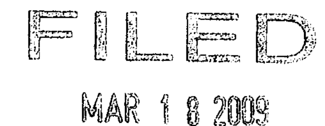

MAR 1 8 2009

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-8688

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 11 Dade
UNIT: MedWaiver
RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on January 21, 2009, at 8:23 a.m., in Miami, Florida. The petitioner was present and was represented by his plenary guardian and mother, . Present, representing the respondent was Martha M. Govea, Medicaid Waiver specialist with the Florida Department of Health (DOH) Traumatic Brain & Spinal Cord Injury Program (TBSCIP). Appearing telephonically as a witness for the respondent was Cris Russell, administrator of the TBSCIP. Margaret Warner, senior specialist with the Agency for Health Care Administration (AHCA) was present. Blanche Rodriguez served as translator.

ISSUE

The petitioner is appealing the respondent's action of December 11, 2008, to reduce services being received through the Traumatic Brain & Spinal Cord Injury

Program, Home and Community-Based Medicaid Waiver. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient residing in Miami-Dade County along with his mother. The petitioner has been diagnosed with cerebral damage with total paralysis on the left side of his body. He requires assistance with activities of daily living due to his condition.
2. The TBSCIP is a Waiver Program operated by the Department of Health, under agreement with the Agency for Health Care Administration. It provides home and community based services, allowing individuals who would otherwise require nursing home care or other institutional care, to receive services in their own home or in home-like setting.
3. The petitioner has been receiving services for the last three years through the Program as follows: Three hours (10am-1pm) daily, 7 days a week of personal care; 6 hours (1pm-7pm) daily, 7 days a week of companion care; $200 monthly in medical supplies; and the services of a support coordinator to assist them. These services have continued throughout the hearing process.
4. The petitioner receives in addition to the Waiver services, 2 hours (8am-10am) daily, 7 days a week of personal care through the Medicaid Program.
5. The Program's administrator explains that the funds received to operate the Program are not received from General Revenue, but from the Traumatic Brain and Spinal Cord Trust Fund which relies on monies in part, generated by the economy.

As the administrator of the Program, she is current on budget information and it was determined that by the end of the fiscal year, they would there would be a deficit in the budget if reductions in services were not made. She explains that because of the slow economy monies are not being replenished as in the past.

6. The Department was then required to review cases in order to identify reductions that could safely be made and that would not impact or jeopardize the safety of the person.
7. The petitioner's current plan of care cost is at almost $5,000 monthly. The average plan of care cost is averaged at $2,500 monthly and persons that live alone receive more services than those that do not.
8. In the petitioner's case a home visit was completed. They found that the petitioner lives with a caring mother, in a safe and comfortable environment. They also found that the petitioner receives in addition to Waiver service hours, two hours daily of personal care, seven days a week. In total, the petitioner was receiving personal care and companion service hours of 9 hours (8am-7pm) daily, 7 days a week.
9. The respondent explains that they reviewed the petitioner's case several times and concluded that without jeopardizing the safety of the petitioner, service hours would be reduced to one (originally zero) hour daily of personal care, seven days a week and five hours daily, seven days a week. During the hearing, the administrator revised their original reduction of personal care to one hour daily in the evening, seven days a week. They took into account that personal care of two hours daily in the morning, seven days a week was being provided by the Medicaid Program.

10. Additionally, they modified the way medical supplies were provided from $200 monthly to an, as needed basis, with a limit of up to $300 monthly. The services of the support coordinator remained the same.

11. On December 11, 2008, the petitioner was issued a denial letter and a Notice of Decision informing him that his services were being reduced due to budget reductions. The petitioner requested the hearing on December 19, 2008.

CONCLUSIONS OF LAW

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

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

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

> *Overview*
>
> Introduction-This chapter describes the services covered under the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver Program. It also describes the requirements to receive services, the requirements for service provision, service limitations, and service exclusions. ...

Service Requirements-Introduction-

Medicaid reimburses providers for home and community-based services rendered to eligible Medicaid recipients who have been enrolled in the TBI/SCI Waiver Program. TBI/SCI waiver services must be rendered by qualified, enrolled providers pursuant to a written plan of care that is developed as a result of a detailed assessment of the recipient's condition and service needs. Because services are based on the individual needs of the recipient, not every recipient receives every service.

Description and Purpose-TBI/SCI Waiver Description

Recipients in the TBI/SCI Waiver Program have access to support and services, which enable them to live at home and in the community. Eligibility is limited to the number of unduplicated recipients stated in the waiver application or amendments that is approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, and by the amount of state matching revenue appropriated by the legislature.

State matching funds for the waiver are generated from the TBI/SCI Trust Fund. Revenue from moving traffic violation fines, Driving Under the Influence, Boating Under the Influence convictions and $1.00 from all temporary tags goes into this fund. The Florida DOH, BSCIP operates the waiver under the authorization of AHCA's Division of Medicaid. ...

TBI/SCI waiver recipients must demonstrate health conditions or limitations in functioning that would result in placement in a skilled nursing facility were it not for the provision of TBI/SCI waiver services.

Service Requirements

Medical Necessity Waiver services may be provided only when the service or item is medically necessary. Medically necessary is defined in 59G-1.010(166)(a)(c), F.A.C. as follows:

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

• Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain; • Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

• Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;

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

• 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.

Reimbursement Information-BSCIP Waiver Service Rates

The rate for payment for all services is determined by the BSCIP Headquarters Office and subject to a maximum rate established by Medicaid and the availability of appropriated funding from the Florida Legislature. Once BSCIP has established a rate with a waiver provider for a certain level of service, that rate must apply to all recipients receiving the same level of service. ...

Availability of Other Coverage Sources-Supports and services are developed and delivered in community settings. The supports and services authorized under the TBI/SCI waiver must be used to supplement the supports already provided by family, friends, neighbors, and the community. When a service must be purchased, services available under the Medicaid state plan must be used before accessing services through the waiver. The waiver cannot supplant or replace a service that is available through the Medicaid state plan. It is a federal requirement to access state plan coverage before the provision of waiver services. ...

Fla. Stat. 409.906 Optional Medicaid services states in part:

Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be

> construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. ...Optional services may include:
>
> ...(13) HOME AND COMMUNITY-BASED SERVICES.--(a) The agency may pay for home-based or community-based services that are rendered to a recipient in accordance with a federally approved waiver program. The agency may limit or eliminate coverage for certain services, preauthorize high-cost or highly utilized services, or make any other adjustments necessary to comply with any limitations or directions provided for in the General Appropriations Act.
>
> (b) The agency may consolidate types of services offered in the Aged and Disabled Waiver, the Channeling Waiver, the Project AIDS Care Waiver, and the Traumatic Brain and Spinal Cord Injury Waiver programs in order to group similar services under a single service, or continue a service upon evidence of the need for including a particular service type in a particular waiver. ...

The petitioner's representative states that she had expressed to the support coordinator that she should be allowed to administer the medical supply funds given, because she is more frugal. She states that she needs to be with her son 24 hours a day and if she received no help, would have to go to work and pay for someone to care for him.

The representative states that she called the Department of Health and was told by someone that they have not had any reduction in the budget and do not anticipate any reductions starting with the new fiscal year.

The representative feels that the reduction in services is not fair and equally done, as she has been told by other recipients that they have not received a reduction in

services. Additionally, she states that the support coordinators assigned have received a pay increase.

The administrator states that rates have been increased to the providers, in order to increase their provider base as required by the Agency for Health Care Administration. However, she states that the support coordinators rates have been reduced significantly due to the budget deficit and that employees have not received a raise in pay. The administrator reiterates that reductions in services were done because of a projected deficit by the end of the fiscal year and only when it does not jeopardize the safety of the person. She states that in the case of the petitioner, between the services being received through Medicaid and the reduced services that are within Program parameters, it would be a safe reduction that would not jeopardize his safety.

The state is allowed to limit services and participation to waivers based on available funding. Both the Florida Constitution and Florida Statutes prohibit agencies from contracting or agreeing to spend any moneys in excess of the amount appropriated to them unless authorized by law. *See* Art. VII, Sec. 1(c), Fla. Const.; § 216.311(1), Fla. Stat. (2002). Applicants are entitled to receive services only within available resources, and the respondent has discretion to prioritize how it will distribute funds. § 393.13(3)(c)-(d), Fla. Stat. (2002); *see also* Dep't of Health & Rehab. Servs. v. Brooke, 573 So.2d 363 (Fla. 1st DCA 1991) (holding budgetary decision-making was within agency head's executive discretion).

In Bridget Ellingham v. Dept. of Children and Family Services, 896 So.2d 926 (Fla. 1st DCA 2005) the court concluded that lack of funding is an affirmative defense to a claim

for developmental disabilities services, analogous to the defense of impossibility of performance in a contract action. The party seeking to assert the affirmative defense has the burden of proof as to that defense.

This case involves the petitioner's assertion that services should not be reduced and the respondent is asserting that because of lack of funding, services are being reviewed for possible reduction, when the recipient's safety is not jeopardized. The respondent is attempting to avoid a deficit by the end of the fiscal year. The hearing officer concludes that the respondent has met its burden of showing the lack of funding, which resulted in the petitioner's services being reduced.

Based on all the evidence and testimony presented, the hearing officer concludes that the respondent's action concerning the petitioner's case was correct. There was no evidence presented to show that the reduction of two hours of personal care and one hour of companion care daily, would jeopardize the petitioner's safety. The budgetary constraints faced by the respondent mandate service provision limitations and reductions.

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 18th day of March, 2009,

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: , Petitioner
Rhea Gray, Field Office Manager, Medicaid Area 11

MAR 1 3 2009

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-00526

PETITIONER,

Vs.

CASE NO. 1288577656

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 12 Sarasota
UNIT: 88326

RESPONDENT.

______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 25, 2009, at 10:00 a.m., in Sarasota, Florida. The petitioner was present and represented herself. The respondent was represented by Patricia Higel, ACCESS supervisor. Present as witnesses for the petitioner from the nursing facility were , business office Manager; and , social services assistant. Present as a witness for the respondent was Stephen Machiz, M.D. with the District Medical Review Team (DMRT).

ISSUE

At issue is the January 7, 2009 action by the respondent denying the petitioner's application for the Institutional Care Program due to her failure to meet the disability criteria.

FINDINGS OF FACT

1. On November 11, 2008, the petitioner filed a Request for Assistance to apply for Medicaid through the Institutional Care Program. She resided in a nursing facility. Since the petitioner was 64 years old, she did not meet the aged criteria. The respondent submitted a request for a disability assessment to the District Medical Review Team (DMRT).
2. On December 30, 2008, DMRT determined that the petitioner did not meet the disability criteria. They reviewed her medical conditions resulting from a fall on November 10, 2008. She suffered a tibia plateau fracture in her right knee. DMRT determined that the petitioner did not meet the durational requirement to be determined disabled. She would not be unable to work for a period of 12 consecutive months. On January 7, 2009, the respondent denied the petitioner's application for Institutional Care Program benefits since she did not meet the disability requirement.
3. When the petitioner went to the emergency room for the fracture, they determined that she would heal without surgery. They predicted that she would be non-weight bearing for 6-8 weeks. It was predicted that she would be totally healed within six months.
4. The petitioner applied for disability through the Social Security Administration on November 12, 2008. On January 14, 2009, they determined that the petitioner did not meet the disability criteria. They reviewed her medical condition as the fracture of her knee. The Social

Security Administration determined that her medical impairment was severe at the time of adjudication but not expected to last 12 months.

CONCLUSIONS OF LAW

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

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

Federal Regulations at 42 C.F.R. §435.541 in part state:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability... (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility...(b) Effect of SSA determinations. (1)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA... (c) *Determination made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:... (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634

agreement with SSA, and... (i) Alleges a disability condition different from, or in addition to, that considered by SSA in making its determination...

The evidence shows that the petitioner was denied Social Security benefits, as she was determined not disabled. DMRT determined that the petitioner did not meet the disability criteria. As a result, the Department denied the petitioner's application for Institutional Care Program benefits for failure to meet the disability requirement.

According to the above-cited regulations, the denial by the Social Security Administration made within the last twelve months is binding on the agency and the hearing officer. The petitioner does not report new medical conditions not currently under review by the Social Security Administration in their appeal process. Upon careful review of the evidence submitted, the hearing officer concludes that the Department's action to deny the petitioner's application for Medicaid is correct and in accordance with the above-cited regulations. Any worsening in these conditions should be referred back to the Social Security Administration as this relates to the issue currently under appeal.

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 13th day of March, 2009,

in Tallahassee, Florida.

Terry Oberhausen
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To. , Petitioner
Roseann Liriano, Suncoast Region

FILED
MAR 23 2009
OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-08686

PETITIONER,

Vs.

CASE NO. 1296203638

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 88981

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on February 4, 2009, at 11:15 a.m. in Cocoa, Florida. The petitioner was not present. His wife, represented him. Bobbie Van Cott, ACCESS supervisor, represented the Department.

ISSUE

At issue is the action taken by the Department to deny Institutional Care Program (ICP) Medicaid benefits for October and November 2008 because the petitioner's income exceeded the Program requirements for those months. The petitioner has the burden of proof in this matter.

A second issue arose at the hearing concerning the amount of the patient responsibility. A hearing was set to reconvene on February 19, 2009, at 9:00 a.m. to address this issue. On February 18, 2009, the undersigned received a written request

to withdraw the hearing set for that day concerning that issue. With receipt of the written withdrawal, no hearing took place on that issue. The focus of this appeal is solely the denial of ICP benefits for October and November 2008.

FINDINGS OF FACT

1. On October 15, 2008, an application for ICP benefits was submitted to the Department on the petitioner's behalf. As part of the eligibility process, the Department must consider among other things, the income of an applicant. For ICP benefits, the income cannot exceed 300% of the federal benefit rate. The income limit for ICP benefits in October and November 2008 was $1911 (Respondent's Exhibit 5).

2. The petitioner's income was verified on November 21, 2008, to be $2450.48. The petitioner receives $1132.48 from a pension and $1318 from Social Security benefits (Respondent's Exhibit 4).

3. On November 25, 2008, the Department sent a Request for Information, giving the petitioner until December 5, 2008 to return the requested information. The petitioner was asked to "Please provide: 1) Need breakdown of the Aetna insurance payment- How much is for and how much is for 2) is over income and will need an income trust - provide proof of qualified income trust, proof of bank acct set up for qualified income trust, and proof of deposit to qualified income trust acct." (Respondent's Exhibit 2). Attached to the Request for Information was an Income Trust Explanation. It showed the petitioner's income and the limit for ICP and what the requirements were to execute the trust.

4. On December 2, 2008, the income trust was set up and funded (Respondent's Exhibit 3). On December 18, 2008 the Department mailed a Notice of Case Action to

the petitioner to inform him that ICP benefits were denied for October and November 2008 because his income exceeded the Program limit. The Department explains that the income trust fund was not properly funded until December 2008; therefore, that is the first month of eligibility.

5. The petitioner's wife disagrees with the Department's denial of ICP benefits for October and November 2008 because she does not believe she was given ample time to get the trust set up, or notified of its urgency to get it set up and funded by the end of November. She was in constant contact with her caseworker during this process. She did not receive the Request for Information until at least November 27th. From the time the Department verified his income on November 21, 2008, to the time the Department mailed a Request for Information November 25, 2008, four days had lapsed. She believes she could have had the income trust set up and funded by the end of the month if she had been notified of its need more timely and told of the urgency to do so.

CONCLUSIONS OF LAW

The Florida Administrative Code (F.A.C.) 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
>
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.

The Department's Integrated Public Assistance Policy Manual, passage 1840.0110 Income Trusts (MSSI) states:

The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

1. it is established on or after 10/01/93 for the benefit of the individual;

2. it is irrevocable;

3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and

4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf. ...

The eligibility specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received. (This may require the individual to begin funding an executed income trust account prior to its official approval by the District Legal Counsel.) (Emphasis added)

The above-cited F.A.C. rule shows that countable income may not exceed 300% of the federal benefit rate to be eligible for ICP benefits. The Department's Integrated Policy Manual, 165-22, Appendix A-9, effective January 2008, sets forth that amount as $1911. This income limit typically increases each January with the increase in the Federal Poverty Level.

Florida Administrative Code 65A-1.713 permits the establishment of a qualified income trust to potentially create ICP eligibility by reducing countable income to an

amount below the income standard. A qualified income trust was created by the petitioner's wife on December 2, 2008, and received by the respondent on the same day; ICP eligibility was approved beginning December 2008.

The Findings show that the income exceeded the ICP income limit for October and November 2008, prior to the establishment of the income trust and its funding. The date of application was October 15, 2008. The income was verified by its sources on November 21, 2008. There was no evidence presented to know if the Department knew at the time of application if the sources of income information were specific enough to reveal the need to establish an income trust, and the amount needed to fund the trust below the income limit. However, according to the Department's policy manual, the respondent had an affirmative duty to advise the petitioner in October 2008 of the federal benefit rate to be eligible for ICP benefits. Not informing the petitioner until a letter mailed on November 25, 2008 is not consistent with the ruling of the higher court in the *Forman* case as shown below. The findings show that the petitioner complied with the income trust requirements as soon as she was informed, which by this time, delayed eligibility until December 2008.

A decision by the Fourth District Court of Appeal (DCA) *Forman v. State of Florida Department of Children & Families,* 4D06-1770 (Fla. 4th DCA 2007) is similar to this appeal and addresses the respondent's requirement to advise ICP applicants and states in part:

> The obligation imposed upon DCF by passage 1840.0110 of the policy manual is similar to that created by 45 C.F.R. §206.10(a)(2)(i) in *Buckley* and *Pond.* Leftow set up an account to transfer the entire proceeds of her mother's pension check to Manor Care. ... Had she known the specifics of

> the income trust, she would have complied with that requirement. Because Forman was erroneously deprived of benefits as a result of the failure of the DCF specialist to comply with the policy manual, the order denying benefits is reversed, and the case is remanded for further proceedings consistent with this opinion.

Since the petitioner was not informed timely of the expeditious requirement to set up and fund the income trust, the denial of ICP benefits for October 2008 and November 2008 must be reversed. The respondent is ordered to re-determine ICP eligibility on relevant factors other than income for the months at issue, October and November 2008.

DECISION

The appeal is granted. The respondent's action to deny benefits based upon income is not upheld. The respondent is ordered to re-determine ICP eligibility for the months of October and November 2008 considering the petitioner to be within the ICP Program income limits for those months. The respondent is to send written notification to the petitioner and facility as soon as the determination is made. The respondent is to take corrective action within 10 days of the date of this order.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 23rd day of March, 2009,

in Tallahassee, Florida.

Margaret Poplin
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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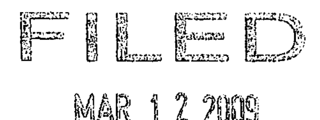


STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 08F-08621

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 12 Manatee
UNIT:

RESPONDENT.

______________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on February 13, 2009, at 3:19 p.m., in Bradenton, Florida. The petitioner was present to testify and represent himself. , a companion aide with Home Health Care, appeared as a witness for the petitioner. David Beaven, program analyst with the Agency For Health Care Administration (AHCA), represented the respondent and testified. Phyllis Rothman, registered nurse with the Department of Health, appeared as a witness for the respondent. Chris Russell, administrator with the Brain and Spinal Cord Injury Program (BSCIP), appeared as a witness for the respondent by telephone.

ISSUE

At issue is the respondent's decision of December 10, 2008 to reduce attendant care services provided under the BSCIP from four hours weekly to

three hours weekly. Further at issue, the respondent reduced companion services from three hours daily to two hours daily, seven days weekly. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner was injured in an accident in the year 1982. The petitioner is currently approved to receive approved services in his home under the BSCIP. The petitioner previously received four hours weekly attendant care services under the BSCIP. The petitioner continues to receive three hours daily personal care services. The respondent previously received companion services three hours daily, seven days weekly.
2. In December 2008, the BSCIP state administrator looked at where individual BSCIP services could be reduced due to a statewide reduction in allocated funds for the program. This administrator found that services could be reduced in 80% of the eligible BSCIP recipients with jeopardizing the health and safety of recipients.
3. Phyllis Rothman, a registered nurse and Medicaid Waiver specialist evaluated the petitioner's need for services under the BSCIP. Ms. Rothman opined that attendant care services could be safely reduced to three hours weekly. Further, Ms. Rothman also opined that companion services could be reduced to two hours daily, seven days weekly. There was no rebuttal evidence that these services could not be safely reduced to the amount at issue. On December 10, 2008, the

respondent sent written notice to the petitioner of these reduced services under the BSCIP.

4. The petitioner understands that BSCIP services are being reduced across the board. He asserts that companion services greatly assist him with cleaning, cooking, errands, banking, medicines, appointments, shopping and cleaning. The petitioner intends to determine if family can help due to the reduced hours. The petitioner previously relied on friends and neighbors for assistance prior to approved services under the BSCIP.

CONCLUSIONS OF LAW

The Florida Medicaid Traumatic Brain and Spinal Cord Injury Waiver Services Coverage and Limitations Handbook (BSCIP Handbook) has been promulgated into rule under Florida Statutes 408.301, 408.302, and 409.919. Per this handbook, the Department of Health is authorized by the respondent agency to operate and oversee the BSCIP Medicaid Waiver Program. The general intent of the BSCIP program is to provide support and services to qualified individuals, which enable recipients the ability to live at home and in the community. Provided services are intended to delay or prevent institutionalization.

The BSCIP Handbook, page 2-15, show that services under the BSCIP must be defined as "medically necessary" to recipients per the definition set forth under the Florida Administrative Code (F.A.C.) Rule 59G-1.010. This F.A.C. rule addresses relevant definitions applicable to the BSCIP, which apply to the

decision on the attendant care and companion 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 reviewing nurse with the Department of Health recommends the reduction of the attendant care and companion services based on her evaluation of the petitioner's needs. There was no rebuttal evidence to show that these services could not be safely reduced to the amount at issue. The petitioner testified that the services are a great help, but the petitioner's safety would not be reduced by the reduction of hours to the amount at issue.

In sum, it is concluded that the respondent decision to reduce attendant and companion services to the amounts at issue is correct, based on the

available evidence applied to the medical necessity definition. Thus, the respondent has met its burden to justify the reduction of these services to the amount at issue.

DECISION

This appeal is denied in that the respondent has met the burden to prove that the reduction of companion and attendant care services can be safely reduced to the amount at issue.

NOTICE OF RIGHT TO APPEAL

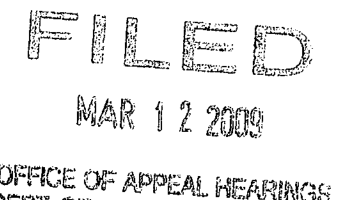
This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 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 12th day of March, 2009,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
Sue McPhee, Area 6 Medicaid Field Manager



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

APPEAL NO. 08F-08747

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 06 Pasco
UNIT: AHCA

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 12, 2009, at 2:18 p.m., in New Port Richey, Florida. The petitioner was present. She was represented by her parents . Present as a witness for the petitioner was , physical therapist for the Pasco County School District. The respondent was represented by Jody Winter, physical therapy consultant, and Stephanie Lang, registered nurse specialist.

ISSUE

The petitioner is appealing the notices of October 8, 2008 for the respondent's action to deny a customized power wheelchair with power standing components.

FINDINGS OF FACT

1. The petitioner is a Medicaid eligible child. The petitioner attends school in Pasco County. The petitioner's diagnoses are spastic diplegic cerebral palsy, neuroscoliosis, pelvic varicosities, venous thromboses, range of motion limitation, contractures and bilateral patella alta. The petitioner requires a wheelchair for ambulation. The petitioner is unable to bear weight on her legs. The petitioner can transfer to similar height surfaces. The petitioner cannot stand up from the floor. She tolerates walking using a suspension walker with a suspension harness to support her body weight.

2. On September 9, 2008, the respondent received a request from Custom Mobility on behalf of the petitioner. The request was for a power wheelchair with power standing components (C500 base stander-C500 PS2). Additional equipment requested was retractable joystick mount, Jay cushion, ergo back support, chest bar, tray table, headrest, push handles, batteries, charger, solid inserts, knee block assembly, pelvic positioning belt, transfer handles, power adjustable seat and adjustable height armrests. The cost of the power wheelchair with power standing components and additional equipment was $38,956. The petitioner had not completed any trials on a power wheelchair with power standing components.

3. The physical therapist wrote the letter of medical necessity and the projected daily use of the power wheelchair with power standing components. In performing activities of daily living, the petitioner leans forward and the excessive forward leaning and straining increases intra-abdominal pressure and pressure

against vulvar varicosities causing pain for the petitioner. The physical therapist opined as follows. Due to the onset of pelvic varicosities and venous thromboses, the petitioner's current power wheelchair did not meet the petitioner's medical needs. The petitioner's present wheelchair cannot be modified to meet the petitioner's medical needs. The petitioner's ability to stand or partially stand and lean forward over a sink will decrease the pressures, eliminate the pain and benefit the petitioner's health by decreasing the risk of venous thromboses. The equipment would open the hip angle and venous return which would improve the petitioner's circulation. The petitioner could stand in a power wheelchair with standing component while she is driven to and from school. The petitioner overpowers the seat on her current wheelchair.

4. The respondent reviewed the request. The respondent stated that Medicaid approves wheelchair every five years. In 2005, Medicaid approved a power wheelchair with custom seating for the petitioner and a specialized walker. The respondent expressed concerns that there was no trial by the petitioner with a power wheelchair with standing component and the downgrading of the level of support for the requested power wheelchair with standing component. The respondent opined that the petitioner is a standing position while being driven is a convenience not a medical necessity. If the standing component is needed at school, then it would be the responsibility of the school to provide that standing component for the petitioner. On October 8, 2009, the respondent denied the requested power wheelchair with power standing components. The stated reasons for the denial were the requested equipment exceeded plan maximums,

the requested equipment does not meet the definition of medical necessity and the request was not the least costly alternative. If the petitioner had requested a separate standing component in addition to her current power wheelchair for use at home and in the community, the respondent would have approved that request for a separate standing component. The respondent offered modification to the petitioner's existing power wheelchair and a standing device, as an equally effective less costly alternative to the power wheelchair with power standing components requested by the petitioner.

5. The petitioner's parents opined that the petitioner needs to increase the time she stands each day to prevent blood clots and heal the varicosities.

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 Administrative Code at 59G-1.010 "Definitions" defines medical necessity and prior authorization:

> (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.

(226) "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

The Florida Administrative Code at 59G-4.070 states in part:

(1) This rule applies to all durable medical equipment and supply providers enrolled in the Medicaid program.
(2) All durable medical equipment and supply providers enrolled in the Medicaid program must comply with the Florida Medicaid Durable Medical Equipment and Supply Services Coverage and Limitations Handbook, April 1998, incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, HCFA 1500 and EPSDT 221, incorporated by reference in Rule 59G-5.020, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

Durable Medical Equipment/ Medical Supply Services Coverage And Limitations Handbook, April 2001, sets forth the description of a wheelchair (page 2-56) and documentation requirements for a customized wheelchair (page 2-57 and 2-58):

Wheelchairs
Description
A wheelchair is a chair mounted on wheels used to transport a nonambulatory individual.

Wheelchair
Medicaid may reimburse for a wheelchair when the recipient is nonambulatory, has severely limited mobility, or it is necessary to accommodate the recipient's physical characteristics.

Customized Wheelchair Documentation
Medicaid may reimburse for a customized wheelchair that is specially constructed (K0008, K0013, K0014). Prior authorization is required. Medicaid will not approve a customized wheelchair or wheelchair upgrade where no medical necessity to accomplish basic ADLs within the home has been established.
For a customized wheelchair, the following information must be submitted with the prior authorization request:

- medical necessity;
- written documentation describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive abilities, coordination, and activity limitations;
- wheelchair evaluations performed by either a registered physical or occupational therapist or a certified physiatrist;
- what physical improvement(s) can be anticipated;
- what physical deterioration can be prevented;
- a list of each customized feature required for unique physical status;
- specify the medical benefit of each customized feature;
- identify the principle places of use;
- an itemized invoice listing actual costs for parts and labor;
- list the source(s) of purchased accessories and modifications; and
- documentation of home accessibility is required for an oversized, heavy duty, or manual customized wheelchair.

The evidence demonstrates that the petitioner would medically benefit from additional standing during the day. The hearing officer concludes that there is medical necessity for the petitioner to have equipment to assist her in standing. What is at issue is whether or not the requested equipment of a power wheelchair with standing component meets all of the definitions for medical necessity, State Plan limitations and the limitations as set forth in the handbook for durable medical equipment.

The petitioner had not tried the power wheelchair with power standing components. No documentation was submitted of ability of the petitioner to independently adjust seating components, ability to independently access the power standing component or ability to shift to meet repositioning from sitting to standing in the power wheelchair with power standing components. The evidence was not clear that the petitioner would be independent to stand in or able to operate the power wheelchair with power standing components. If the petitioner would not be independent to stand in or able to operate the power wheelchair with power standing components, the equipment would be in excess of the petitioner's needs.

The respondent has demonstrated and offered an effective, less costly alternative which would include modifications to the existing power wheelchair including seat changes and a standing device. Therefore, the hearing officer concludes that the power wheelchair with standing component is not the least costly alternative. The requested equipment does not meet all criteria for medical necessity.

The respondent provided a power wheelchair to the petitioner in 2005. The State Plan allows for a new power wheelchair every five years. Therefore, the request for a power wheelchair with standing component exceeds the State Plan maximum.

The petitioner's request for a power wheelchair with power standing components was not consistent with the rule for medical necessity, is in excess of the State Plan limitations and did not meet the limitations as set forth in the

handbook for durable medical equipment. Based upon the above cited authorities, the respondent's action to deny the power wheelchair with power standing components was within the rules of the Program.

DECISION

This appeal is denied.

NOTICE OF RIGHT TO APPEAL

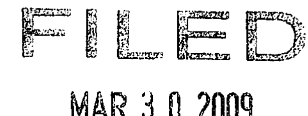
This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration,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

DONE and ORDERED this 12th day of March, 2009,

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: ......, Petitioner
Noreen Hemmen, Area 5 Medicaid Adm.



MAR 3 0 2009

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09F-00508

PETITIONER,

Vs.

CASE NO. 590370547

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT:

RESPONDENT.
_________________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on February 20, 2009, at 2:14 p.m., in Tampa, Florida. The minor petitioner was present as an observer. The petitioner was represented by his father, , who also testified. , support coordinator contracted by the Agency For Persons with Disabilities (APD), appeared as a witness for the petitioner. The respondent was represented by David Beaven, program analyst with the respondent agency, who also testified. Danette Wal-Santiago, senior human services program specialist also with the respondent agency, also appeared as a potential witness for the respondent.

ISSUE

At issue is an approximate $2,000 reduction in consumer directed care funds provided the petitioner under the APD Home and Community Based Services (HCBS) Medicaid Waiver Program. Prior to a review of specific case merits, it must be determined whether or not the issue is jurisdictional to this hearing authority.

FINDINGS OF FACT

1. The petitioner is eligible to receive approved services under the APD-HCBS Medicaid waiver Program as a developmentally delayed individual. The petitioner is 15 years old.
2. Individuals who are eligible for services under the APD-HCBS Medicaid Waiver Program can elect to receive approved services under the subset entitled Consumer Directed Care (CDC). The petitioner has experienced a reduction of funding under this program of about $2,000.

CONCLUSIONS OF LAW

It must be determined whether or not hearing matters are jurisdictional to this hearing authority prior to a review of the specific merits of the action under appeal. The action under appeal pertains to a funding reduction for services approved under the APD-HCBS Medicaid Waiver Program. The First District Court of Appeal ruled on the jurisdiction of this hearing authority to review actions under the APD-HCBS Medicaid Waiver Program in the year 2006 cited as J.M. v.

Agency for Persons with Disabilities, 938 So. 2d 535 (Fla. 1DCA 2006). A pertinent excerpt from this case law decision is as follows:

> Notwithstanding s. 120.57(1)(a), hearings conducted within the Department of Children and Family Services in the execution of those social and economic programs administered by the former Division of Family Services of the former Department of Health and Rehabilitative Services prior to the reorganization effected by chapter 75-48, Laws of Florida, need not be conducted by an administrative law judge assigned by the division.
> 120.80(7), Fla. Stat. (2005). We need not decide in the present case the precise scope of the exemption section 120.80(7) creates, **because chapter 393 unambiguously calls for administrative hearings pursuant to section 120.57 in cases like J.M.'s.** We therefore leave for another day mapping the exemption's exact contours.

Fla. Stat. 120.80(7) describes the general jurisdictional contours of this hearing authority rather than the Division of Administrative Hearings (DOAH), as follows:

> 120.80 Exceptions and special requirements; agencies.--
>
> (7) DEPARTMENT OF CHILDREN AND FAMILY SERVICES.-- Notwithstanding s. 120.57(1)(a), hearings conducted within the Department of Children and Family Services in the execution of those social and economic programs administered by the former Division of Family Services of the former Department of Health and Rehabilitative Services prior to the reorganization effected by chapter 75-48, Laws of Florida, need not be conducted by an administrative law judge assigned by the division.

The above cited decision references Chapter 393 to show that a similar APD decision is to be reviewed by an administrative law judge assigned by the Division of Administrative Hearings (DOAH), per Fla. Stat. 120.57(1)(a), as follows:

120.57 Additional procedures for particular cases.--

(1) ADDITIONAL PROCEDURES APPLICABLE TO HEARINGS INVOLVING DISPUTED ISSUES OF MATERIAL FACT.--

(a) Except as provided in ss. 120.80 and 120.81, an administrative law judge assigned by the division shall conduct all hearings under this subsection, except for hearings before agency heads or a member thereof. If the administrative law judge assigned to a hearing becomes unavailable, the division shall assign another administrative law judge who shall use any existing record and receive any additional evidence or argument, if any, which the new administrative law judge finds necessary.

In sum, the APD-HCBS Medicaid Waiver issue in this instant appeal is not jurisdictional to this hearing authority. The petitioner is referred to surface this matter to the Division of Administrative Hearings (DOAH) for review, if desired.

DECISION

This appeal is denied or dismissed as non-jurisdictional to this hearing authority. The petitioner is referred to the DOAH to surface this issue, if desired.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 30th day of March, 2009,

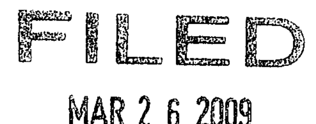
in Tallahassee, Florida.

Jim Travis

Jim Travis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: , Petitioner
Sue McPhee, Area 6 Medicaid Field Manager

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



MAR 2 6 2009

OFFICE OF APPEAL HEARINGS
DEPT. OF CHLDREN & FAMILIES

APPEAL NO. 08F-08786

PETITIONER,

Vs.

CASE NO. 1184306079

AGENCY FOR HEALTH CARE ADMINISTRATION
CIRCUIT: 13 Hillsborough
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on February 6, 2009, at 3:19 p.m., in Tampa, Florida. The petitioner was not present but was represented by her mother, who also testified. David Beaven, program analyst with the Agency For Health Care Administration (AHCA), represented the respondent and testified. Hillary Nelson, senior registered nurse supervisor with Children's Medical Services, appeared as a witness for the respondent.

Several of the petitioner's relatives appeared as witnesses for the petitioner: , father; maternal grand-mother, , paternal grand-father, and , maternal grand-father.

ISSUE

At issue is the respondent's decision around the third week of December 2008 to deny the petitioner's request for out-of-state medical treatment under the Children's Medicaid Services (CMS) Program. The respondent believes the medical treatment can be provided in Florida but the petitioner disputes this assertion.

FINDINGS OF FACT

1. The petitioner is now 16 months old and was born on November 20, 2007. Her mother provides care.
2. Dr. is a past treating pediatrician since January 2008. In her letter dated August 20, 2008, Dr. opines the petitioner to have diagnoses of gastroesophageal reflux disease, severe constipation and anal stenosis, breath holding spells, anterior ectopic anus and perineal fistula, limited number of colonic ganglion cells, history of eczema and pyloric stenosis status post repair. The petitioner receives anal dilations with every diaper change. She has undergone transrectal biopsies under anesthesia, gastrograffin enema, upper GI and brain and spinal MRI. Dr. recommended an evaluation by Dr. of the Colorectal Center in Cincinnati, Ohio, for an anroctoplasty due to anorectal malformation.
3. Dr. is the of the Colorectal Center in Cincinnati Ohio. This center was created to offer patients a comprehensive approach to problems to include pre-operative care and

evaluation, definitive surgery for reconstruction, and short and long-term management. In the center, pediatric surgeons collaborate with several clinical specialist tailored to each specific case. The Colorectal Center is the world's only center focused on pediatric colorectal issues including anorectal malformation, Hirschsprung's Disease, and colonic motility disorders. Dr. opines that the petitioner was born with anorectal malformation, the specific type of rectoperineal fistula.

4. Dr. is a treating pediatric gastroenterologist. In his letter of August 14, 2008, Dr. opines the petitioner to have an anterior ectopic anus that will require a complicated surgical procedure. Dr. opines the surgical procedure of choice is posterior saggittal anorectoplasty. Dr. opines the procedure is best done at a center most equipped to deal with any complications under the care of an experienced colo-rectal surgeon. Dr. I opines the Cincinnati Children's Hospital to be the best and most experienced in this procedure.
5. Dr. I is a pediatric gastroenterologist who examined the petitioner in February 2009 for an evaluation of bowel dysfunction and anorectal malformation. Dr. reviewed the petitioner's past medical records and previous evaluation. Dr. opined that there are presently two different opinions, one of an enteric topic anus, and a second of a perineal fistula, both very different surgeries. Dr. I opines that it is obvious that the petitioner requires an evaluation by a pediatric colorectal surgeon. Dr. opines that the evaluation in

Florida has not resulted in a single recommendation. Dr. strongly recommends Medicaid to approve her evaluation at the Colorectal Center in Cincinnati, Ohio.

6. Dr. is the Deputy Secretary for Children's Medical Services. In his letter of October 22, 2008, Dr. advised that he had investigated the petitioner's case with the local CMS Office physicians, Dr. ı, and Dr. The letter stated that Dr. (determined that a pediatric surgeon from the University of South Florida Physicians Group, Dr. had evaluated the petitioner. Dr. opines Dr. to have the requisite knowledge and skills necessary to perform highly complex surgical procedures on children. Based on information from Dr. and Dr. (, Dr. (concurs with Dr. I ecommendation for the petitioner to have an exam under anesthesia, and to perform any necessary surgical repair if required. Through the letter, Dr. opined that this service can be performed in several areas around the state, based on the information from the local doctors. Therefore, the request for out of state treatment at the Cincinnati Colorectal Center based on the belief that the services are available in Florida. However, there is no documentary evidence or testimony as to what those treatments where or the qualifications of the physicians that could perform the procedures. There was not medical documentation to explain or describe the services and procedures that were requested by the treating physicians were available in Florida.

7. The petitioner's mother believes that the petitioner requires a comprehensive evaluation because of different opinions on medical treatment. The petitioner's mother seeks evaluation from the Colorectal Center in Cincinnati, Ohio. The petitioner and her family are willing to pay for any travel expenses related to the petitioner's care in Cincinnati, Ohio.

CONCLUSIONS OF LAW

The Medicaid Provider Reimbursement Handbook, CMS-1500, page 3-17, describes criteria for Prior Authorization for Out-of-State Services. The introduction section sets forth the following:

> A Florida Medicaid primary care or specialist physician may refer a Medicaid recipient for out-of-state care to obtain medically necessary services that cannot be provided in Florida. The Florida attending physician must request and obtain prior authorization before the recipient receives out-of-state services.

The Florida Administrative Code Rule 59G-1.010(166) 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.

In this instant matter it must be determined whether or not referral for out-of state medical evaluation and treatment is medically necessary, and whether such evaluation and treatment is available in Florida, based on the available evidence.

Paragraph 2. shows that defined medically necessary services must be consistent with symptoms or confirmed diagnosis of the illness or injury under treatment. The opinion of the treating physicians must be given considerable and substantial weight on the diagnosis of the illness and necessary treatment. There must be a conclusion of good cause to overcome the customary weight given the treating physician's opinion (see C.F. v. Department of Children of Families, 934 So.2d 1(2005)).

One of the treating physicians opines that there are differing medical opinions on the diagnosis, either enteric topic anus or perineal fistula, which would require very different surgeries. All three treating physicians recommend for the petitioner to be evaluated, and then treated at the Colorectal Center in Cincinnati Ohio. The Colorectal Center provides for specialized, comprehensive and definitive surgery. Due to the question on the petitioner's specific diagnosis and resulting treatment, it is concluded as medically necessary for the petitioner to be evaluated at a specialized center for colorectal problems, the Colorectal Center in Cincinnati, Ohio, as also opined by a treating physician, Dr.

The evidence is absent a direct reviewing medical opinion from the respondent and recommended treatment. The evidence is not sufficient to establish that another medical provider in Florida has resolved the discrepancy in diagnosis to then provide necessary treatment. Therefore, the respondent is ordered to refer the petitioner for out-of-state evaluation by the Colorectal Center in Cincinnati to confirm the specific diagnoses, and then provide appropriate treatment. This conclusion is consistent with the opinion of the three treating physicians.

DECISION

This appeal is granted. The respondent is ordered to refer the petitioner for evaluation and treatment to the Cincinnati Colorectal Center in Cincinnati, Ohio, according to standard out-of-state referral procedures.

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 26th day of March, 2009,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
Sue McPhee, Area 6 Medicaid Field Manager

F I L E D

MAR 05 2009

OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-07775

PETITIONER,

Vs.

CASE NO. 1289665818

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

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 3, 2009, at 1:00 p.m., in Pensacola, Florida. The petitioner was not present. The petitioner was represented by

Esq. The Department was represented by Eric Schurger, assistant regional counsel.

The hearing was originally scheduled to be held on December 12, 2008 but was continued at the request of the petitioner. The hearing was rescheduled for January 23, 2009. A request for continuance was received by the undersigned authority and the hearing was held on February 3, 2009.

ISSUE

At issue is the Department's action of August 27, 2008 and December 2, 2008 to deny Institutional Care Program (ICP) Medicaid based on a decision that the Medicaid Income Trust was invalid. The parties submitted a Prehearing Stipulation identifying one disputed fact which narrows the issue to the validity of the trustee of an irrevocable Medicaid income trust (Joint Exhibit 1).

BURDEN OF PROOF

The petitioner bears the burden of proof as this was a denial of benefits.

FINDINGS OF FACT

The parties have stipulated to the following facts:

1. The petitioner resides in Rehabilitation and Nursing Center (hereafter ").
2. (hereafter) is a billing, collection, and patient trust fund management service for health care facilities.
3. hired to provide accounts receivable billing and analysis services.
4. owns is associated with
5. The Income Trust" was prepared for the purposes of qualifying for ICP Medicaid on March 17, 2008. This was established as an irrevocable trust. The designated trustee is . The designated successor trustee is Trust Management Committee was not

named in the language of the trust as a successor trustee. The Department's legal office did not approve the Medicaid Income Trust based on a conflict of interest in that the Medicaid Income Trust trustee, is employed by

The Department relied on Florida Statute 400.162 for this determination. The ICP portion of the application was denied. The petitioner was approved for the Medically Needy Program; however, this does not pay for the nursing home cost of care.

6. The petitioner amended her Medicaid Income Trust by appointing Trust Management Committee as the trustee on August 28, 2008.
7. The is employed by to create trust documents for nursing facilities.
8. The Department did not approve the amended Medicaid Income Trust as the petitioner already had an irrevocable Medicaid Income Trust and the remedy in the language of the trust was not followed. A second ICP Medicaid denial was issued.

CONCLUSIONS OF LAW

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

> SSI-Related Medicaid Income Eligibility Criteria.
>
> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows: ... (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in Rule 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in Rule 65A-1.702(14)(a),

F.A.C....(2)(c) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP...(4)(b)1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month...

The petitioner's income exceeded the ICP Medicaid income standard. According to the above authority, individuals with income over the ICP Medicaid income limit may qualify by establishing a qualified income trust which meets criteria set forth in Florida Administrative Code at Chapter 65A-1.702.

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

The eligibility specialist must forward all income trusts to their Region or Circuit Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A-22.1, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.

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

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

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

> from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.

There is no dispute regarding the need for the petitioner to establish an irrevocable Income Trust for ICP Medicaid eligibility. To be eligible to receive ICP, the irrevocable income trust must meet the requirements of a qualified Medicaid income trust.

Florida Statues 400.162 (2008) states:

> (2) No licensee, owner, administrator, employee, or representative thereof shall act as guardian, trustee, or conservator for any resident of the facility or any of such resident's property unless the person is the resident's spouse or a blood relative within the third degree of consanguinity.

The petitioner created an irrevocable Income Trust for the purposes of becoming eligible for ICP. The trustee named was , who is the owner of l. l is employed by . The Department believes that ;annot serve as a trustee for the petitioner's Medicaid income trust because of a conflict of interest created by the relationship between and This decision was made based on the above cited Florida law stating that no employee can act as trustee of a nursing home resident's property, unless the person is a spouse or a specific blood relative. Because the Medicaid Income Trust is irrevocable and the language of the irrevocable trust named one successor trustee, the Department determined that the amended trust by the petitioner to appoint a different trustee who

was not the successor trustee ( ) was invalid. This resulted in the second ICP Medicaid denial.

In the Department's review of the Medicaid income trust, specifically Section 12, Powers of Trustee, at 12.6, which states, "The Trustee may amend the Trust to conform with changes in federal or state law, so as to better effect the purposes of the Trust," it determined that the federal or state law did not change after the creation of the trust and F.S. 400.162 was in effect at the time of the trust creation. Therefore, this provision did not apply. Also, the Department determined that Section 14, Trustee Succession and General Administrative Provisions, at Section 14.3 which states, "If the Trust at any time has no Trustee and no designated successor Trustee who is willing and able to serve, then a Court having jurisdiction may appoint a successor Trustee at the request of any person interested in the Trust, including the Grantor, the Grantor's attorney in fact or guardian, or the State Medicaid Agency" sets forth the appropriate remedy for the trustee problem. The amended trust document by the petitioner changing the trustee to a group not named in the irrevocable trust was not a provision of the income trust.

The petitioner argued that the Department's decision to deny the ICP Medicaid was incorrect because Florida Statute 400.162 does not apply to [illegible] as he is an individual and not a nursing facility and he is a valid trustee for the Medicaid Income Trust. He does not find any authority that requires the petitioner to go to Court to change the trustee in the Medicaid income trust. In the alternative, if this statute does apply, then the petitioner believes the ICP denial was incorrect as the notice issued by

the Department is insufficient in that it does not give the reason for the denial and the reason given is not a basis for application denial and the ICP coverage should be granted.

The undersigned has reviewed the trust documents, the prehearing stipulation and appendices as well as the controlling authorities. In the absence of the petitioner producing an authority which proves otherwise, the undersigned concludes that the above cited Florida Statute does apply to this situation and results in the irrevocable Medicaid income trust not being valid for ICP eligibility purposes. The trustee, performs a duty for that is traditionally performed by the nursing facility and therefore, he would be included in the prohibition. The undersigned concludes that the first ICP Medicaid denial was correct (as all other factors of eligibility were undisputed).

The undersigned concludes that the irrevocable Income Trust at issue addresses trustee successions and specifically names a second individual to succeed in the event of his death, incapacity or resignation. The named individual is associated with and was not chosen as the successor trustee. However, a group, not named in the trust was selected as the trustee on the amended trust. The trust at issue does have a provision for the trustee to amend the trust when the federal or state law changes. However, there was no evidence that the federal or state law changed causing this provision to apply. There is also a provision for when there is no trustee that provides that the Court can appoint one. This provision was not utilized.

The undersigned concludes that because the trust is irrevocable and has a specific named trustee and successor trustee, and the amended trust attempting to change the trustee to someone other than set forth in the irrevocable trust language, the amended trust is not valid and the second ICP Medicaid denial was correct (as all other factors of eligibility were undisputed).

The undersigned concludes that the notices issued to inform the petitioner of the ICP denials are sufficient and did not preclude due process. There is nothing about the notices issued by the Department that would cause ICP eligibility to be granted.

DECISION

The appeal is denied. The Department's ICP Medicaid denial actions are 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 5th day of March, 2009,

in Tallahassee, Florida.

Linda Garton
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: Petitioner
1 DPOES: Jan Blauvelt

FILED

MAR 06 2009

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-07673

PETITIONER,

Vs.

CASE NO. 1288440251

FLORIDA DEPT OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88322

RESPONDENT.

_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 4, 2009, at 9:37 a.m., in West Palm Beach, Florida. The petitioner was not present. Representing the petitioner was , designated representative, Medicaid Eligibility, Inc. Appearing as a witness was , asset protection specialist, Medicaid Eligibility, Inc. Representing the respondent was Terry Verduin, attorney, Circuit 15 Legal. Appearing as a witness was Mildred Talbert, specialist supervisor.

ISSUE

At issue is whether the respondent was correct in denying Institutional Care Program (ICP) Medicaid due to the petitioner's income exceeding Program eligibility limits. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is eighty-three years old (DOB 6-22-25) and resides in a nursing facility. His wife, the community spouse, is seventy-three.
2. An application for ICP Medicaid was submitted, on his behalf, June 30, 2008. As part of the eligibility determination process, the respondent must consider, among all factors, the household income and assets.
3. Prior to the application, joint assets were combined and an annuity was set up June 6, 2008 for $150,000. The annuity was set up with the petitioner in full ownership. Income from the annuity was assigned to the community spouse. The annuity contract was made irrevocable and non-assignable.
4. The total household monthly income is as follows: the petitioner has a pension and Social Security for $1,742; the community spouse for $4,195.71; and the annuity income is $4,172.45.
5. Initially the respondent required additional information concerning the annuity and sent a Notice October 8, 2008. This was not a denial Notice. The representative sent the additional information concerning the annuity in question and the respondent reviewed same by forwarding it to a specialist, November 12, 2008.
6. On November 13, 2008, the specialist noted that the income from the annuity belongs to the petitioner, even though the community spouse was the payee. When this is combined with the petitioner's Social

Security and pension (total $5914.45), the income limit for an individual of $1,911 was exceeded.

7. The respondent then sent the denial Notice November 14, 2008.
8. It is noted that there was discussion with the representative concerning the establishment of an income trust. However, the annuity was established and the trust was not because it would have been less beneficial to the spouse.
9. The representative explains that she followed the step-by-step procedure established by the respondent in determining whether there was a transfer of income or assets. This procedure is found in the respondent's Public Policy Manual, Appendix A-8. She explains that there was no asset or income transfer (see policy 1640.0606-0613).
10. The representative also explains that the policy at 1840.0111, transfer of income, is confusing. She thought she was doing the correct procedure concerning setting up the annuity.
11. The representative would also like to make any corrections to the annuity in order to allow for the ICP eligibility. This is for the benefit of the spouse.
12. Lastly, the representative is concerned that the eligibility determination took longer than the allowable 45 days from the date of application. The respondent explains that there are circumstances that would allow

for longer extensions particularly when there are asset and income situations that need to be explored.

CONCLUSIONS OF LAW

Fla. Admin. Code 65A-1.303 Assets states in part:

(1) Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.

(2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria states in 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.

For the purposes of this instant case, the respondent has not considered whether there is a transfer of asset or income penalty. The respondent has

explained that the cause for the denial is that the income, generated by the annuity, belongs to the petitioner, not his spouse.

65A-1.713 SSI-Related Medicaid Income Eligibility Criteria states in part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
>
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.
>
> (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income....

20 C.F.R. § 416.1121 Types of unearned income states in part:

> (a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

Fla. Integrated Pub. Policy Manual states in part:

> **1840.0109.02 Determining Ownership of Income (MSSI, SFP)**
>
> The individual who has title to the proceeds of a payment or property is the individual who "owns" the income.

If the income is received by an individual's legal representative or guardian, the individual still owns the income.

When a legal representative receives the income, the eligibility specialist may verify ownership through the following documents the designation on the payment, check, award letter, or other document or the title to the property.

In this instant case, the annuity is owned by the petitioner. Therefore, all income generated must belong to the petitioner. Although the monthly income goes to the spouse as the payee, it is still considered the petitioner's.

This case does not consider the transfer issue nor does it consider that the annuity has the spouse and not the State of Florida as the primary beneficiary.

Because the transfer issue in not of consequence, passage 1840.0111 from the Manual, Transfer of Income, is moot.

Fla. Admin. Code 65A-1.205 Eligibility Determination Process states in part:

(b) Time standards for processing applications vary by public assistance program in accordance with 7 C.F.R. §273.2(g), 45 C.F.R. §206.10(a)(3)(i) and 42 C.F.R. §435.911. For Food Stamp and Cash Assistance programs, time standards begin the date following the date the application was filed and end on the date the Department makes benefits available or mails a notice concerning eligibility. For the Medicaid Program, the time standard ends on the date the Department mails an eligibility notice. The Department must process and determine eligibility within the following time frames: For Medicaid, 45 days.

(c) If the eligibility specialist determines at the interview or at any time during the application process that the applicant must provide additional information or verification..., the eligibility specialist must give the applicant ten calendar days to furnish the requested information or to comply with the verification or

employment registration requirement(s). For all programs, verifications are due ten calendar days from the date of written request or 30 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the request or 30 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline 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 applicant does not provide required verifications or information, as applicable, by the deadline date, the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension. When the applicant provides all required information or verification, as applicable, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

(d) In accordance with 42 C.F.R. §435.911, unusual circumstances that might affect the timely processing of Medicaid applications include applicant delay, physician delay and emergency delay as defined below. Unusual circumstances are non-agency processing delays, and the calendar time passing during such delay(s) does not count as part of the 90-day time standard for determining the timeliness of Medicaid eligibility decisions based on disability.

1. Applicant delay is the time attributed to the applicant who fails to keep any scheduled appointment or to provide requested and required eligibility information or verification.

In this instant case, the time standard to complete the case is 45 days. However, when there is additional information required to complete the case, there are allowable delays. Here, the respondent required a copy of the annuity to determine if there was a possible transfer or how to consider the income generated.

The delay in processing, although a burden to the petitioner and his spouse, was unavoidable and had to be undertaken. If there was eligibility, then the respondent would have considered the date eligibility began, to include any possible retroactive months.

DECISION

The appeal is denied. The respondent's action is affirmed. The petitioner's income exceeds Program limits.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 6th day of March, 2009,

in Tallahassee, Florida.

Melvyn Littman

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

Copies Furnished To: Petitioner
9 DPOES Martha Prock

Colleen Farnsworth, Esq.

FILED
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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08F-07770

PETITIONER,

Vs.

CASE NO. 1230474757

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

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 3, 2009, at 1:00 p.m., in Pensacola, Florida. The petitioner was not present. The petitioner was represented by Esq. The Department was represented by Eric Schurger, assistant regional counsel.

The hearing was originally scheduled to be held on December 12, 2008 but was continued at the request of the petitioner. The hearing was rescheduled for January 23, 2009. A request for continuance was received and the hearing was held on February 3, 2009.

ISSUE

At issue is the Department's action to deny Institutional Care Program (ICP) Medicaid based on a decision that the Medicaid Income Trust was invalid. The parties submitted a Prehearing Stipulation identifying one disputed fact which narrows the issue to the validity of the trustee of an irrevocable Medicaid income trust (Joint Exhibit 1).

BURDEN OF PROOF

The petitioner bears the burden of proof as this was a denial of benefits.

FINDINGS OF FACT

The parties have stipulated to the following facts:

1. The petitioner resided in Rehabilitation and Nursing Center (hereafter ").
2. is a billing, collection, and patient trust fund management service for health care facilities.
3. hired to provide accounts receivable billing and analysis services.
4. owns is associated with
5. The was prepared for the purposes of qualifying for ICP Medicaid on March 25, 2007. The designated trustee was The original Income Trust was not offered into evidence.

6. resigned as Trustee of the Income Trust. The restated Income Trust, signed on January 25, 2008, named as the Trustee (Appendix 12, Joint Exhibit 1). This was established as an irrevocable trust. The designated successor trustee identified in the trust is . The Management Committee was not named in the language of the restated trust as a successor trustee.

7. The Department's legal office reviewed the trust naming as trustee. The original trust was not submitted into evidence, however, both parties stipulated the trust dated March 25, 2007 was executed in the same manner as the restated trust with the exception that it attempted to name as successor trustee. The Department's legal office did not approve the Medicaid Income Trust based on a conflict of interest in that the Medicaid Income Trust trustee, , is employed by The Department relied on Florida Statute 400.162 for this determination. The ICP portion of the application was denied. The petitioner was approved for the Medically Needy Program; however, this does not pay for the nursing home cost of care.

8. An attempt was made to amend the Medicaid Income Trust by replacing with Management Committee as the trustee on July 29, 2008.

9. The is employed by to create trust documents for nursing facilities.

10. The Department did not approve the amended Medicaid Income Trust as the petitioner already had an irrevocable Medicaid Income Trust.

11. The petitioner died prior to the commencement of the hearing. The date of death was not provided.

CONCLUSIONS OF LAW

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

> SSI-Related Medicaid Income Eligibility Criteria.
> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows: ... (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in Rule 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in Rule 65A-1.702(14)(a), F.A.C....(2)(c) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP...(4)(b)1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month...

The petitioner's income exceeded allowable ICP income standards. According to the above authority, individuals with income over the ICP income limit may qualify by establishing a qualified income trust which meets criteria set forth in Florida Administrative Code at Chapter 65A-1.702.

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

> The eligibility specialist must forward all income trusts to their Region or Circuit Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A-22.1, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.

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

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

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

There is no dispute regarding the need for the petitioner to establish an irrevocable Income Trust for ICP eligibility. To be eligible to receive ICP, the irrevocable income trust must meet the requirements of a qualified Medicaid income trust. The Department argued that the irrevocable income trust did not meet the requirements of a qualified income trust in that there was a conflict of interest to allow Mr. Stern to be the trustee. Further, the original trust, named another individual as the Trustee. The revised trust was not signed by the original trustee or by the petitioner. As a result, the

ICP application was denied. The petitioner died before a valid trust document acceptable to the Department was established.

Florida Statues 400.162 (2008) states:

(2) No licensee, owner, administrator, employee, or representative thereof shall act as guardian, trustee, or conservator for any resident of the facility or any of such resident's property unless the person is the resident's spouse or a blood relative within the third degree of consanguinity.

The petitioner created an Irrevocable Income Trust for the purposes of becoming eligible for ICP. The trustee of the original trust was [illegible] resigned as trustee of the initial [illegible] Income Trust. The reformed Income Trust named [illegible], who is the owner of [illegible], as trustee. [illegible] is employed by [illegible]. The Department believes that [illegible] cannot serve as a trustee for the petitioner's Medicaid income trust because of a conflict of interest created by the relationship between [illegible] and [illegible]s. This decision was made based on the above cited Florida law stating that no employee can act as trustee of a resident's property, unless a spouse or a specific blood relative. Because the Medicaid Income Trust is irrevocable and the language of the irrevocable trust named one successor trustee, the Department determined that the amended trust by [illegible] to appoint a different trustee ([illegible] who was not the successor trustee was invalid.

In the Department's review of the Medicaid income trust, specifically Section 12, Powers of Trustee, at 12.6, which states, "The Trustee may amend the Trust to conform with changes in federal or state law, so as to better effect the purposes of the Trust" it determined that the federal or state law did not change after the creation of the trust and

F.S. 400.162 was in effect at the time of the trust creation. Therefore, this provision did not apply. Also, the Department determined that Section 14, Trustee Succession and General Administrative Provisions, at Section 14.3 which states, "If the Trust at any time has no Trustee and no designated successor Trustee who is willing and able to serve, then a Court having jurisdiction may appoint a successor Trustee at the request of any person interested in the Trust, including the Grantor, the Grantor's attorney in fact or guardian, of the State Medicaid Agency" sets forth the appropriate remedy for the trustee problem. The amended trust document by the petitioner' trustee, changing the trustee to a group not named in the irrevocable trust was not a provision of the income trust.

The petitioner argued that the Department's decision to deny the ICP Medicaid was incorrect because Florida Statute 400.162 does not apply to ' n as he is an individual and not a nursing facility and he is a valid trustee for the Medicaid Income Trust. He does not find any authority that requires the petitioner to go to Court to change the trustee in the Medicaid Income Trust. In the alternative, if this statute does apply, then the petitioner believes the ICP denial was incorrect as the notice issued by the Department is insufficient in that it does not give the reason for the denial and the reason given is not a basis for application denial and the ICP coverage should be granted.

The undersigned has reviewed the trust documents, the prehearing stipulation and appendices as well as the controlling authorities. In the absence of the petitioner

producing an authority which proves otherwise, the undersigned concludes that the above cited Florida Statute does apply to this situation and results in the irrevocable Medicaid income trust not being valid for ICP eligibility purposes. The attempt to rename as trustee, ' , who performs a duty for that is traditionally performed by the nursing facility represents a conflict of interest. Therefore, he would be included in the prohibition. The undersigned concludes that the ICP Medicaid denial was correct (as all other factors of eligibility were undisputed).

The undersigned finds that the irrevocable trust at issue addresses trustee successions and specifically names a second individual to succeed in the event of his death, incapacity or resignation. The named individual is associated with and was not chosen as the successor trustee. However, a group, not named in the trust was selected as the trustee on the amended trust. The trust at issue does have a provision for the trustee to amend the trust when the federal or state law changes. However, there was no evidence that the federal or state law changed causing this provision to apply. There is also a provision for when there is no trustee that provides that the Court can appoint one. This provision was not utilized.

The original income trust naming as trustee was not submitted into evidence; therefore, there was no evidence to show that the trust met the terms of a qualified Medicaid Income Trust. The undersigned addressed the narrow issue identified by the parties regarding the validity of the trustee, , of the amended trust.

The undersigned concludes that because the trust is irrevocable and has a specific named trustee and successor trustee, and the amended trust attempted to change the trustee to someone other than set forth in the irrevocable trust language, the amended trust is not valid and the ICP Medicaid denial was correct (as all other factors of eligibility were undisputed).

The undersigned concludes that the notice issued to inform the petitioner of the ICP denial was sufficient and did not preclude due process. There is nothing about the notice issued by the Department that would cause ICP eligibility to be granted.

DECISION

The appeal is denied. The Department's ICP Medicaid denial action is affirmed.

NOTICE OF RIGHT TO APPEAL

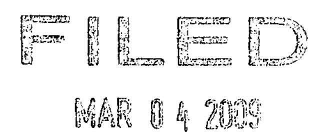
This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, 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 5th day of March, 2009,

in Tallahassee, Florida.

Linda Garton
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To: , Petitioner
1 DPOES: Jan Blauvelt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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 09N-00005

PETITIONER,

Vs.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 20, 2009, at 1:17 p.m., at and Rehabilitation Center, in St. Petersburg, Florida. The petitioner was present. Present on behalf of the petitioner were district manager Long Term Care Ombudsman Counsel, , and ombudsman, M.D. The respondent was represented by administrator. Witnesses for the respondent were director of nursing and social services director.

ISSUE

The respondent will have the burden to prove by clear and convincing evidence that the petitioner's discharge from the notice of December 29, 2008 was in accordance with the requirements of the Code of Federal Regulations at 42 C.F.R. § 483.12:

(a)(2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility

FINDINGS OF FACT

1. The petitioner is a resident of the facility. The facility issued a Nursing Home Transfer and Discharge Notice stating the notice was given on December 29, 2008. The Nursing Home Transfer and Discharge Notice was signed by the administrator and the petitioner on December 30, 2008. The Nursing Home Transfer and Discharge Notice was not signed by a physician nor was a physician's written order attached.

2. At the hearing, the facility did not submit any physician's written order or documentation from the clinical record that the discharge is necessary for the petitioner's welfare and the petitioner's needs cannot be met in the facility. As there was no evidence of a physician order for discharge, the hearing officer did not develop any further merits of the case.

CONCLUSIONS OF LAW

Federal Regulation limits the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that she would be discharged from the facility in accordance with Code of Federal Regulations at 42 C.F.R. § 483.12:

> (a)(2)(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility

The Code of Federal Regulations at 42 C.F.R. § 483.12 sets forth the required documentation:

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

In additional to the regulations, the Nursing Home Transfer and Discharge Notice stated on page one: "The following reasons require either this form be signed by a physician or a physician's written order for discharge or transfer be attached. The signing physician maybe the resident's attending or treating physician, the facility medical director or a nurse practitioner or physician's assistant as a physician designee". The Nursing Home Transfer and Discharge Notice was not signed by a signing physician nor was a signing physician's written order attached. At the hearing, the facility did not submit any signing physician's written order or documentation from the clinical record that the discharge is necessary for the petitioner's welfare and the petitioner's needs cannot be met in the facility. Based on the above cited authorities, the facility action to discharge the petitioner is not consistent with the regulations of the Program.

DECISION

This appeal is granted. The facility may not proceed with the discharge as indicated in the Nursing Home Transfer and Discharge Notice of December 29, 2008.

NOTICE OF RIGHT TO APPEAL

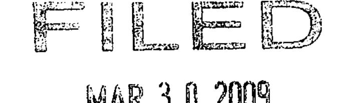
The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the 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 4th day of March, 2009,

in Tallahassee, Florida.

Linda Jo Nicholson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To



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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08N-00235

PETITIONER,

Vs.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 3, 2009, at Nursing and Rehabilitation, at 2:05 p.m., in St. Petersburg, Florida. The petitioner was not present. The petitioner was represented by

Present as a witness for the petitioner was the petitioner's daughter

the petitioner's son, testified by phone. The petitioner's daughters, in person and by phone, were observing. The respondent was represented by regional account receivable specialist. Witnesses for the respondent were

, business office manager, and social services director. , ombudsman was observing.

The record was left open for closing arguments. The hearing officer received the respondent's closing arguments on March 9, 2009. The hearing

officer received the petitioner's closing arguments on March 12, 2009. The record was closed on March 17, 2009.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of December 4, 2008 was in accordance with the requirements of 42 CFR § 483.12(a):

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

FINDINGS OF FACT

1. The petitioner was married to . The petitioner's income was $1,317 in Social Security and a $1,281 pension. The petitioner was admitted to the nursing home on August 1, 2008. On August 1, 2008, the social services director met an individual who identified herself to the social services director as the wife of the petitioner, ı. They discussed payment for the petitioner's stay at the nursing home. The Pay Source Acknowledgement and Facility Guide were signed by the individual who identified herself as , the petitioner's wife. ‹ died in January 2009.

2. The petitioner first twenty days (August 1, 2008 through August 20, 2008) of the petitioner's stay was paid by Medicare. For the next 80 days, Medicare paid a portion of the bill and there remained an amount owed, which the facility refers to as the resident responsibility. An application was filed on behalf of the petitioner for Medicaid Institutional Care Program benefits in September 2008. The application was denied on October 7, 2008. The nursing

home sent billing to the petitioner's wife for services received by petitioner at the nursing home on August 21, 2008, September 1, 2008 and October 1, 2008.

3. In October 2008, the petitioner's son and daughter were named the petitioner's co-guardians. The son and daughter received the court documents in November 2008. The petitioner's son gained access to the petitioner bank accounts in November 2008. The son discovered that all of the petitioner's income was directly deposited in November 2008 into the petitioner and his wife's joint account and that the funds were withdrawn by the wife shortly after deposit. He attested that this left none of the petitioner's funds available for payment to the nursing home for November 2008. The son made payment to the nursing home in the amount of $2,300 in December 2008. In January 2009, the son sent a payment of $2,300 to the nursing home. The son attested that he established a Qualified Income Trust for the petitioner in January 2009. The son stopped payment on the $2,300 check send to the nursing home for payment in January 2009. He determined that it was necessary to stop payment on the January 2009 check sent to the nursing home as the Qualified Income Trust needed to be funded. The guardians have not made payment to the nursing home from the Qualified Income Trust. The petitioner's daughter reapplied for Medicaid in February 2009. As of the date of the hearing, the application was pending approval.

4. On October 24, 2008, the nursing facility sent the guardians letters that the facility was made aware that the son and daughter were handling the petitioner's affairs. On November 7, 2008 and November 21, 2008, the nursing

home sent billing statements to the guardians for payment of services received by petitioner at the nursing home. There was an outstanding balance due for services the petitioner had received at the nursing home. The nursing home sent the petitioner's guardians a Notice of Transfer and Discharge by certified mail on December 4, 2008. The nursing home received a $2,300 payment from the petitioner's son which was accepted on December 15, 2008. On December 22, 2008 and January 18, 2009, the nursing home sent billing statement to the guardians for payment of services received by petitioner at the nursing home. In January 2008, the nursing home received a $2,300 payment from the petitioner's son. That January 2009 payment of $2,300 was indicated by the nursing home as returned for non payment. The billing statement of January 19, 2008 shows a balance owed of $25,202. As of the date of the hearing, there remains an unpaid balance due to the nursing home for services received by the petitioner at the nursing home.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255. The Florida Statutes at 400.0255 (10)(a) set forth that a resident is entitled to a fair hearing to challenge a nursing home's proposed transfer or discharge. Matters that are considered at this type of hearing are the decisions by the facilities to discharge patients. Federal regulations limit the reason for which a Medicaid or Medicare certified nursing home facility may discharge a patient. In this case, the petitioner was sent notice

indicating that he would be discharged from the nursing home in accordance with the Code of Federal Regulations at 42 CFR § 483.12(a):

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

In this venue, the appealable issue for this case is whether or not the resident has failed, after reasonable and appropriate notice, to pay for a stay at the nursing home. The petitioner has been a resident in this nursing home since August 1, 2008. Medicare paid for the petitioner's stay from August 1, 2008 through August 20, 2008. For the next 80 days, Medicare paid a portion of the bill and there remained an amount owed, referred to by the nursing home as the resident responsibility.

Billing statements were sent to the family for each month the nursing home provided services to the petitioner. The resident did not make payment for the remainder of the month of August 2008 and has not made payment for the months of September 2008, October 2008, November 2008 or February 2009. One partial payment was received in December 2008 in the amount of $2,300. For the payment of $2,300 made by the son in January 2009, was not honored by the bank for which the check was drawn. As of the date of the hearing, reasonable and adequate financial arrangement has not resulted. A substantial balance is still owed as of the hearing date.

The petitioner has asserted two theories for the nonpayment of the bill. One theory is that the resident is not the responsible party for the payment. The second theory appears to be question the amount owed. This tribunal is limited

in the scope of reviewing accounts that are owed for services rendered to the resident. As previously stated, the only factors that can be reviewed are whether there was reasonable and appropriate notice provided and whether there is an outstanding balance owed. The other matters that have been asserted are more appropriate for a different court of competent jurisdiction. If there are issues regarding the petitioner's March 2009 application for Medicaid eligibility or benefits, those matters should be addressed in a fair hearing. How to request that hearing is described in notices provided by the Department of Children and Families.

The hearing officer concludes that the nursing home has given the petitioner and his family reasonable and appropriate notice of the need to pay for expenses incurred for the petitioner's stay at the nursing home since August 21, 2008. Notice was provided and a balance remains. Based upon the above cited authorities, the hearing officer finds that the nursing home'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 petitioner's 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, to an appropriate 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 30th day of March 2009,

in Tallahassee, Florida.

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

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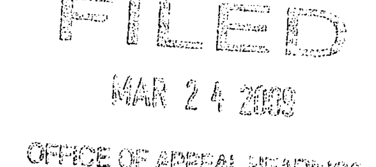

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 08N-00250

PETITIONER,

Vs.

RESPONDENT.
______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on February 26, 2009, at 1:50 p.m., at the respondent facility. The petitioner was not present. Her granddaughter, , represented her. , ombudsman, Long-Term Care Ombudsman Program, was also present. The respondent was represented by , nursing home administrator, business office manager, and director of social services.

A continuance was granted to the respondent for a prior scheduled hearing.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of December 17, 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

1. The petitioner became a resident in the above mentioned nursing facility in November 2008. At the time of her admission, she was considered to be in a Medicaid pending status. An application for Institutional Care Program (ICP) Medicaid was submitted to the Department of Children and Families with assistance from the staff at the nursing facility.

2. On December 15, 2008, the ICP application was denied because the petitioner had assets in excess of the ICP Medicaid asset limit. The petitioner has a $125,000 CD. It is held by a bank and the family is unable to access it.

3. Once the application for ICP was denied, the petitioner's status changed to private pay rather than Medicaid pending status. On December 17, 2008, the respondent issued a Nursing Home Transfer and Discharge Notice, with the discharge location as her granddaughter's address of ,
Florida (Respondent's Exhibit 1). A copy was sent to the petitioner's granddaughter along with a statement showing an outstanding balance of $16,443. This was the first statement to the family about the amount of the bill.

4. The Respondent's Exhibit 2 is a statement showing the outstanding balance that will be owed at the end of March 2009 as $23,944.00. The statement shows the petitioner has been paying a patient liability each month since her admission. In November and December 2008, it was $1073. In January 2009, it increased to $1176.

5. The respondent explained that the petitioner's granddaughter has been in constant touch with the facility trying to access the CD to pay for her grandmother's care. She signed for the registered mail that contained the discharge notice and bill. She has not received any other statements. The respondent further explained that statements were returned from the granddaughter's address as undeliverable. No explanation could be given for that since the granddaughter verified the address was correct. Other statements were mailed to [illegible], which is not her address. It could have been a prior facility the petitioner resided in.

6. The discharge location is the home of the granddaughter. She is not able to care for her 100 year old grandmother. She cares for her mother now and works full time. The facility could not find placement for the petitioner because of her private pay status. Originally, the plan was to send her to her granddaughter's with hospice care, but she is no longer receiving hospice services.

7. The petitioner's granddaughter did not know that her grandmother had a large CD until the Department of Children and Families told her about it. Since then, she has been trying to access it to pay for her grandmother's care. She has an attorney who is filing for guardianship rights for her. She hopes this will allow her access to the CD to pay for the petitioner's care. She was unable to get access as power of attorney for her mother since the CD is in trust for her mother and brothers.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255 F.S. 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 the nursing facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a):

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless...
> (v)The resident has failed, **after reasonable and appropriate notice to pay for a stay at the facility.** (emphasis added)

The petitioner is a resident of the respondent's nursing facility. She became private pay retroactive back to her admission date, once her ICP Medicaid application was denied.

The above cited rule states that the respondent can discharge if the resident has failed to pay **after** reasonable and appropriate notice to pay has been given. The findings show that the first notice to pay was sent along with the discharge notice. Based upon the above cited authorities, the hearing officer finds that the facility's December 17, 2008 action to discharge the petitioner is not in accordance with federal regulations. The bills sent subsequent to the discharge notice were not to correct addresses. However, bills sent after the discharge notice would not satisfy this regulation.

The respondent has the burden of proof. As the petitioner disputed receiving any monthly statements, only the one with the discharge notice, the respondent would have the burden to prove the monthly statements were sent. The respondent did not provide copies of the monthly billing, and gave testimony that one statement was sent with the discharge notice. Returned mail was received for any future mailings to the petitioner's granddaughter's address. Another statement was sent to an incorrect address since

neither the petitioner nor her family receives mail at that address. Therefore, the undersigned concludes that the facility has not met its burden proof.

As reasonable and appropriate notice has not been demonstrated, the respondent must permit the petitioner to remain in the facility and the respondent may not proceed with the proposed discharge. This decision does not act to alter or change any outstanding facility bill for the petitioner or preclude the respondent from any future discharge actions.

DECISION

The appeal is granted. The respondent may not proceed with the intended discharge of the petitioner from its facility as explained in the above conclusions.

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, 2009,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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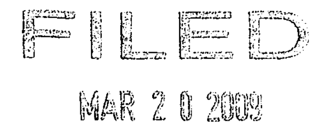

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 09N-0012

PETITIONER,

Vs.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 10, 2009, at 12:00 p.m., in Miami, Florida. The petitioner was present and represented himself at the hearing along with the assistance of , ombudsman. Representing the facility was , nursing home administrator. Present as witnesses for the respondent were: Dr. facility physician and social worker. served as translator.

ISSUE

At issue is whether or not the facility's action of January 9, 2009 to discharge the petitioner is an appropriate action, based upon the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because, "Your health has improved sufficiently so that you no longer need the services provided by this facility." The nursing home has the burden of proof to establish that the discharge action is consistent with federal regulations.

FINDINGS OF FACT

1. The petitioner (age 64) is a resident of _ Medical Center in Miami-Dade County. The petitioner was admitted to the facility in July 2008 with multiple medical problems. The petitioner was prescribed medications and physical and occupational therapies.
2. On July 18, 2008 while in the facility, the petitioner experienced rectal pain and he was found suffering from hemorrhoids. They found that he had anemia due to bleeding hemorrhoids and underwent surgery and returned to the facility on July 23, 2008. The anemia was resolved by December 2008 as demonstrated by test results received.
3. The petitioner's left shoulder problem has improved with therapies and has range of motion in his shoulder and arm, and has been doing without the pain medication.
4. In September 2008, the petitioner was progressing well and walking independently and his physical therapies continued.
5. In October 2008, the petitioner was transferred to the hospital and was diagnosed with diabetes mellitus and returned to the facility within a few days. The petitioner was now on insulin for the diabetes.
6. On October 27, 2008, the petitioner was seen by the psychiatrist and diagnosed with depression. He was placed on antidepressant medication as he felt that he was unable to work and provide for his family in Haiti.

7. The physician states that the petitioner's medical problems are all controlled with medication and that he is totally independent with all activities of daily living including meals.
8. On January 8, 2009, the facility's physician authorized the facility to initiate the discharge process for the petitioner, as he was found from a medical standpoint, that he has improved sufficiently where he no longer requires the services of the facility.
9. A Notice of Discharge was issued to the petitioner with an intended discharge date of January 9, 2009. The petitioner filed for an appeal of that action.

CONCLUSIONS OF LAW

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

> (a) *Transfer and discharge*- (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plants or not. (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident ... (iii) Include in the notice the items described in paragraph (a)(6) of this section. (6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following: (i) The reason for the transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; ...

The petitioner's concern during the hearing was in knowing, that in the event he needed to return to the facility would he be able to do so.

Pursuant to federal guidelines, the nursing facility issued a Nursing Facility Transfer and Discharge Notice (AHCA form) to the petitioner. The nursing home representative and the facility's physician signed the form, as well as the petitioner. The notice, as required, noted the reason for the discharge as "your health has improved sufficiently so that you no longer need the services provided by this facility."

The hearing officer finds that the petitioner presented no medical evidence or testimony to contradict the medical opinion presented by the facility's physician. The notice issued by the facility provided a location, to which the petitioner was to be discharged and therefore, all requirements were found to have been met by the nursing facility.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 20th day of March, 2009,

in Tallahassee, Florida.

A. G. Littman

A. G. Littman
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

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OFFICE OF APPEAL HEARING
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 08N-00244

PETITIONER,

Vs.

CASE NO.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on February 16, 2009, at 1:41 p.m., in Orlando, Florida. The petitioner appeared. ombudsman, appeared and represented the petitioner. petitioner's mother, and petitioner's fiancé, appeared as witnesses for the petitioner. , petitioner's stepfather, appeared but did not testify. facility administrator, appeared and represented the respondent. unit manager, , admissions director, , director of nursing, rehabilitation director, and , licensed practical nurse and care plan coordinator, appeared as witnesses for the respondent.

ISSUE

At issue is the respondent's action of December 16, 2008, intending to discharge the petitioner effective January 17, 2009, due to his health improving sufficiently so that he no longer needs the respondent's services. The respondent bears the burden of proof in this appeal.

FINDINGS OF FACT

1. The respondent admitted the petitioner to its facility on August 5, 2008, after the petitioner suffered and was recovering from severe injuries resulting from a vehicular accident. His injuries included traumatic brain injury.
2. The petitioner was sent to the facility to begin short-term rehabilitative therapy to regain the ability to perform activities of daily living. His treatment included both occupational and physical therapy.
3. His first set of therapy occurred from August 6, 2008, through August 20, 2008. He made progress.
4. Due to a near fall in November 2008, the petitioner was given intense therapy again from November 18, 2008, through December 3, 2008. He was discharged from therapy on December 3, 2008, due to his achievement of the maximum result possible.
5. The facility found that the petitioner's therapy resulted in his improvement in completing activities of daily living (ADLs) including repositioning and transferring himself, ambulation, bathroom and hygiene tasks, and feeding himself.

6. The facility also administered a mental health and cognitive evaluation of the petitioner. He scored high on the test.
7. Because of the petitioner's physical and mental improvements, the facility felt he achieved sufficient health to be discharged. The facility held a final discharge meeting and issued a Nursing Home Transfer and Discharge Notice to the petitioner on December 16, 2008. The discharge was effective January 17, 2009. The petitioner's attending physician did not sign the discharge notice nor did he write an order for the petitioner's discharge to take place.
8. The petitioner appeals. At the hearing, both parties stated that after the discharge notice was issued, the petitioner was evaluated by a neurologist. The neurologist's report indicates that the petitioner needs further testing and recommended continued physical, occupational, and cognitive therapies.

CONCLUSIONS OF LAW

Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Regarding transfer and discharge rights from a facility, 42 C.F.R. § 483.12 states in relevant part:

> **...(2) *Transfer and discharge requirements*. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-**
>
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; [emphasis added]

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

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) ***Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-**

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. [emphasis added]

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

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

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

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

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

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

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged...

(7) *Orientation for transfer or discharge.* A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

The evidence shows that the neither the petitioner's attending physician nor any physician involved signed the notice authorizing the discharge from the facility. No separate doctor's order authorizing discharge was issued either. The regulation above requires that when a facility intends to discharge a patient due to his health improving, a physician must authorize, in writing, such discharge. The hearing officer finds that the facility failed to comply with the federal regulation cited above because the petitioner's physician did not authorize his discharge.

DECISION

The appeal is granted. The facility may not discharge the petitioner based on the notice dated December 16, 2008.

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 5th day of March, 2009,

in Tallahassee, Florida.

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

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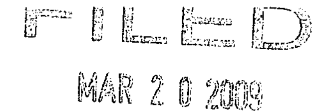
Respondent



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

APPEAL NO. 08N-00242

PETITIONER,

Vs.

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on February 26, 2009, at 11:15 a.m. at the respondent facility in Saint Augustine, Florida. The petitioner was not present. She was represented by her niece, facility administrator, represented the respondent. financial specialist and assistant financial specialist were present as witnesses for the respondent. The petitioner's nephew, was present as an observer.

ISSUE

At issue is whether or not the nursing home's January 28, 2009 proposed action discharge the petitioner from the facility is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because her "bill for services at the facility has not been paid after reasonable

and appropriate notice to pay". The nursing home has the burden of proof at the level of clear and convincing.

FINDINGS OF FACT

1. The petitioner (age 95) has been a resident at the respondent nursing facility since February 2008. The petitioner's payer source at the time of entry was Medicare. For the first twenty days of the petitioner's stay, Medicare paid 100% of the facility's charges; for another eighty days Medicare paid approximately 20% of the facility charges. All Medicare coverage ended in May 2008. The petitioner was then considered private pay. The facility bills the petitioner at a rate of $190 per day.

2. On January 28, 2009, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner effective "thirty days from date received or 30 days from date on certified receipt." The Notice indicated the reason for transfer as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The balance due shown on the notice was $52,490.51. As of the day of the hearing, the petitioner's balance had increased to $54,947.51

3. The facility provided evidence which proves that bills were mailed by regular mail monthly to the petitioner's niece who is also her Power of Attorney. The petitioner's niece admitted that she received the monthly billing statements. The facility asserted that in addition to mailing the monthly bills, numerous calls and e-mails have been exchanged with the petitioner's niece regarding the outstanding balance. The facility initiated discharge action in January 2009; the location to which the petitioner is to be discharged is the niece's home.

5. The petitioner's niece did not dispute that monies are owed to the facility; however, she believes respondent failed to adequately facilitate the approval of multiple applications for Institutional Care Program (ICP) Medicaid on the petitioner's behalf. She argued that facility staff assured her that the facility was responsible for acting on the petitioner's behalf during the Medicaid eligibility determination process and therefore the subsequent denials of ICP Medicaid by the Department of Children and Families were the fault of the facility. She believes the denials of the Medicaid applications (both parties stipulated that at least two ICP applications were filed) were a result of the facility not relaying or explaining the Department's requests for additional information to her and were it not for these facility deficiencies, the Medicaid applications would have been approved and the facility's bills would have been paid by Medicaid. The facility explained that the financial specialists attempt to assist residents with Medicaid applications, but the ultimate responsibility is always that of the resident or the resident's representative.

CONCLUSIONS OF LAW

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

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

(2) Transfer and discharge requirements. The facility must permit

each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

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

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(vi) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

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

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

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

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

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

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

The legal authority cited above explains the reasons for which a Medicaid or Medicare certified nursing facility may discharge a resident.

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

(15)(b) ...The burden of proof must be clear and convincing evidence...

The facility wishes to discharge the petitioner. The legal authority cited above makes it clear that the facility holds the burden of proof at the level of clear and convincing.

The fact that the petitioner owes a balance to the facility is not disputed. The facility provided evidence which shows that as of the date of the hearing, the petitioner's outstanding balance was $54,947.51. The petitioner's representative believes the facility's bills have not been paid because the facility did not take the action necessary ensure the petitioner's applications for Institutional Care Medicaid were approved and therefore the facility is ultimately responsible for the unpaid balance.

After carefully reviewing all the evidence, the undersigned concludes the respondent met its burden; the proposed discharge of the petitioner from the facility is in accordance with the reasons stated in the Federal Regulations.

DECISION

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

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.

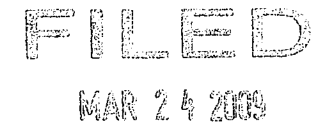
DONE and ORDERED this 20th day of March, 2009,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:



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

APPEAL NO. 08N-00245

PETITIONER,

Vs.

RESPONDENT.
_________________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned hearing officer on February 11, 2009, at 2:40 p.m., in Melbourne, Florida. The petitioner was not present. Her daughter, , represented her. Department of Children and Families' eligibility supervisor, appeared by telephone as a witness. , nursing home administrator, represented the respondent. , social services director, and , business officer manager, also gave testimony.

ISSUE

The respondent had the burden to prove by clear and convincing evidence that the petitioner's discharge in the notice of December 17, 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

1. The petitioner was admitted to the respondent's nursing facility on September 16, 2008. She was admitted in a Medicaid-pending status.

2. On September 26, 2008, an application for Institutional Care Program (ICP) Medicaid was submitted to the Department of Children and Families (DCF) on the petitioner's behalf. DCF requested information to complete the eligibility determination process. Some of the information requested was difficult for the petitioner's daughter to secure. On December 9, 2008, DCF denied the petitioner's ICP application. An appointment with the petitioner's daughter and the nursing facility was set for December 12, 2008 to reapply for ICP benefits with the help of the nursing facility. The petitioner's daughter did not keep that appointment. She explains that she still did not have the information that DCF wanted, so she saw no point in reapplying at that time. She believes that she battled with DCF over the value of a condominium, where the money from the sale of it went, and over a bank account her mother supposedly had that she could not find.

3. Once the application for ICP was denied, the petitioner's status changed to private pay. On December 17, 2008, the respondent issued a Nursing Home Transfer and Discharge Notice, with the discharge location listed as her daughter's address of (Respondent's Exhibit 1).

4. The respondent explained that monthly statements were sent to the petitioner's daughter for the patient responsibility amounts only. A corrected invoice was sent once the petitioner moved to private pay in December 2008. The Respondent's Exhibit 2 is a

statement dated February 11, 2009. As of that date, the outstanding balance was $26,862.98. It shows total charges of $35,056 and payments made of $8,193.02.

5. A new application for ICP benefits was submitted to DCF on December 23, 2008. Although the application had been denied, DCF's supervisor explained that it has been re-opened and is still in pending status. She informed the petitioner's daughter exactly what was needed to complete the eligibility process. She explained that it looked like coverage could go back as far as November 2008. The petitioner may not be eligible for September and October 2008 because of some assets that would have made her ineligible. The nursing facility wants to resolve the issue if ICP benefits are approved, as a payment plan could be set up for the rest of the balance.

6. Discharge planning was stopped when a hearing was requested. The petitioner's daughter explained that she cannot take care of her mother. The nursing home administrator assured her that they will provide a safe discharge location, if needed.

CONCLUSIONS OF LAW

Jurisdiction to conduct this type of hearing is conveyed to the Department by Florida Statutes at 400.0255 F.S. 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 the nursing facility in accordance with the Code of Federal Regulations at 42 C.F.R. § 483.12(a):

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless...
> (v)The resident has failed, after reasonable and appropriate notice to pay for a stay at the facility.

any outstanding bill for the petitioner or preclude the respondent from any future discharge actions.

DECISION

The appeal is granted. The respondent may not proceed with the intended discharge of the petitioner from its facility as explained in the above conclusions.

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, 2009, in Tallahassee, Florida.

Margaret Poplin
Hearing Officer
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Tallahassee, FL 32399-0700
850-488-1429

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