this rule, burden of proof was on the respondent and would not be considered met. Notice of reduction is not supported by evidence at this time. In view of the stipulation setting forth favorable resolution and describing plan to restore 22 hours daily nursing service, it is appropriate to conclude that intent to reduce nursing hours has not been justified. This conclusion is favorable to the petitioner.

DECISION

The appeal is granted and nursing hour reduction is set aside.

NOTICE OF RIGHT TO APPEAL

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

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

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

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

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

[redacted]

APPEAL NO. 08F-00362

PETITIONER,

Vs.

CASE NO. 1122061021

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 February 15, 2008, at 8:30 a.m., in Fort Lauderdale, Florida. The hearing was rescheduled from January 30, 2008, at the respondent's request. The petitioner was not present. She was represented by [redacted] administrator of the [redacted] Pediatric Care Center. Also present from the care center was [redacted] registered nurse. The respondent was represented by Ken Hamblin, program operations administrator. Present from Children's Medical Services (CMS) was Dr. Bruce Rapaport, medical director; Carol Knall, registered nurse medical operations director; Mary Hooshmand, nursing director; Kathy Sandy, nursing supervisor; Marie Geffrard, registered nurse care coordinator; and Kevin Dottin, social worker.

ISSUE

At issue is the Agency's November 20, 2007 action of cancelling the petitioner's son's Prescribed Pediatric Extended Care (PPEC) services effective December 15, 2007, due to not meeting medical necessity. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner's son [redacted] date of birth October 31, 2000, is seven years old, and he has been receiving PPEC services through the Medicaid Program.

2. Included in the evidence is a copy of a CMS notice, dated November 16, 2007, stating that PPEC services were approved for September 1, 2007 through December 14, 2007 for the petitioner's son. Listed service numbers are T1026, T1025, which are after school care, and a full day's care when he is not in school. Also listed is service number 92507, which is speech therapy according to the petitioner's representative at the hearing.

3. Included in the evidence is a copy of a CMS notice from Dr. Joselyn Mateo, medical director, dated November 20, 2007, stating that PPEC services were cancelled effective December 15, 2007.

4. Included in the evidence is a copy of a CMS Child Assessment & Plan form, dated October 24, 2007, listing the petitioner's son's diagnosis of diabetes mellitus without mention of complication, attention deficit disorder of childhood with hyperactivity, asthma, contact dermatitis and other eczema with unspecified cause.

5. Included in the evidence is a copy of a letter, dated December 10, 2007, from Dr. Jaime Lambrecht, CMS regional medical director. The doctor agrees with the CMS Multidisciplinary Committee that criteria for continued PPEC services were not met for the petitioner's son.

6. At the hearing, Dr. Rapaport agreed with Dr. Joselyn Mateo, CMS north medical director; Dr. William Bruno, CMS south medical director; and Dr. Jaime Lambrecht, CMS regional medical director, that the action to cancel PPEC for the petitioner's son is correct.

7. Included in the evidence is a copy of a letter from the petitioner's treating physician, Dr. [redacted] dated February 12, 2008, stating that he disagrees with the action to cancel the petitioner's son's PPEC services.

8. Included in the evidence is a copy of a letter from the petitioner's son's school nurse [redacted] RN, stating that she disagrees with the action to cancel the petitioner's son's PPEC services.

9. Included in the evidence is a copy of a statement from [redacted] R.N. director of nursing at the [redacted] Pediatric Care Center, disagreeing with the action to cancel the PPEC services. At the hearing, the petitioner's representative, and [redacted] also disagreed with the action to cancel the PPEC services.

10. At the hearing, the individuals from CMS explained the decision to cancel the PPEC services, asserting that the petitioner's son's condition is not severe enough to attend such a restrictive environment of a medical day care facility.

CONCLUSIONS OF LAW

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

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

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

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

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

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

Purpose
The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Program is to enable children with medically-complex conditions or

the need for acute medical care to receive medical care at a non-residential pediatric center.

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

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

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

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

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

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

The petitioner's son's PPEC services through the Medicaid Program were cancelled. The physician that testified at the hearing agreed that cancellation of PPEC services for the petitioner is correct, due to him not meeting the medical necessity criteria. In addition to the physician that testified at the hearing, other physicians from CMS also agree that the cancellation of the PPEC services were correct. They are Dr. Joselyn Mateo, Dr. Jaime Lambrecht, and Dr. William Bruno.

The petitioner's treating physician, Dr. [redacted] disagrees with the action to cancel the petitioner's son's PPEC services. The petitioner's representative argued that medical necessity must be made by the treating physician. As explained at the hearing by the respondent's physician, and as in this case, sometimes physicians have different opinions. The petitioner's representative argued that another child receiving PPEC services has similar medical needs, and the petitioner's son should receive similar medical care. It is determined that the medical needs of another child cannot be considered in this hearing process, therefore a finding has not been made concerning the petitioner's son's medical needs compared to another child.

The petitioner's representative argued that CMS did not make other arrangements for the petitioner's son. On the November 20, 2007, notice informing the petitioner about the action taken, it states that she should contact her CMS care coordinator, who will assist her in arranging appropriate after school care. Individuals at the hearing from CMS explained that they tried to work with the petitioner to help her in arranging appropriate after school care, however she did not wish to do this because she wanted continued PPEC services.

A non medical day care facility should be able to handle the petitioner's son's needs. Evidence submitted supports the Agency's determination as to the appropriateness of the transition to an equally effective, less restrictive alternative. Based upon the evidence, including the petitioner's son's diagnosis and medical condition, and appropriate authorities, it is concluded that the plan to cease Medicaid authorization of PPEC, is a reasonable determination. After careful consideration, it is concluded that the Agency's action to cancel the petitioner's PPEC services, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, 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 17th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner

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

[redacted]

PETITIONER,

Vs

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

RESPONDENT.
_____/

APPEAL NO. 07F-06583

CASE NO. 1193707901

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on February 12, 2008 at 1:00 p.m. in Sanford, Florida. His mother, [redacted] represented the petitioner telephonically. The respondent was represented by Lissette Knott, human service program specialist, with testimony available from Ben Czeslowski, service authorization nurse, and by telephone, Larry Deeb, M.D. pediatrician. In order to accommodate the telephone appearance of the petitioner's mother, Respondent's Exhibit 2, which was submitted during the hearing, was mailed to her on date of hearing. The petitioner's mother was afforded opportunity to respond and submit additional information. Additional information was received and has been labeled. Information received on February 29, 2008 is Petitioner's Exhibit 1 and information received on March 4, 2008 is Petitioner's Exhibit 2. These are attached to this Final Order.

ISSUE

At issue was whether or not it was correct to cancel Prescribed Pediatric Extended Care (PPEC) services due to "medical condition no longer requires this type of care." The respondent had the burden of proof.

FINDINGS OF FACT

1. The petitioner was born on May 18, 2006 and because of serious health problems since birth, he began receiving PPEC services September 2006 under state-plan Medicaid. His mother also has significant health problems.

2. Following AHCA review during October 2007, the agency intended to discontinue PPEC effective November 9, 2007 due to insufficient need for such service. Notice was issued on October 30, 2007 (Respondent's Exhibit 1) and was appealed.

3. Pediatric Health Choice was the PPEC service provider. Request to continue PPEC was submitted by Pediatric Health Choice registered nurse case manager on October 24, 2007. Administrative guidelines and documentation from the AHCA review were in Respondent's Exhibit 2.

4. Information submitted by the provider during the review showed the petitioner was no longer on an apnea monitor, was eating everything by mouth, had gastrostomy tube in place but it was unused by PPEC over the last 6 months, and goal of walking while in PPEC was met. Physician's orders included "PPEC up to 6 days per week" with notation that discharge could be considered when the petitioner "no longer requires nursing." Medications included ½ tab of Prevacid and Tylenol as needed. Foods were Enfamil and pureed table food by mouth. Respiratory therapy was aerochamber, Albuterol puffs if coughing with option to increase and use nebulizer, plus Pulmicort, and

QVar with aerochamber. Safety precautions were "Universal precaution" plus basic crib safety, basic home and car safety measures. Medical supplies or durable medical equipment were the aerochamber and nebulizer.

5. Hospitalization for aspiration pneumonia occurred during September 2007 and asthma was diagnosed.

6. The petitioner's mother declared he has suffered from dehydration, she had been using the GTube, and in December the doctor had directed further use of the GTube at home for Pedialyte, and she had been using it, although she realized the PPEC did not. She thought she had a December 2007 medical order for use of the GTube for Pedialyte, but the new information (see next finding) did not establish such.

7. New information submitted after the hearing (Petitioner's Exhibit 1 and 2) from Pediatric Health Choice, showed that in February and March 2008, the prescribed service plan said "GT feed milk, juice, if having severe coughing spells...a feeding pump is being ordered so GT feedings can be given slowly to prevent vomiting and aspiration." On February 26, 2008, the doctor's prescription said, "Please use GTube for Pedialyte or feedings and patient's medicines if pt is sick." (This information or similar data was not submitted for the October 2007 PPEC review or before cancellation intended November 9, 2007).

CONCLUSIONS OF LAW

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

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** (emphasis added).

Additionally relevant is Fla. Admin. Code 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, February 2007, 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's website....

The Florida Medicaid **Prescribed Pediatric Extended Care Services Coverage and Limitations Handbook** informs in Chapters 1 and 2 as follows:

> **Purpose**
> The purpose of the Florida Medicaid Prescribed Pediatric Extended Care (PPEC) Program is to enable children with medically-complex conditions 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 non-residential facility that serves three or more children under the age of 21 who require short, long-term, or intermittent medical care due to medically-complex conditions. 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 complex or medically fragile...
> • Be age 20 or under;
> • Be medically stable; and
> • Require short, long-term or intermittent continuous therapeutic interventions or skilled nursing supervision due to a medically-complex condition.
>
> **Definition of Medically Necessary or Medical Necessity**
> Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service...
>
> **Approval of Services**
> PPEC services must be:
> • Ordered by an attending physician or the Medicaid physician consultant;
> • Outlined in the plan of care that is written by the PPEC center...
> • Authorized by Medicaid or an approved designee.

Under appropriate statute and administrative guidelines, AHCA 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 would best be met in PPEC and that PPEC should have been using the GTube, evidence did not support such during the review process or before date of hearing. Moreover, the PPEC goals had been met, nutrition at PPEC was not achieved via GTube, and PPEC staff had provided the information upon which AHCA review occurred.

As of the October 2007 review period and cancellation on November 9, 2007, the information available from the appropriate source did not support need for skilled intervention or supervision of a medically complex situation. Available information supported the AHCA plan to discontinue PPEC services as set forth on notice of October 30, 2007. Thus, it is concluded that cancellation notice was justified as issued.

DECISION

The appeal is denied and the agency action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24th day of March, 2008, in Tallahassee, Florida.

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

Copies & attachments furnished to: [redacted] Petitioner
Judy Jacobs, Area 7 Medicaid Adm.

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

[redacted]

APPEAL NO. 08F-00031

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 23, 2008, at 11:00 a.m., in Fort Lauderdale, Florida. The petitioner was present with his mother [redacted] and his brother [redacted] Also present was [redacted] and [redacted] registered nurses from [redacted] Nursing Services. The respondent was represented by Ken Hamblin, program operations administrator. Also present from AHCA was Yvonne Vargas, human services specialist. Present from Children's Medical Services was Carolyn Nall, registered nurse medical operations director; Kathy Sandy, nursing supervisor; Eneida Medina, social worker; and case managers Jocelyn Mateo and Cassandra Stephens.

ISSUE

At issue is the Agency's December 21, 2007 action of approving the petitioner for skilled home nursing services for 23 hours daily from January 1, 2008 to January 3, 2008,

then for 20 hours daily from January 4, 2008 to February 3, 2008, then for 16 hours daily from February 4, 2008 to February 29, 2008. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner, date of birth .. , is seven years old, and he receives skilled home nursing services through the Medicaid Program.

2. Included in the evidence are copies of Children's Medical Services (CMS) notices dated December 21, 2007. They state that home health services have been approved for the petitioner for 23 hours daily from January 1, 2008 to January 3, 2008, then for 20 hours daily from January 4, 2008 to February 3, 2008, then for 16 hours daily from February 4, 2008 to February 29, 2008.

3. Previous to January 2008, the petitioner was receiving 23 hours of daily skilled home nursing services, and in this appeal, these amount of services are being requested.

4. Included in the evidence is a copy of a CMS Child Assessment & Plan Care Coordination Assessment form dated December 17, 2007. According to this assessment form, the petitioner has a diagnosis of convulsions, a mixed development disorder, and other congenital anomalies of the larynx, trachea, and bronchus.

5. According to the December 17, 2007 CMS assessment form, the petitioner receives G-Tube feedings, and he takes nothing by mouth. He is incontinent of bladder and bowel, and he wears diapers. He has a wheelchair, and in addition to receiving services through CMS, he receives Medicaid benefits, SSI benefits, and WIC benefits.

6. According to the individuals at the hearing from Children's Medical Services (CMS), Dr. Lambert and Dr. Bruno from CMS agree with the CMS team that the action taken concerning the number of hours of the petitioner's skilled home nursing care was correct.

7. Also according to the individuals at the hearing from CMS, the petitioner should go to PPEC, which is a day care facility. The petitioner's mother's position is that he should not go to a PPEC facility.

8. Included in the evidence is a copy of a statement from Dr. [redacted] dated January 7, 2008, stating that the petitioner was diagnosed with static encephalopathy, gastoesophageal reflux, hypoxemia, recurrent aspiration pneumonia, upper airway obstruction, status post tracheostomy, and bleeding ulcers. The doctor's recommendation is to provide the petitioner with 23 hours of daily nursing care.

9. Included in the evidence is a copy of a statement from Dr. [redacted] dated January 7, 2008. The doctor states that the petitioner has apnea episodes, and seizures, and that it is medically necessary for him to have 23 hours of daily skilled nursing care.

CONCLUSIONS OF LAW

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

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

> (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

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

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary. The petitioner's skilled home nursing services was approved for 23 hours daily from January 1, 2008 to January 3, 2008, then for 20 hours

daily from January 4, 2008 to February 3, 2008, then for 16 hours daily from February 4, 2008 to February 29, 2008. According to individuals at CMS, there are two doctors that agree with this action. Statements from these doctors were not submitted into evidence.

According to Dr. [redacted] and Dr. [redacted] they disagree with the Agency's action, and assert that 23 hours of daily skilled nursing services are medically necessary for the petitioner. Careful consideration of the proper authorities and evidence, including the petitioner's diagnosis and condition were taken into account in making this decision. The Fla. Admin. Code 65-2.060 explains that the burden of proof is on the party asserting the affirmative of an issue. In this case, the respondent has the burden of proof.

It is determined that the Agency did not meet its burden of proof to show that the action taken was correct. It is therefore determined that the action to approve the petitioner's skilled home nursing services for 23 hours daily from January 1, 2008 to January 3, 2008, then for 20 hours daily from January 4, 2008 to February 3, 2008, then for 16 hours daily from February 4, 2008 to February 29, 2008, is not upheld.

DECISION

The appeal is granted, as explained in the Conclusions Of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: Christopher Marks, Petitioner
Gail Wilk, Area 10 Medicaid Adm.

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

[redacted]

APPEAL NO. 07F-07529

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on January 30, 2007, at 10:47 a.m., in Bradenton, Florida. The petitioner was not present but was represented by his mother, [redacted] who also testified. Pat Brooks, program office administrator for the Area 8 Agency For Health Care Administration (AHCA), represented the respondent and testified. Karen Smith, registered nurse specialist with AHCA, appeared as a witness.

Two persons with Kepro appeared as witnesses for the respondent by telephone: Teresa Ashey, nurse reviewer, and Dr. Rakesh Mattal, pediatrician and physician reviewer.

ISSUE

At issue is the respondent's decision of November 29, 2007 to reduce the amount of private duty nursing (PDN) hours paid by Medicaid from 16 hours daily

daily, 7 days weekly, to 8 hours daily, 7 days weekly. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is about 18 months old. The petitioner lives with and receives care from his 20 year-old mother, [redacted] There are no other children in the home.
2. The petitioner has diagnoses to include Down's Syndrome, tetralogy of Fallot, AV Canal and significant Pulmonal Stenosis, obstructive sleep apnea, dysphasia, and precardial effusion. The petitioner receives G-tube feedings three times daily, with g-tube continuous at night. Oxygen is received only as needed. The petitioner has a trach which requires frequent suctioning. The petitioner does not have seizures.
3. The petitioner receives Prescribed Pediatric Extended Care (PPEC) from 8:00 to 3:00 p.m. The petitioner's mother is not presently employed. It is difficult for the petitioner's mother to seek employment due to the lack of transportation. Further, the petitioner had had difficulty in finding nurses to care for the petitioner, except from 11 p.m. to 7 a.m. The petitioner knows how to provide care to the petitioner.
4. The respondent's reviewing medical physicians at Kepro continue to approve nursing for the hours 11 p.m. to 7 a.m. Kepro believes

that the petitioner could provide care while the child is not at PPEC, from 3:00 p.m. to 11:00 p.m.

CONCLUSIONS OF LAW

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

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

Paragraph 2. of the above rule shows that services must not be "in excess of the individual's needs" to be defined "medically necessary," per the above definition. Findings show that the contracted Kepro reviewing physician recommends the reduction of nursing services to 8 hours daily, 7 days weekly.

The petitioner's caregiver is capable to provide needed care to the

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

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

It is concluded that the respondent decision to reduce approved nursing hours to 11 p.m. to 7 a.m. is reasonable, given the petitioner's responsibility to provide care to the fullest extent possible. These evening hours should allow the caregiver to have needed sleep. The hours the petitioner is in PPEC should permit the caregiver to perform any other needed household activities.

In sum, the respondent has met the burden to prove the defined medical necessity for PDN hours at 8 hours daily, 7 days weekly. If the petitioner's and/or his caregiver's circumstances change to warrant a request for an increase in PDN hours, the petitioner may request such hours.

DECISION

This appeal is denied in that the respondent has met the burden to prove defined medical necessity for a decrease in private duty nursing hours to 8 hours daily, 7 days weekly.

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 11th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting

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

[redacted]

APPEAL NO. 07F-6496

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 January 9, 2008, at 9:45 a.m., in Miami, Florida. The petitioner, [redacted] was present however she was represented by her parents, [redacted] and [redacted]. Present, on behalf of the respondent was Jeffrey Douglas, program administrator with the Agency for Health Care Administration (AHCA). Appearing telephonically as witnesses for the agency was Dr. Rakah Miettel, physician reviewer and Mary Wheeler, nurse reviewer, both with Keystone Peer Review Organization (KēPRO) South. Carlos Rodriguez, specialist with AHCA served as translator. The hearing was previously scheduled for December 4, 2007, but was continued at the request of the petitioner.

ISSUE

At issue is the agency's action on September 29, 2007 and October 16, 2007 in denying 720 hours (12 hours daily, 7 days a week) of private duty nursing (PDN). The

certification period is for October 1, 2007 through November 29, 2007. The agency has the burden of proof.

FINDINGS OF FACT

1. The petitioner is fourteen years old and a Medicaid beneficiary in the state of Florida. The petitioner's medical condition as reported to the agency was: "Quadriplegia, unspecified, Other/Unspecified intracranial injury without open intracranial wound with brief (<1 hour) loss consciousness."

2. On September 28, 2007, the provider (RGR LLC [home health agency]) requested 720 (12 hours daily, 7 days a week, 7pm-7am) of skilled nursing hours, for the petitioner for the certification period. This request was denied, as information in order to determine medical necessity was requested and was not provided.

3. Home health aide (HHA) hours were also requested in the amount of 304 (3pm-7pm Monday-Friday) (9am-5pm on weekends). HHA hours were approved in its entirety and are not at issue.

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

5. An initial screening of the request was performed by a registered nurse reviewer that referred the request to a board-certified pediatrician for review of medical necessity for the level of service that was being requested.

6. A KēPRO physician consultant reviewed the request and additional specific information was requested such as, times of feedings; how many feedings; date of last seizure; frequency of seizure; reason for night feeding; and time medication is administered. A response was not received with the detailed information that was requested. The physician reviewer denied the PDN request, "based on the incomplete info given" (Respondent's Composite Exhibit 1). The physician reviewer was provided with the petitioner's medical and social information.

7. On September 29, 2007, the provider and the petitioner were informed of the denial, of the 720 PDN hours that had been requested for the certification period of October 1, 2007 through November 29, 2007.

8. On October 1, 2007, the provider submitted additional information which is documented by KēPRO in their electronic record as follows: "Trileptal is given bid, baclofen tid, valium prn. G-tube feedings given twice during the shift."

9. A second board certified in pediatrics physician consultant reviewed the initial denial of the request for 720 hours of PDN. The additional information was considered as well. The second physician reviewer denied the request documenting, "We need exact times during the shift, and I must add the question why are these bolus feedings done through the night and specifically what times as was asked by physician consultant. I would have to uphold the Denial because provider failed to submit the necessary

information which was requested by the physician consultant. Detailed clinical treatment plan may have provided the necessary clinical information to support medical necessity for skilled nursing. Since this information is not known I cannot reverse the decision by the physician consultant and therefore I will have to uphold the denial."

10. On October 16, 2007, a PDN/PC Recipient Reconsideration-Denial Upheld letter was issued to the petitioner and the provider.

11. The petitioner requested a hearing on the issue on November 2, 2007 and benefits have continued at its prior level, pending the outcome of the hearing.

CONCLUSIONS OF LAW

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

Fla. Admin. Code 59.G-1.010, "Definitions", states for medical necessity:

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

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

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

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

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

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

The Home Health Services Coverage and Limitation Handbook (July 2007) under Private Duty Nursing Services states in part:

Private Duty Nursing *Requirements*-Private duty nursing services *must* be: ... Documented as medically necessary;... Consistent with the physician approved plan of care; and Prior authorized before services are provided.

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.

Authorization Process-Private duty nursing services are authorized by the Medicaid peer review organization if the services are determined to be medically necessary. Private duty nursing services will be decreased over time as parents and caregivers are taught skills to care for their child and are capable of safely providing that care or as the child's condition improves.

Prior Authorization-All private duty nursing services must be prior authorized by the Medicaid peer review organization prior to the delivery of services. Note: See Prior Authorization in this chapter for additional information.

Prior Authorization for Private Duty Nursing or Personal Care-Description Prior authorization is the approval process required prior to providing certain services to recipients under 21 years of age. Medicaid will not reimburse for these services without prior authorization when it is required.

Services *Requiring* Prior Authorization-The following home health services require prior authorization for reimbursement: Private duty nursing; ...

Requesting Prior Authorization-All requests for prior authorization must be submitted to the Medicaid peer review organization ... *At a minimum*, the prior authorization request must include:

- Recipient's name, date of birth and Medicaid ID number;
- Recipient's current health status, including diagnoses codes; brief medical history by the physician; and the medical necessity of the service;
- Type of service needed described by procedure code;
- Planned dates and times of service;
- Units of service requested;
- Treating provider's Medicaid provider number, name and address;
- Attending physician's authorized plan of care;
- Other documentation requested by Medicaid such as the caregiver's availability and ability to provide care.

Approval Process-The Medicaid peer review organization will review each request and approve, deny or request additional information to support the request.

The parents state that in the past they have had incidents of administering the wrong dosages of the petitioner's medications, since there is a language barrier. The petitioner was attending PPEC until November 2007 and then started a new program at [redacted]Hospital. The HHA helps to administer the petitioner's medications as well. The petitioner's mother states that they have a 17 year old son and that her husband has a vision impairment. They state that their daughter needs various feedings and has to be repositioned and they require help at night, if not skilled nursing some other assistance.

The physician consultant responded by saying that the information that was requested in order to determine medical necessity for the level of service that was being requested was not provided. Therefore, they were unable to determine medical necessity and the request for 720 hours of PDN was denied. The physician consultant stated that the parents "should be OK" with administering the petitioner's medication as instructions and training are available in spanish.

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible and that the provider, at a minimum is required to submit certain information and additional information/documentation can be requested. Medical necessity must be demonstrated before a requested level of service is approved. In this case, additional detailed information was requested and was not provided. The respondent denied the request as it could not determine medical necessity for the service.

Based on the above cited authorities, the respondent's action to deny the request for 720 PDN hours due to, requested information that was not provided was within the rules of the Program and is affirmed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 6th day of March, 2008,

in Tallahassee, Florida.

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

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

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

[redacted]

APPEAL NO. 07F-06007

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on January 22, 2008, at 3:50 p.m., in Ocala, Florida. The petitioner was not present but was represented by his mother, [redacted] who also testified. The petitioner's step-father, [redacted] appeared as a witness for the petitioner. Greg Hathaway, Medicaid health care program analyst with the Agency for Health Care Administration (AHCA), represented the respondent and testified. Scottie Townsend, Medicaid Waiver support coordinator with ADEPT Community Services, appeared as a witness for the petitioner.

Two persons with Kepro appeared as witnesses for the respondent by telephone: Mary Wheeler, review operations manager, and Dr. Rakesh Mattal, physician reviewer with Kepro South.

The hearing record was held open for an additional 30 day period to allow time for the nursing agency to enter information on their data exchange for Kepro to review. On January 31, 2008, the respondent sent another notice to advise that the original termination of private duty nursing (PDN) hours had been overturned. This response is labeled Respondent Exhibit 3.

ISSUE

At issue is the respondent's decision of September 20, 2007 to terminate private duty nursing (PDN) hours paid by Medicaid. The petitioner previously received PDN hours 10 hours daily, 5 days weekly, prior to the termination action at issue. The respondent did not believe the petitioner meets medical necessity criteria for continued PDN hours. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is ten years old. The petitioner has diagnoses of diabetes insipidus, epilepsy, and respiratory disease. The petitioner lives with and receives care from his mother. The petitioner's mother is not presently working. The petitioner's step-father works for the Sheriff's Department as a correctional officer, and lives in the home.
2. The Kepro reviewing physician first opined there was insufficient information to conclude that continued PDN services were medically necessary. Kepro made this decision based solely on the minimal information provided for review by the nursing provider.

The respondent sent notice dated September 20, 2007 that PDN hours were terminated.

3. The hearing record was held open for thirty days to allow for additional time for information to be submitted in the nursing notes. Kepro was to then review this information and determine if their position changed on the matters at issue.
4. On February 1, 2008, the respondent representative sent this hearing authority an AHCA notice to the petitioner dated January 31, 2008. This notice advises that the respondent has now approved all requested nursing hours that were previously terminated.

CONCLUSIONS OF LAW

Findings establish that the respondent has now approved all the requested PDN hours at issue. Therefore, the matters of this appeal have been made moot by the respondent decision to approve the hours that had been originally denied or terminated. Thus, the appeal is dismissed or denied as moot since the requested PDN hours have been approved, per notice dated January 31, 2008.

DECISION

This appeal is dismissed or denied as moot. The respondent AHCA has agreed to provide and continue the requested PDN hours that were at issue.

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 17th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Marilyn Schlott, Area 3 Medicaid Adm.

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

[redacted]

APPEAL NO. 07F-07271

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 March 5, 2008, at 2:35 p.m., in Miami, Florida. The petitioner was not present. [redacted] petitioner's father, represented the petitioner. Sandy Moss, program administrator, Agency for Health Care Administration, represented the agency. Maria Hernandez, operation and management I, Agency for Health Care Administration, was present on behalf of the agency. Also present as witnesses for the agency, via the telephone, from Keystone Peer Review Organization (KePRO), were Dr. Rakesh Mittel, physician reviewer and Theresa Ashey, RN reviewer. This hearing, originally scheduled for January 9, 2008, was continued at the request of the petitioner.

ISSUE

At issue is the agency's action of January 11, 2008, to deny 60 hours of Private Duty Nursing services (PDN) of 1,120 requested, for the period of December 27, 2007

through February 24, 2008, because the medical care as described to them was not medically necessary. Since this was a request for an increase in hours from the previous certification period, the petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, [redacted], two years of age, was born at 24 weeks gestation. He is the first born of the [redacted] triplets. [redacted] has chronic lung disease and stage III retinopathy of prematurity. He also has severe esophageal reflux and must be watched for aspiration. He needs to be monitored and transported to frequent doctor appointments.

2. [redacted] mother has a history of seizures and cannot be left alone with the children. [redacted] father works from 5:30 p.m. to 5:30 a.m., Monday through Saturday.

3. On November 8, 2007, Maxim Healthcare Services, as the provider, submitted a request on behalf of the petitioner for 1,120 hours of PDN, 16 hours a day, Monday through Friday, and 24 hours on weekends and days PPEC is closed, for the period of December 27, 2007 through February 24, 2008.

4. KePRO is the Peer Review Organization contracted by the Agency for Health Care Administration (AHCA) to perform medical review for the private nursing and personal care prior authorization program for Medicaid beneficiaries in the state of Florida. This service is reviewed every 60 days.

5. On January 5, 2008, a board certified pediatric specialty physician consultant reviewed the request. Based on the information provided, the physician consultant determined that the petitioner's father can provide care on Sunday evening and morning

afternoon before going to work. Therefore, the physician consultant denied PDN hours on Sunday from 5:00 p.m. to 9:00 p.m. and on Monday from 3:00 p.m. to 5:00 p.m.

6. A notice was sent to the petitioner on January 11, 2008. The notice denied 60 hours and approved 1,060 of Private Duty Nursing for the period of December 27, 2007 through February 24, 2008.

7. On December 25, 2007, the request was reviewed by a second board certified pediatric specialty physician consultant who had not issued the initial denial. This physician consultant agreed with the denial of hours stated for Monday and Sunday only, when both parents are available.

8. At the hearing, the petitioner stated that he agrees with this determination.

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

The agency, through KePRO, took action on January 11, 2008, to deny 60 hours of Private Duty Nursing services (PDN) for the period of December 27, 2007 through

February 24, 2008. The rationale for this denial is that the petitioner's father is able to assist in the care of the petitioner on Sunday, from 5:00 p.m. to 9:00 p.m., and on Monday, from 3:00 p.m. to 5:00 p.m. The petitioner stipulated that he agrees with this decision.

After considering the evidence, the Florida Administrative Code Rules and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21st day of March 2008,

in Tallahassee, Florida.

Alfredo Fernandez

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

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

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

[redacted]

APPEAL NO. 07F-07346

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 18, 2008, at 9:52 a.m., in Tampa, Florida. The petitioner was not present. He was represented by his mother, [redacted] Also present on behalf of the petitioner was the petitioner's grandmother, [redacted] The Agency was represented by Ann Williams, registered nurse specialist. Witness for the Agency from Keystone Peer Review Organization (KePRO) were Rakesh Mittal, M.D., physician reviewer, and Mary Wheeler, review operation manager.

ISSUE

The petitioner is appealing the notice of November 30, 2007 for the respondent's action to deny 240 hours private duty nursing hours for the period of November 15, 2007 through January 13, 2008 from a request for 858 hours.

FINDINGS OF FACT

1. The petitioner is one year of age and is a Medicaid recipient. The petitioner's care is medically complex. For the previous 60 days period ending November 14, 2007, the petitioner was receiving 1,064 hours private duty nursing. The private duty nursing is provided by Maxim Healthcare Services Incorporated. The petitioner resides with his mother and his father. At the time of the denial, the petitioner's mother was in school and the petitioner's father was working. There are no other children in the home.

2. The Maxim Healthcare Services Incorporated, as the provider, submitted a request for 858 hours of private duty nursing for the period of November 15, 2007 through January 13, 2008.

3. The respondent has contracted KePRO to determine the number of service hours for private duty nursing. KePRO is the contract provider for the respondent for the prior authorization decisions for private duty nursing. Private duty nursing is reviewed every 60 days. KePRO received this request on November 29, 2007. The request for private duty nursing is reviewed by a nurse reviewer and a physician consultant.

4. The initial nurse reviewer screened the petitioner's request for private duty nursing using the Internal Focus Finding. The Internal Focus Finding provides information to KePRO of case identifiers and additional information regarding the petitioner. This information is generated to the computer for review by KePRO from the information entered by the petitioner's home health agency

via computer. The request was then referred to the board certified physician consultant.

5. The initial board certified pediatric specialty physician consultant determined was based on the information received from the nursing agency. Based on the documentation, the physician consultant approved 572 hours and denied 286 hours for the period of November 15, 2007 through January 13, 2008. The physician consultant indicated: "...1 ½ year old with developmental delay, seizures, trach, g-tube. Dad works M-F and is home by 5pm. Mom attends school T, Th, F and 1 hour commute to school. Skilled nursing request is medically necessary, however, 858 for this cert period is excessive. Agree with daytime coverage T, Th, F while mom is at school, but would reduce the nightly request of 7p-7a to 11p-7a." A notice denying 286 hours was sent to the petitioner on November 30, 2007.

6. The nursing agency requested a reconsideration. The reconsideration was reviewed by a second physician consultant. The reconsideration was denied for the 240 hours of private duty nursing. The second physician consultant stated: "...Physician consultant is denying nightly requested hours between 7pm and 11pm. It would seem that father is home at this time, and can provide care, as the provider has stated above he is capable of doing so. This would continue to assist mother the primary caregiver with studying in the evening, as father is available to provide the care. I suggest to UPHOLD the DENIAL as proposed by the physician consultant." The respondent sent a PDN/PC Recipient Reconsideration - Denial Upheld notice on December 5,

2007. Additionally noted on December 5, 2007: "Please note that the calculation of approved/denied hours on the initial review was incorrect. The correct calculation was 618 approved/240 denied...".

7. The petitioner's mother requested additional hours for her to do homework while the petitioner's father is out of town working. The father is working out of town from Monday to either Wednesday or Thursday night. He will be out of town two to three nights a week for approximately five months.

8. This information was not given to KePRO. This information was not available at the time of the review. The physician reviewer attested that had KePRO know that the father was out of town on those nights the hours would have been approved.

CONCLUSIONS OF LAW

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

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

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

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

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

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

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

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

The handbook sets forth that parents and caregivers must participate in providing care to the fullest extent possible. The denial was based on the availability of the mother. The information of the additional nights the petitioner's father was out of town was not given to KePRO. This information was not available at the time of the review. The physician reviewer attested that had KePRO know that the father was out of town on those nights the hours would

have been approved. The hearing officer concludes that KePRO did not have all the information necessary to make their determination. The nursing agency requested 848 hours of private duty nursing for the period of November 15, 2007 through January 13, 2008. Based on the above cited authorities, the respondent's action to deny 240 hours of private duty nursing for the period of November 15, 2007 through January 13, 2008 is reversed.

DECISION

This appeal is granted.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 7th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting

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

[redacted]

APPEAL NO. 07F-05201

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 14 Polk
UNIT:

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on October 19, 2007, at 1:16 p.m., in Lakeland, Florida. The petitioner was not present. She was represented by [redacted] case manager with Heartland for children; and [redacted] guardian ad litem. The respondent was represented by Roxanne Marques, utilization review specialist with the agency. Present as witnesses for the respondent telephonically were Ann Marie Gersch, R.N., reviewer and Dr. Diane Majcher, physician advisor.

The respondent was allowed 14 days to return further evidence and review their determination. Evidence was received from the respondent on November 1, 2007. It was accepted as Respondent's Exhibit 11.

ISSUE

At issue is the September 3, 2007 action by the agency denying Medicaid payment for Statewide Inpatient Psychiatric Program (SIPP) services beginning September 4, 2007.

FINDINGS OF FACT

1. The petitioner is a 15-year-old female with a history of self-injurious behavior. She was admitted to United Behavior Center (UBC) for inpatient treatment on October 6, 2006. First Health Services reviews mental health services to see if they meet the "medically necessary" criteria for Medicaid payment. A significant requirement for inpatient services is that the patient be "at risk for potential harm to themselves or others."
2. Inpatient psychiatric services are mental health services that require prior authorization. Proviso language adopted by the Florida State Legislature in May 2002, requires AHCA to adopt a prior authorization process using a targeted utilization management approach. First Health Services, Inc. is the contracted agency that determines "medical necessity" of prior authorization requests for AHCA. On behalf of AHCA, First Health Services performs all SIPP admissions and continued stay reviews of services provided to Medicaid recipients under the age of 18 years old.
3. It is noted that the petitioner now resides in [redacted] Residential Treatment Center where she is receiving Inpatient Psychiatric Services. The [redacted] Center has a Therapeutic Group Home on site. It is available to transition the petitioner when she is deemed qualified for the step down in services.

4. The petitioner has been diagnosed with Post Traumatic Stress Syndrome, Melancholic Depression, Personality Disorder, and Obsessive Compulsive Disorder. She has a history of three admissions for inpatient services, several Baker-Acts, and multiple treatments for mental health disorders. She demonstrates self-injurious behaviors, and non-compliance acts of aggression. Her medications included Thorazine, Seroquel, Wellbutrin, and Prozac.

5. The petitioner was in treatment at the center in July 2007 when a review of Medicaid payment for inpatient services occurred. On July 5, 2007, First Health Services reviewed the petitioner's request for inpatient treatment for the period of July 6, 2007 through August 4, 2007. The reviewer approved the petitioner for inpatient services for the period requested but stated "Certification for hospitalization beyond August 4, 2007 was found to be "not necessary" under the terms of the Medicaid Program.

6. In making their decision, the reviewer recorded the following comments:

> Pt appears to have deteriorated recently in her behaviors, with increased non-compliance, aggression, and self-injurious behaviors. In the past month, she has required ten PRNS of Thorazine 150 mg IM. In spite of this, her dose of Seroquel has been reduced and is now at 250 mg q AM. Her Prozac has been increased to 60 mg q AM and Wellbutrin XR 300 mg q AM has been added. It is possible that the Prozac/Wellbutrin combination is increasing her agitation. She has described feeling helpless and hopeless, her irritability has increased. Pt has responded only minimally to med changes, except (perhaps) in negative ways. Behavioral interventions appear not to have been any more successful than pharmacologic ones. In spite of the failure to respond to what should have been an adequate intervention in this SIPP program, the patient's recent deterioration makes it difficult for her to be discharged to a less restrictive level of care. Will give partial approval for 30 days for problems to be addressed and improved...

7. The petitioner requested a reconsideration of this decision on July 9, 2007. First Health Services conducted a peer review with Dr. Malik. The comments from this review were the following:

   Dr. Malik called for scheduled peer review. She reports that pt has true melancholic MDD (Melancholic Depressive Disorder). She was fairly recently transferred to her current unit as she had not been working the program well on the previous unit, which is largely for girls with PTSD and similar issue. The current unit has a lot of girls with conduct d/o. Although pt does not have this dx, she tends to mimic the girls who do. She repeatedly bangs her head; this serves also to get staff attention. Pt sabotages herself whenever she is noted to make gains. There has been a minimal improvement in her affect. One of the few things that appear to have been helpful (at least on a temporary basis) has been outings for community service. She return from them calmer and happier. Dr. agrees that pt's long-term prognosis is "bleak." She is currently working to reduce the pt's daily meds, as she believes that the dose of Seroquel, in particular was too high and made pt tired and a bit agitated. After discussion, Dr. stated that a step down to less restrictive care might actually be in pt's pest interests.

8. The petitioner filed another request for reconsideration on July 23, 2007. On July 25, 2007, First Health Services considered the latest request and recorded the following comments:

   Case review notes and hospital records available were reviewed to make a SIPP Reconsideration determination. Pt. is a 14 y/o female with a dx of PTSD, Major Depression, and IED (Intermittent Explosive Disorder) who was admitted to SIPP (State Inpatient Psychiatric Program) Care on 10/9/06 due to severe mood symptoms and aggressive outbursts and self-abusive behaviors. Pt. was stabilized on her meds (Seroquel, Prozac, Wellbutrin XL, Depakote ER, Trazadone, and Thorazine on a PRN basis. On July 10, 2007, Staff Psychiatrist was reported to have said that pt was banging her head as per record. On July 19, 2007, pt was reported to have felt better with the med changes as per record. Partial approval is recommended for 30 days for stabilization of pt's symptoms and to allow for a smooth transition to her discharge. No further days can be approved as pt. doesn't meet Criteria C for further hospitalization.

9. The petitioner submitted a Suitability Assessment – 90 day Review completed July 1, 2007. The assessment was completed by Anastasia Wells, Ph.D. licensed psychologist. This was an independent Qualified Evaluator as required by the 2000 Florida Legislature. The review is required every 90 days for a child in the care and custody of the Department of Children and Families. The report explained that the petitioner:

> ...was admitted for inpatient services due to noncompliance with medications, running away, self-injury, aggressiveness, and property destruction. The onset of her behavior problems began when she was eleven after both of her adoptive parents died. She was aggressive toward her foster parents, staff, and a police officer. She was also self-injurious, had severe mood swings, and destroyed property in the foster homes. She was in PEMS for seven months for assaulting the police officer and was Baker Acted from there for head banging and cutting on herself...

The psychiatrist reviewed the petitioner's records including a psychiatric evaluation, psychiatric progress notes, psychiatric progress reports, therapy progress reports, master treatment plan, treatment plan review, and prior suitability assessments. A face-to-face interview was held with the petitioner. The petitioner's treatment goals were:

Comply with unit regulations
Be compliant with medication
Exhibit no homicidal or suicidal ideation
Eliminate outbursts of temper
Do away with threats of physical aggressive to self or others
Identify coping skills to improve impulse control

The records were summarized along with current treatment outcomes stating:

Records indicate that throughout June, [redacted] appears to have regressed behaviorally. She was noncompliant with medication, refused to attend

groups, and had to be restrained numerous times with PRN's. For example, she was restrained and given PRNs on 6/6, 6/7, 6/8, 6/13, 6/16, 6/22, 6/23, 6/24, 6/26, and 6/27. She also began head banging again and appeared to be depressed appearing disheveled and voicing some suicidal ideation. Some psychomotor retardation was also noted earlier in the month. As of June 25th, [redacted] had only met 54% of her goals. She has remained on Level 1 since her admission. On May 23rd, she was transferred to the Promises unit.

The psychiatrist interviewed the petitioner and made the following observations:

Her fund of general information was fair to poor. She only knew a few simple facts that are commonly known by most high school students....Insight and practical reasoning were assess to be very poor...Her mood was depressed. Affect was sad and despondent. Toward the end of the session, she implied that 'I've given up. Things are hopeless'...She denied excessive crying or any self-destructive thoughts. [redacted] said "I have not banged my head in five days.' [redacted] has problems with anger management and claims to be at a loss as to what the triggers are for such behavior.. [redacted] came across as a depressed despondent young lady who also exhibits many passive personality traits.

The psychiatrist made the following recommendations:

Her progress has been very inconsistent since this UBC admission and since early June, her behavior has regressed almost completely requiring numerous restraints and PRNS. [redacted] has returned to head banging and noncompliance. However, the most salient issue currently is that she has been diagnosed as having a severe major depression. Sadness, some psychomotor retardation, withdrawal, and a disinterest in personal grooming have been reported. During the interview with [redacted], the examiner noted considerable despondency and a sense of hopelessness. Because of the seriousness of her regressed behavior, a recommendation is made that she continues with her current level of care. Since she has benefited from previous UBC treatment, it is likely that she will eventually benefit from this continued level of care as well.

Dr. Wells recommended continued inpatient treatment in a psychiatric residential placement.

10. When asked about the justification for discharging the petitioner when her current behaviors appeared to be unstable, the respondent replied that they "saw improvement in her behaviors" the early part of July 2007 with a change in her medications.

CONCLUSIONS OF LAW

Florida Administrative Code 59G-4.050. Community Behavioral Health Services sets the guidelines for compliance for providers and states:

> (1) This rule applies to all community mental health services providers enrolled in the Medicaid program.
>
> (2) All community behavioral health services providers enrolled in the Medicaid program must be in compliance with the Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook, October 2004, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

Medical services that are covered under Medicaid are defined as being "medically necessary" and are set forth in the Florida Administrative Code Rule 59G-1.010(166)(a)(c) as follows:

> "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.

Fla. Admin. Code 65A 1-702 defines SIPP as:

(16) Statewide Inpatient Psychiatric Program (SIPP) waiver. This program provides inpatient mental health treatment and comprehensive case management planning to enable discharge to less restrictive settings in the community for children under the age of 18 who are placed in an inpatient psychiatric program. Those who are Medically Needy and those who are Medicare recipients are excluded from this program. Services must be received from a designated provider selected by AHCA. This program provides an exception to provisions that residents of an institution for mental disease (IMD) are not eligible for Medicaid.

The Code of Federal Regulations at 42 C. F. R. 441.152 Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs states:

Certification of need for services.
(a) A team specified in Sec. 441.154 must certify that--
(1) Ambulatory care resources available in the community

do not meet the treatment needs of the recipient;
(2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
(3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.
(b) The certification specified in this section and in Sec. 441.153 satisfies the utilization control requirement for physician certification in Sec. 456.60, 456.160, and 456.360 of this subchapter.

AHCA/First Health Services Manual, June 1, 2006, defines Utilization Management for the SIPP and states:

Each admission must be prior approved by an independent team that includes a physician advisor not employed by the program. Admissions must be reviewed regularly to ensure that a child continues to meet medical necessity for this level of care and is receiving active treatment, as defined in Code of Federal Regulation, CFR 441.151.
The SIPP Program includes the following utilization management components:
1) Prior authorization of all Medicaid SIPP admissions.
2) Continued stay reviews conducted for all Medicaid SIPP admissions: at least every twenty-one (21) days for children under 10 years of age and at least every thirty (30) days for children ages 10 years and older.
3) On-site annual reviews to evaluate medical necessity criteria and quality of care.

In summary, the SIPP waiver permits Florida's Medicaid Program to:

1. provide specialized psychiatric residential inpatient diagnostic and active treatment services to high-risk recipients under age 18;
2. provide utilization management to ensure appropriateness of admission, length of stay, quality of care; and
3. reduce recidivism by providing or facilitating aftercare services and/or linkages with appropriate community services.

The manual also states:

Estimated Length of Stay and Discharge Planning
At each continued stay review, the facility should address the estimated length of stay for the recipient and plans for discharge. There should be basic agreement regarding length of stay and the anticipated date of discharge.
At each continued stay review, the facility should address the anticipated placement for the child or adolescent upon discharge, the identified support services needed upon discharge and the current status of referral and/or linkage to those services.

First Health Services Manual, Medicaid Behavioral Health Care Utilization Management Services revised May 1, 2004, states in relevant part regarding criteria for placement for SIPP services:

3.6.1.1.1 Under Age 21

Requirements A, B, and C shall be met for admission to a psychiatric hospital:

A. Ambulatory care resources available in the community do not meet the treatment needs of the recipient (42 CFR 441.152(a)).

To meet this requirement, one (1) of the following shall be established.
1. A lower level of care will not meet the recipient's treatment needs.
   Examples of lower levels of care include:
a. Family or relative placement with outpatient therapy
b. Day or after-school treatment
c. Foster care with outpatient therapy
d. Therapeutic foster care
e. Group child care supported by outpatient therapy
f. Therapeutic group child care
g. Partial hospitalization
h. Residential setting; or
2. An appropriate lower level of care is unavailable or inaccessible; or
3. The recipient's mental disorder could be treated with a lower level of care; but because the recipient suffers one or more complicating concurrent disorders, inpatient care is medically necessary at a higher level of care.

Examples:

a. Major Depression with epilepsy
b. Major Depression with unstable insulin-dependent diabetes
c. Major Depression with renal dialysis; or
4. Factors related to the recipient's family or community indicate against treatment at a lower level of care; for example:
a. Patient does not have adequate support (family, school or community) to use a lower level of care and the recipient is not appropriate for an alternative living arrangement (e.g., foster care).
b. Family persistently hampers treatment, making treatment in a lower level of care ineffective.
c. Patient behavior persists despite appropriate treatment in a lower level of care and either seriously disrupts family life or arouses antagonism toward the patient, placing the recipient at risk or making treatment in a lower level of care ineffective.

B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152(a).

To meet this requirement determine all of the following requirements:
1. The patient has a psychiatric condition or disorder, which is classified as a DSM-IVTR (Current Diagnostic and Statistical Manual) diagnosis and/or an ICD 9 diagnosis. Axis I diagnosis; recipients with an Axis II diagnosis may be considered if an Axis I diagnosis indicates a need for treatment; and
2. The rating on DSM IV-TR Axis V at admission to a psychiatric hospital is fifty (50) or less. However, the Axis V diagnosis rating will be used as the basis for a denial only if those diagnoses are critical to establish the need for inpatient psychiatric hospital treatment; and
3. The recipient is currently experiencing problems related to the mental disorder diagnosed in B.1 above in one (1) of the following categories designated as (a), (b), (c) and (d):
a. Self-care Deficit (not Age Related): Basic impairment of needs for nutrition, sleep, hygiene, rest, or stimulation related to the recipient's mental disorder.
Indicators:
(1) Self-care deficit severe and long-standing enough to prohibit participation in an available alternative setting in the community, including refusal to comply with treatment (e.g. refuse medications).
(2) Self-care deficit places recipient in life-threatening Physiological imbalance without 24 hour medical nursing intervention and supervision (examples: dehydration,

starvation states, exhaustion due to extreme hyperactivity); or

b. Impaired Safety (Threat to Self or Others):
Evidence of serious intent to harm self or others caused by the recipient's mental disorder.
Indicators:
(1) Threats accompanied by one of the following:
(a) Severely depressed mood
(b) Recent loss
(c) Recent suicide attempt or gesture or past history of multiple attempts or gestures
(d) Concomitant substance abuse
(e) Recent suicide or history of multiple suicides in family or peer group
(2) Verbalization escalating in intensity; or verbalization of intent accompanied by gesture or plan; or

c. Impaired Thought and/or Perceptual Processes (Reality Testing):
Inability to perceive and validate reality to the extent that the Patient cannot negotiate his basic environment, nor participate in family or school (paranoia, hallucinations, delusions) and it is likely that the recipient will suffer serious harm.
Indicators:
(1) Disruption of safety of self, family, peer or community group.
(2) Impaired reality testing sufficient to prohibit participation in Any community educational alternative.
(3) Not responsive to outpatient trial of medication or supportive care.
(4) Requires inpatient diagnostic evaluation to determine Treatment needs, or

d. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes, which place the recipient at risk.
Indicators (one of the following):
(1) Family environment is causing escalation of recipient's Symptoms or places recipient at risk.
(2) The family situation is not responsive to available outpatient or community resources and intervention.
(3) Instability or disruption is escalating.
(4) The situation does not improve with the provision of economic or social resources.
(5) Severe behavior prohibits any participation in a lower level of care, e.g. habitual runaway, prostitution, repeated substance abuse; and

4. The Qualified Mental Health Professional describes a proposed

plan of Treatment that requires the intensity of services available at an inpatient psychiatric level of care; specifically:

a. Services shall be under the supervision of a psychiatrist.
b. Intervention of qualified professionals shall be available twenty-four (24) hours a day.
c. Multiple therapies (group counseling, individual counseling, recreational therapy, expressive therapies, etc.) shall be actively provided to the recipient.

C. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).

1. The treating facility shall provide a description of the plan for treatment illustrating the required intensity of services available at an inpatient psychiatric level of care.
2. The treating facility shall provide a plan for discharge and Aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, and time-framed discharge criteria.
3. Available clinical and research data supports the likelihood of Positive outcome from inpatient psychiatric treatment for the patient's diagnosis and presenting symptoms.

First Health Services determined that the petitioner did not meet the "medically necessary" criteria for SIPP services. In addition, First Health Services gives the opinion in their reconsideration process that the petitioner does not meet the A, B, and C criteria found in the procedural manual for SIPP services. The conclusions reached by First Health Services were contradictory as demonstrated by First Health's comments regarding the petitioner:

> patient's recent deterioration makes it difficult for her to be discharged to a less restrictive level of care.
>
> There has been minimal improvement in her affect. One of the few things that appear to have been helpful (at least on a temporary basis) has been outings for community service. She returns from them calmer and happier. Dr. agrees that pt's long-term prognosis is "bleak...After discussion, Dr. stated that a step down to less restrictive care might be in pt's best interest.

While the medical records reflected continued acts of self-injurious behavior, acts noncompliance, and aggression that seemed to escalate in June 2007, the First Health reviewer recommends a move to less restrictive care when the petitioner show that she "likes community outings." Yet a previous comment by a reviewer stated that the petitioner's medical condition "makes it difficult for her to be discharged to a less restrictive level of care."

The independent assessment completed by Qualified Evaluator disagrees with the assessment of the First Health Services reviewer. It was her opinion that the petitioner met the "medically necessary" criteria for SIPP services and met the A, B, and C criteria outlined in the procedural manual. This assessor recommended continued SIPP services due to the serious nature of the behaviors exhibited by the petitioner and her severe depressed mood. In her opinion, the SIPP setting has eventually worked to improve the petitioner's behaviors in the past.

The hearing officer has reviewed the evidence and testimony presented by both parties. The burden of proof is with the respondent. After reviewing the above-sited laws and procedural guidelines, the hearing officer finds that the petitioner does meet the "medically necessary" criteria and the A, B, C criteria for the SIPP Program. The assessment conducted by the independent psychologist was given more weight than the assessment by First Health Services due to less contradictory conclusions based on the medical evidence. Therefore, the hearing officer is relying on the assessment by the independent psychologist. The respondent has not met their burden of proof in order to deny services.

DECISION

This appeal is granted. The respondent's decision is reversed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 13th day of March, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted] Petitioner
Lorraine Kimbley-Campanaro, Area 6 Medicaid Adm, Acting