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

[redacted]

APPEAL NO. 08F-01144

PETITIONER,

Vs.

CASE NO. 1083677161

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 10 BROWARD
UNIT: BV972

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 12, 2008, at 10:10 a.m., in [redacted] Florida. The petitioner was not present. She was represented by her daughter, [redacted] Also present was [redacted], the petitioner's son-in-law. The respondent was represented by [redacted] claims manager from the Benefit Recovery Program.

The record was held open for 14 days from the date of the hearing, which was through March 26, 2008, to allow the parties an opportunity to provide information into evidence. The respondent submitted copies of 12 pages of the Medicaid Program transfer of assets policy from the Public Assistance Policy Manual, into evidence within the time limit. No information was submitted into evidence from the petitioner within the time limit.

ISSUE

At issue is the Department's October 23, 2007 action to determine that the petitioner was overpaid $28,041.72 in Medicaid benefits in October 2005 through March 2006, due to an inadvertent household error. The respondent has the burden of proof.

FINDINGS OF FACT

1. Included in the evidence is a copy of a Notice of Overpayment form that is dated October 23, 2007, informing the petitioner that the Benefit Recovery Program determined that she was overpaid $28,041.72 in Medicaid benefits in October 2005 through March 2006, due to an inadvertent household error.

2. The October 23, 2007 notice was mailed to the petitioner at the [redacted] Florida. This is where the petitioner has been residing from at least since the time of the overpayment claim.

3. The date of this appeal was February 14, 2008. This is more than the 90 days allowed to appeal a Department's action, however the petitioner's representative claimed to not receive the October 23, 2007 notice that was mailed to the nursing home. She claimed that she first found out about the overpayment claim when her mother later started receiving statements informing her about it.

4. Included in the evidence are copies of computer Paid Claims File screens showing that Institutional Care Program Medicaid benefits of $28,041.72 was paid for the petitioner for October 2005 through March 2006.

5. The petitioner owned a condominium apartment located at [redacted] Included in the evidence is a copy of a computer screen showing that this property was sold in March 2005 for $68,000.00.

6. Included in the evidence is a copy of a notice dated October 8, 2007, that was mailed to the petitioner at the nursing home. It states that the Benefit Recovery Program learned that her property was sold in March 2005, and the petitioner was given a deadline of October 18, 2007, to provide the Department with information about the sale of the property. Information from the petitioner was not provided to the Department within the time limit. The petitioner's representative asserted at the hearing that she did not receive the October 8, 2008 notice.

7. According to the petitioner's representative at the hearing, the property was bought by the petitioner in the year 2000 for about $19,000.00. Then the petitioner went into the nursing home in 2002. Then in 2004, the property was quit-claimed deeded from the petitioner to her daughter [redacted]. Then in March 2005, [redacted] sold the property to another party for $68,000.00.

8. It was determined by the Benefit Recovery Program that the petitioner was overpaid the Medicaid benefits as an inadvertent household error, due to the petitioner transferring her property.

CONCLUSIONS OF LAW

Fla. Admin. Code at 65A-1.900 explains overpayments, and states in part:

> (c) Medicaid overpayments shall be recovered as required in Section 414.41, F.S.

The Public Assistance Policy Manual at 1640.0600 explains the transfer of assets policy in the Medicaid Program. On October 23, 2007, the Benefit Recovery Program determined that the petitioner was overpaid $28,041.72 in Medicaid benefits in October

2005 through March 2006, due to an inadvertent household error. The date of this appeal was February 14, 2008.

This is more than the 90 days allowed to request a hearing from an action taken on October 23, 2007. The notice informing the petitioner about the Medicaid overpayment claim was mailed to her at a nursing home. The petitioner's representative claimed that she did not receive the notice. Since it was not shown that she received the notice, the appeal is not denied due to requesting a hearing beyond the 90 day time limit.

The findings show that the petitioner bought a condominium apartment in the year 2000 for about $19,000.00. Then the petitioner went into the nursing home in 2002. Then in 2004, the property was quit-claimed deeded from the petitioner to her daughter. Then in March 2005, her daughter sold the property to another party for $68,000.00. It was determined by the Benefit Recovery Program that the petitioner was overpaid $28,041.72 in Institutional Care Program Medicaid benefits as an inadvertent household error, due to the petitioner transferring her property.

After careful consideration, it is concluded that the petitioner transferred her property without fair compensation. The Benefit Recovery Program's determination that the petitioner was overpaid $28,041.72 in Medicaid benefits in October 2005 through March 2006, due to an inadvertent household error, is upheld. The petitioner is responsible for the repayment of the Medicaid benefits that were paid on her behalf.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner

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

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

in Tallahassee, Florida.

Stuart Imberman

Stuart Imberman
Hearing Officer
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850-488-1429

Copies Furnished To [redacted]

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

[redacted]

APPEAL NO. 08F-02657

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 9, 2008, at 9:48 a.m., in [redacted] Florida. The petitioner was not present. He was represented by his parents, [redacted] Witness for the petitioner was [redacted] licensed practical nurse. The respondent was represented by [redacted], health care program analyst. Witness for the respondent from Keystone Peer Review Organization (KePRO) was [redacted] M.D., physician reviewer. [redacted] review operation manager, was observing.

ISSUE

The petitioner is appealing the notices of April 4 and 10, 2008 for the respondent's action to deny 360 hours of private duty nursing for the period of

April 1, 2008 through September 27, 2008. The respondent has the burden of proof.

FINDINGS OF FACT

The petitioner received a PDN/PC Recipient Reconsideration - Denial Upheld notice on April 4, 2008. The notice informed the petitioner that for the requested hours of private duty nursing for the period April 1, 2008 through September 27, 2008, 360 hours were denied.

1. The petitioner care is medically complex. He was receiving private duty nursing private duty nursing. The petitioner resides with his parents and two siblings. The both parents work. The parents have been trained in the petitioner's care.

2. The nursing agency requested 2883 hours of private duty nursing for the petitioner for the period of April 1, 2008 through September 27, 2008. The nursing agency provided information regarding his diagnosis, skilled needs and medication and family dynamics. The provider indicated that mother worked Monday and Friday 7:30 a.m. to 4:00 p.m., Tuesday through Thursday 7:30 am to 3:00 p.m. and every other Saturday from 10: a.m. to 2 p.m. The provider indicated that the father works Sunday through Saturday from 7:30 a.m. to 6: 30 p.m. and evenings at home from 8:00 p.m. to 10:00 p.m. The father is also required to go out of town for work one week every month.

3. Prior authorization for private duty nursing is reviewed every 180 days. KePRO is the contract provider for the respondent for the prior authorization

decisions for private duty nursing. The request for private duty nursing is reviewed by a nurse reviewer and a physician consultant.

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

5. The initial physician reviewer determination was based on the information received from the nursing agency. The initial physician reviewer determined that the 360 hours of private duty nursing was not medically necessary. The 360 hours of private duty nursing was everyday between the hours of 9:00 p.m. and 11:00 p.m. That determination was based on the physician review's opinion that the mother was able to sleep from 11:00 p.m. to 7:00 a.m. and was capable of caring for the petitioner during the hours of 9:00 p.m. to 11:00 p.m. A PDN/PC Recipient Denial Letter was sent to the petitioner on April 4, 2008. The notice informed the petitioner that 360 hours of private duty nursing were denied for the period of April 1, 2008 through September 27, 2008.

6. The nursing agency requested a reconsideration. The reconsideration was reviewed by a second physician reviewer. The reconsideration was denied for 360 hours of private duty nursing. The respondent sent a PDN/PC Recipient Reconsideration - Denial Upheld notice on April 10, 2008.

7. The mother attested that she is falling asleep by the time it is 9:00 p.m. The petitioner is in need of constant care with constant suctioning and possibility of aspiration at all times. From the time she gets home from work, she provides total care for the petitioner until the nurse arrives at 9:00 p.m. She sleeps from 9:00 p.m. to 5:00 a.m. She wakes up at 5:00 a.m. She gets herself ready for work and the other two children ready for school. She is at work by 7:00 a.m. She is not sleeping until 7:00 am. She opinioned that is would be a danger to the petitioner if she were to provide additional care for the petitioner from 9:00 p.m. to 11:00 p.m. and sleep only from 11:00 p.m. to 5:00 a.m.

8. The provider notified KePRO extensively of the petitioner G-tube feeding. The provider did not provide information that the parents were unavailable from 9:00 p.m. to 11:00 p.m. The KePRO physician reviewer indicated that had KePRO received from the provider the information attested to at the hearing of the parents' unavailability, coverage for those hours of unavailability would have been considered.

CONCLUSIONS OF LAW

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

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

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

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

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

The denial was based on the availability of the parents. Based on the evidence received from the provider, the respondent's decisions at the time of

the reduction on April 1, 2008 and for the reconsideration on April 10, 2008 were correct. However, the provider did not fully inform the respondent of the parents' availability. The parents sleep from 9:00 p.m. to 5:00 a.m. The mother gets herself ready for work and gets other two children ready for school. By 7:00 a.m. the mother is at work. The father is not always in the home as he is away on business at least one week a month. The KePRO physician reviewer indicated that had KePRO received from the provider the information attested to at the hearing of the parents' unavailability, coverage for those hours of unavailability would have been considered. The hearing officer concludes that private duty nursing between the hours of 9:00 p.m. and 11:00 p.m. is medically necessary. Based on the above cited authorities, the respondent's action to deny 360 hours of private duty nursing for the period of April 1, 2008 through September 27, 2008 is reversed.

DECISION

This appeal is granted.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 20th day of May, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO: 08F-02697

PETITIONER,

Vs.

CASE NO. 1119694841

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on May 20, 2008, at 11:20 a.m., in [redacted] Florida. The petitioner was not present. Representing the petitioner was his daughter-in-law, [redacted] Representing the respondent was [redacted] specialist II. Appearing as a witness wa[redacted], specialist I.

ISSUE

At issue is whether the respondent correctly calculated the petitioner's Social Security income in the Institutional Care Program (ICP) Medicaid. The respondent has the burden of proof.

FINDINGS OF FACT

1. The petitioner has been receiving ICP Medicaid. As part of the patient responsibility, the respondent considers the petitioner's income to include that from Social Security.
2. The respondent used its FLORIDA computer system to obtain information from Social Security (SSA). The gross amount of the petitioner's monthly check, effective December 2007 following the cost of living increase, was $1,629. This is the amount that the respondent used in its calculations.
3. The representative explains that the Internal Revenue Service (IRS) is withholding $200 per month from the Social Security check due to unpaid back taxes. The representative explains that she can no longer make up this deficit for the petitioner.
4. The respondent explains that they must consider the gross pay as their policy does not allow for them to exclude the IRS garnishment.

CONCLUSIONS OF LAW

Fla. Admin. Code 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

1840.0102 Deductions from Gross Income (MSSI, SFP)

Some deductions withheld from gross income must be included as income. Examples of these deductions include:

1. premiums for Supplemental Medical Insurance (SMI/Medicare) from a Title II (Social Security) benefit,

2. premiums for health insurance or hospitalization,

3. premiums for life insurance,

4. federal and state income taxes,

5. Social Security taxes,

6. optional deductions,

7. a garnished or seized payment,

8. guardianship fees, and

9. child support if redirected irrevocably from the source.

Note: If the naming of a guardian is a requirement to receive the income, deductions for guardianship fees are disregarded, i.e., are not counted as income. **This is the only exception**. [My emphasis]

Upon review, the respondent has correctly calculated the petitioner's gross SSA income. There is no exception when IRS garnishes part of the income to exclude it when calculating the patient responsibility.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 28th day of May, 2008,

in Tallahassee, Florida.

Melvyn Littman

Melvyn Littman
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850-488-1429

Copies Furnished To: [redacted]

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 08F-01556

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
DISTRICT: 03 Alachua
UNIT: 88325

CASE NO. 1225366372

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on April 7, 2008, at 10:15 a.m., in [redacted] Florida. The petitioner was not present. Present representing the petitioner by telephone was his daughter, [redacted] Present as witnesses for the petitioner were [redacted] unit nurse [redacted] and [redacted] administrator, [redacted] The Department was represented by [redacted], ACCESS supervisor. Present as witnesses for the Department were [redacted] supervisor CARES unit, Department of Elder Affairs and [redacted] CARES assessor, Department of Elder affairs.

ISSUE

The petitioner is appealing the Department's action of February 19, 2008, to deny his application for Institutional Care Program Medicaid benefits. The petitioner is

requesting Institutional Care Program Medicaid benefits effective December 2007 and ongoing.

The petitioner had the burden of proof as he was applying for assistance.

FINDINGS OF FACT

1. The petitioner is a resident of [redacted] County, Florida. On February 17, 2007, he was admitted into [redacted], which is a skilled nursing facility. The facility has a secure unit for individuals with behavioral problems due to dementia and/or Alzheimer disease.

2. The petitioner has been diagnosed with dementia, Alzheimer disease, anemia and gastroesophageal reflux disease (GERD). The petitioner has a history of episodes of resisting care, episodes of aggression and episodes of sexually inappropriate behavior. The petitioner's psychologist does not consider the petitioner to be an immediate danger to him or others. Based on the un-rebutted evidence presented [redacted] staff can address the petitioner's medical needs and his behavioral problems. The petitioner's physician recommended that the petitioner be placed in a skilled nursing facility.

3. On November 16, 2007, the petitioner filed an application for Institutional Care Program Medicaid. On February 13, 2008 the Department of Elder Affairs, CARES withheld the petitioner's level of care because of concerns regarding continued incidents of aggression involving other patients. However, the Department of Elder Affairs, CARES determined that the petitioner met the level of care criteria due to his dementia from at least December 1, 2007.

4. On February 19, 2008, the Department denied the petitioner's application for Institutional Care Program benefits because CARES withheld his level of care. The Department also denied the petitioner's application for Institutional Care Program benefits because of excess assets. However, during the hearing the Department stated that they were rescinding the denial based on excess assets as the petitioner's total assets have not been determined.

CONCLUSIONS OF LAW

42 C.F.R. § 483.132 Evaluating the need for NF services and NF level of care. In part states:

> (c) Data. At a minimum, the data relied on to make a determination must include:...(2) Evaluation of mental status (for example, diagnoses, date of onset, medical history, likelihood that the individual may be a danger to himself/herself or others);...

Fla. Admin. Code 59G-4.180 and 59G-4.290 establishes criteria, which must be met in order for nursing, and rehabilitation services to qualify as intermediate care services or skilled services. For an individual to be eligible for Institutional Care Program benefits he must meet the level of care criteria set forth in the above rules.

Fla. Admin. Code 59G-4.180 in part states:

> Intermediate Care Services. (1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitation services to qualify as intermediate care services and clarifies the criteria that must be met in order for such services to qualify as an intermediate level I or intermediate level II service under Medicaid.
> (2) Definitions as used in this section.
> (a) Intermediate care nursing home resident. A Medicaid nursing home applicant or recipient who requires intermediate care services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and treatment

provided in a hospital or that which meets the criteria for skilled nursing services.

Fla. Admin. Code 59G-4.290 in part states:

Skilled Services. (1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitative services to qualify as skilled services under Medicaid.
(2) Definitions as used in this section.
(a) Continuous. The need for 24-hour care in a skilled nursing facility with professional nursing services available.

Fla. Integrated Pub. Policy Manual, passage1440.1300 in part states:

APPROPRIATE PLACEMENT (MSSI) To qualify for the Institutional Care Program (ICP) or Home and Community Based Services (HCBS), or the Program for All-Inclusive Care for the Elderly (PACE), the individual must meet special institutional eligibility criteria, including "appropriate placement."

Appropriate placement means that an individual must be placed in a facility or program certified to provide the type and level of care the department has determined the individual requires.
Two basic requirements must be met for placement to be considered appropriate. These are:
the person must be determined by the department to be medically in need of the type of care provided by the specific program, AND
the person must be actually receiving the services (or for HCBS, must be enrolled in the waiver) which the department has determined that the individual needs.
To be appropriately placed for ICP, a person must have been determined in need of an ICP level of care (by CARES) and actually be placed in a Medicaid facility which provides the specified level of care.

To qualify for the Institutional Care Program the individual must meet special institutional eligibility criteria, including appropriate placement. Appropriate placement means that an individual must be placed in a facility or program certified to provide the type and level of care the Department has determined the individual requires. To be

appropriately placed, Department of Elder Affairs, CARES must determine that the individual is in need of an Institutional Care Program Medicaid level of care.

The petitioner met the level of care criteria from at least December 1, 2007. There was no medical evidence or authority presented that established that the petitioner did not need skilled nursing care. There was no authority presented that would allow CARES to withhold a level of care when the individual otherwise meets the legal requirements of a level of care. Based on these findings, it is determined that the level of care was inappropriately withheld. Additionally, there was no evidence presented that established that the petitioner was not eligible due to assets. Therefore, the Department erroneously denied the petitioner's application for Institutional Care Program benefits.

DECISION

The appeal is granted. The Department's denial action is reversed. The petitioner is appropriately placed in accordance with Medicaid regulations to receive Institutional Care Program Medicaid payments. However, the asset determination is outstanding and the Department will need to determine eligibility on that factor back to the date of application. The Department 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 27th day of May, 2008,

in Tallahassee, Florida.

Morris Zamboca

Morris Zamboca
Hearing Officer
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850-488-1429

Copies Furnished To: [redacted]

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 07 Brevard
UNIT: 88999

RESPONDENT.
_____/

APPEAL NO. 08F-00467

CASE NO. 1267271621

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on April 24, 2008, at 11:20 a.m., in [redacted], Florida. The petitioner was not present. [redacted] attorney, represented her. Her daughter and son-in-law, [redacted] were present. [redacted] assistant circuit legal counsel, represented the respondent. [redacted] senior human services program specialist, and [redacted] ACCESS supervisor, were present as witnesses for the respondent. [redacted] government-operating consultant II, was subpoenaed by the petitioner and appeared by telephone. Michelle Bragg, notary, witnessed her taking the oath. [redacted] court reporter, [redacted] was also present at the hearing.

ISSUE

At issue is the action taken by the Department on January 14, 2008, to deny the petitioner's application for Institutional Care Program (ICP) Medicaid based on the contention that her assets exceeded the Program limit. The asset in question is the value of her land trust. The petitioner holds the burden of proof in this matter.

FINDINGS OF FACT

1. On July 30, 2007, an application for ICP benefits through the Medicaid program was submitted on the petitioner's behalf. The petitioner was determined eligible for ICP benefits effective December 1, 2007. Both parties agreed that the petitioner did not have ICP eligibility for July 2007. The petitioner is seeking ICP Medicaid for August 2007 through November 2007.

2. The petitioner created a revocable land trust for which she is the initial beneficiary. The petitioner's funds were used to buy a partial interest in a piece of property that was titled to the land trust. It is not homestead property; it is rental property. The U.S. Department of Housing and Urban Development Settlement Statement shows [redacted] and [redacted] co-trustees of the [redacted] Land Trust dated July 10, 2007, were the buyers of 23 percent undivided interest in property located in [redacted] county, from [redacted] LLC. This settlement statement shows the contract sales price as $123,035 with the total paid as $128,000. The [redacted] Land Trust Dated July 10, 2007 will hereafter be referred to as the land trust document. [redacted] and [redacted] are co-trustees. It shows that the remainder beneficiaries, [redacted], and [redacted], each with an equal percent (33 1/3 %) will have no rights to the

availability or proceeds of land trust until the death of the initial beneficiary. The land trust document shows "Title to the Property shall be conveyed to the Trustee in accordance with and the rights of the parties shall be governed...by the provisions of Section 689.071, Florida Statutes" (Respondent's Composite Exhibit 2).

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

4. The Department's policy manual does not contain any policy regarding land trusts. When the Department staff received the land trust document and the Lease Agreement, part of the Respondent's Composite Exhibit 2, staff sought guidance from the Department's program office on whether to classify the asset in question as real or personal property, and what exclusions might apply.

5. The local program specialist who specializes in SSI-Related Medicaid became involved with this case when he received a request from the district staff on how to consider the land trust when determining the petitioner's eligibility based on assets. The specialist researched the issue and asked the district legal counsel for an opinion on how to define the petitioner's partial interest in the property in the land trust before he submitted a policy clearance requesting guidance from the program office in Tallahassee. District legal opined that the land trust was personal property even though

it was income producing. The land trust document and the Florida Statute refer to the land trust as personal property.

6. The specialist checked the trust for the ownership, availability, value, and if any exclusions either in whole or in part, could apply. It is not disputed that it was purchased for fair market value, or that it is returning income at fair market value.

7. The Petitioner's Exhibit 2 is the policy clearance that was issued on December 28, 2007. Christine Frier, of the Department, prepared the clearance. She explained that part of her job duties was to evaluate policy, write policy, develop new policies, and offer technical assistance. One of the questions raised by the specialist was to find out if the personal property was considered an item of unusual value, and to receive interpretation on applying the exclusions that apply to the value of the personal property. Ms. Frier concurred that the land trust was personal property because the land trust document stated it was personal property and cited the Florida Statute 689.071 as justification to define it that way. She consulted with the Center for Medicare and Medicaid Services Headquarters, who agreed that "it is appropriate to evaluate the land trust as personal property if provided in the Florida statute".

8. The petitioner's assets include two checking accounts, a burial contract, a personal services contract, and the land trust. The Department excluded the value of the checking account at WaMu set aside for burial valued at $2500.00, a burial contract valued at $4335.00, and a personal services contract valued at $122,850.00. The Department determined countable assets of $123,009.44, which included a checking account of $1,974.44 and the countable value of the land trust as $121,035.00 (Respondent's Exhibit 5). The applicable asset limit for ICP is $2000.

9. Because the petitioner's counted assets exceeded the asset limit for ICP, the Department denied the petitioner's July 30, 2007 application. Notice of the Department's decision was sent on January 14, 2008.

10. On December 27, 2007, a Corrected Corporate Warranty Deed was filed. This deed shows that the petitioner personally owned the interest in the rental property in Dixie County (Respondent's Exhibit 3). It states, "This Deed corrects the name of the Grantee cited in Warranty Deed recorded in Official Records Book 374, Page 756." The evidence includes A "Special Warranty Deed from Trustee of Land Trust" dated July 13, 2007 and "Warranty Deed to Trustee Under Land Trust Agreement Pursuant to Section 689.071, Florida Statutes" dated July 20, 2007, yet neither shows the above book or page number. All three deeds refer to Parcel Identification Number 03-10-14-6980-0000-0400.

11. Based on the deeds listed above, the hearing officer finds the property was deeded in the name of the petitioner's land trust from July 2007 until December 27, 2007. On that date it was removed from the land trust and deeded in the name of the petitioner. Although the deed is titled a corrected deed, there was no evidence that the deed was titled in the name of the land trust through an administrative error.

12. Once the property was titled in the petitioner's name, the Department considered it real property. The evidence includes the Lease Agreement dated July 9, 2007 and the Agreement to Purchase, Lease and Sell Property dated July 9, 2007. The lease was entered into by and between [redacted] and [redacted] as co-trustees of the [redacted] Land Trust Dated July 9, 2007 (landlord) and [redacted] LLC (tenant). The agreement was entered into by and between [redacted]

[redacted] LLC (EPIC) and [redacted] and [redacted] as co-trustees of the [redacted] and Trust dated July 9, 2007 (Investor). Based on this evidence, the Department considered the property to be income producing at the fair market level and excluded the value of the property in determining ICP eligibility beginning December 2007.

CONCLUSIONS OF LAW

The issue to be decided in this case is whether there is ICP Medicaid eligibility for the months of August through November 2007. During that time, the petitioner's revocable land trust owned an interest in rental property. While the rental property was owned by the land trust, the Department considered the trust to be personal property with the only applicable exclusion being $2000 for a countable value of $121,035.

Argument 1:

The petitioner argues that the property in the land trust should have been considered real property and thus meets the exclusion of income-producing property and allowing ICP eligibility. He argues that the Department's policy defines real property as any real estate owned by the individual and income producing property.

The Department's Integrated Policy Manual, 165-22, Section 1640.0577(MSSI, SFP), states:

> Real property includes assets (in which an individual has ownership interest) that fall into the following categories: 1. any real estate owned by the individual or couple, and 2. income producing property.

The Department's position is that during the time the rental property was a part of the land trust, it must be considered personal property as the land trust document identifies

it as such and refers to Florida Statute 689.071 Florida Land Trust Act, stating,

> In all cases in which the recorded instrument, as hereinabove provided, contains a provision defining and declaring the interests of beneficiaries thereunder to be personal property only, such provision shall be controlling for all purposes when such determination becomes an issue under the laws or in the courts of this state.

The Department believes it had no reason to look at the property in any way other than the language of the land trust document itself. Petitioner argues that this statute does not require the Department to view the property as personal property.

The petitioner presented case law and argued that a federal bankruptcy court determined that homestead property in a trust retained its homestead character and did not change to personal property. This court determined that the underlying purpose should be considered at what the interest is and the evaluation should not end at what the trust brands the interest. The crux of the case is based on the definition of personality and realty as is the case under appeal. In this case, the property is rental property. Petitioner believes this case deals with the same Florida Statute as the instant case does. The Department responded that the question to the court in this case related to how to treat homestead exemption and does not control this case. The Department's policy directs to look to the trust language.

After considering the arguments, the hearing officer concludes that the land trust is personal property. The nature of the land trust is not determined by its holdings but rather by the document creating the trust. The case law supplied to support the argument that the trust should be considered real property or have real property rights, does not control in this case as it is dealing with whether or not a homestead placed in a trust can be exempt from bankruptcy filing.

Argument 2:

In the alternative, petitioner argues if it is personal property, it should still meet the income-producing property exclusion as nothing in the Department's policy precludes that. Petitioner argues that in Florida, construction of drafts is held against the drafter and in favor of the person the policy is applied to. The manual does not limit the income-producing exclusion to real property, although the Department would like it to say real property. The Department's response is that the policy itemizes assets that can be excluded under the income-producing exclusion, rather than listing any asset that might not be excluded.

The Department's Integrated Policy Manual, 165-22, Sections 1640.0544 and 1640.0548, Income Producing Property (MSSI, SFP), states:

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

applicant/recipient who owns a produce truck to earn a livelihood may be prohibited from parking the truck in a residential area. The applicant/recipient may own a 100 acre field and use a quarter acre of the field to park and/or service the truck. Only the value of the quarter acre would be excludable, not the entire 100 acre field.
5. Non-liquid notes and mortgages owned by the applicant/recipient and signed on or before March 1, 2005 shall be excluded if the contract or agreement is producing income consistent with its fair market value. Non-liquid notes and mortgages are considered to be producing income consistent with their fair market value if the conditions of the contract are being met. The exclusion shall also apply to the value of the property sold under the contract, or held as security in exchange for a purchase price consistent with the fair market value of that property. Notes and mortgages signed on or after March 1, 2005 cannot be considered for exclusion under this policy.
6. Ownership of timber rights, mineral, or oil exploration rights shall be excluded if the income produced is consistent with the value of the property.

After considering the arguments, the hearing officer concludes that the policy language cited above and the Department's interpretation that this exclusion only applies to real property is consistent with the wording of the exclusion and the examples given; the only mention of personal property being excluded as income-producing is in paragraph 4 in connection with maintenance or use of an income-producing vehicle. The hearing officer concludes the exclusion in paragraph 1 only applies to real property and that the Department was correct to not apply this exclusion to the personal property.

Argument 3:

The petitioner also argues that the corrective deed made in December 2007 should remedy the ineligibility back to the original deed date. The petitioner argued that the American Jurisprudence cite provided, allows you to go back to the date of the original deed unless there has been an intervening transaction and in this case there was no intervening transaction. The Department rebutted that this deals with a mistake being made in the original deed and in this case there was no mistake made in the original deed. The Department pointed out there was no testimony as to why there was a corrected deed, other than to change the ownership.

The Department argued that this issue cannot be resolved by this tribunal and instead should be decided by the circuit court. The Department had no reason to look at any date other than the date the deed was made, which allowed eligibility beginning December 2007. The Department argued that declaratory judgments are addressed in chapter 86, Florida Statues.

After considering the arguments, the hearing officer concludes that the change in ownership occurred on December 27, 2007, the date the new deed was made. Prior to that date, the property was owned by the trust. After that date, the property was owned directly by the petitioner. In this case, Medicaid eligibility is being determined based on an interest of rental property being placed in a trust which calls the property "personal" property on the face of the trust document. In *Buckley v. Department of Health and Rehabilitative Services,* 516 So.2d 1008 (Fla. 1st DCA 1987), the court determined that the final order did not err based on what the property deed shows on its face. The court also determined that the administrative hearing before the Department is not the

appropriate forum in which to establish legal restrictions other than reflected on the face of the deed and refers to a suit for partition of the property or an action for declaratory judgment under chapter 86, Florida Statutes. Also, the undersigned concludes that the Department was correct to use the begin date of ICP eligibility as December 2007 rather than the original deed date. This administrative hearing cannot resolve whether or not the corrected deed takes on the original deed's effective date.

Argument 4:

The petitioner argues that the Department is rule making in the absence of a specific land trust policy in its manual. The Department responded that it is not rule making as there is policy on trusts and policy on real property. The Department believes that it is not possible to write policy on every type of trust that could be created, due to the voluminous numbers of trusts available.

In analyzing this argument, the following authorities were considered:

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

> (15) Trusts...
> (c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income.

42 U.S.C. §1396p(d) states:

> (1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph

> (4), the rules specified in paragraph (3) shall apply to a trust established by such individual. ...
>
> (3) (A) In the case of a revocable trust—
>
> (i) the corpus of the trust shall be considered resources available to the individual,
>
> (ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and
>
> (iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c) of this section.

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

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

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

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

Based on these authorities the value of the revocable trust is considered an available asset to a Medicaid applicant. It is a reasonable interpretation of these authorities that a revocable land trust falls within this definition.

The Department did not improperly engage in rule making as its policy manual directs on how to evaluate trusts; there is no Department guidance on every type of

trust available. In *Rosenshein v. Florida Department of Children and Families*, 971 So.2d 837, (Fla. 3rd DCA 2007), the court determined the DCF memorandum to be a valid agency interpretation of the federal rules and sets forth what unearned income can be excluded from income calculation. The court determined the memo to be a clarification of existing policy and stated that numerous federal cases support the conclusion that the DCF memo is a permissible agency interpretation and the final order relied primarily on federal regulations and used the transmittal only as additional support. Therefore the undersigned concludes the Department correctly relied on the clearance memorandum as an interpretation of established authorities.

Argument 5:

The petitioner argued that the Department's analyst that wrote the clearance was only seeking a reason to deny the petitioner and thus, came up with the reason stated in the clearance and that the decision was arbitrary and capricious; even malicious. He urged that her testimony be examined as she could not say what documents she reviewed to come to the conclusion in the clearance and some of the language in the clearance seemed to be confused with the Department's annuity and IRA policy. The Department responded that there was no evidence of malicious decisions made in this case and in fact, the Department immediately approved the ICP Medicaid as soon as the property met an exemption.

The above conclusion shows that the property was included in a land trust; revocable trusts are countable assets; and the trust was personal property. As the analyst's position is supported by controlling authorities; it is not arbitrary and capricious. Before drafting the clearance on the land trust, the Department's analyst

conferred with the federal Medicaid agency for an interpretation. The federal agency responded that since the land trust document called the property "personal" and cited F.S. 689.071, the State agency should consider it "personal" property. The Department published the policy clearance for the benefit of the rest of the state, should this exact situation arise.

Closing

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

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

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

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

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

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

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

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

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

The above authorities set forth the applicable Medicaid ICP asset limit at $2000 for an individual. Therefore, the undersigned concludes that the Department correctly denied the ICP request for the months of August through November 2007, due to countable assets exceeding the limit.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 23rd day of May, 2008,

in Tallahassee, Florida.

Margaret Poplin

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

Copies Furnished To [redacted]

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

[redacted]

APPEAL NO. 08F-01724

PETITIONER,

Vs.

CASE NO. 1005283028

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Hillsborough
UNIT: 883CF

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on April 17, 2008, at 9:07 a.m., in [redacted] Florida. The petitioner is deceased. The deceased petitioner's interests were represented by [redacted] medical coordinator with [redacted] also testified. The respondent was represented by [redacted], supervisor in the respondent ACCESS Program.

ISSUE

At issue is the respondent's decision of February 25, 2008 to deny the petitioner's Institutional Care Program and Medicaid (ICP) application because of a failure to provide requested verification of alleged pension income. The

petitioner seeks ICP eligibility for the month of November 2007 only. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner was a resident of [redacted] nursing facility from November 7, 2007 to November 19, 2007. The petitioner was discharged to [redacted] on November 19, 2007. The petitioner died while in the hospital on November 30, 2007. The petitioner's representative seeks ICP eligibility for the month of November 2007 only.
2. The petitioner's was born on November 10, 1940. The petitioner was a lawful permanent resident of the United States originally from Columbia, South America. The petitioner had lived in the United States since before 1980, per the respondent Running Record Comments.
3. The respondent Running Record Comments reflect the petitioner's numerous applications for Food Stamp benefits back to December 1992, labeled Respondent Exhibit 12. The petitioner had many different employment sources back to the year 1992. The petitioner received unemployment compensation several times since 1992. The respondent comments do not reflect any consistent long-term employment since 1992. The respondent comments reflect the petitioner's medical complaints of diabetes complication.
4. The deceased petitioner was determined entitled to Social Security Disability benefits (SSDI) in December 2002. The deceased petitioner

began to receive SSDI benefits of $586 monthly in December 2003. In January 2005, the SSDI amount increased to $602 monthly.

5. On November 9, 2005, the petitioner, himself, completed an electronic application for Food Stamp benefits. The petitioner listed his only income as Social Security benefits in this application. The respondent approved the petitioner's Food Stamp benefits based on this application. The merit of this determination is not at issue in this appeal.

6. The then 65 year-old petitioner, himself, completed another electronic application for Food Stamp benefits on March 22, 2006. The petitioner then listed his only income as "Public Retirement" of $500 monthly on this application. The petitioner did not list his SSDI income of $626.50 monthly on this application. The respondent then believed that the petitioner received *both* SSDI income and "public retirement" or pension income, based on this application. The respondent then denied this Food Stamp application on March 23, 2006, based on a determination of excess income. The merit of this prior Food Stamp decision is not specifically at issue in this instant appeal.

7. On November 15, 2007, the petitioner's hospital representative, Allen Dewitt, completed an application for ICP benefits in the petitioner's behalf. Social Security income was the only income source listed on this application. This application was denied on December 24, 2007 based on an asserted failure to return requested verification. The merit of this decision is not specifically at issue in this appeal.

8. On January 3, 2008, the petitioner's hospital representative, completed a second application for ICP benefits in the petitioner's behalf. The petitioner's representative listed the then deceased petitioner's income as Social Security and "Union Funds or Pension Benefits" on this application. The petitioner's representative listed the deceased petitioner to have income of "Union Funds or Pension Benefits" only based on past conversation with the respondent. Neither the petitioner's representative nor the respondent knows of any source of the alleged union or pension funds allegedly received by the petitioner.
9. The petitioner's representative received a request to verify the alleged pension income and alleged bank account. The respondent agrees that the petitioner may not have had a bank account. Therefore, the respondent eliminated this request for verification. However, the respondent requested verification of the petitioner's alleged pension income. The respondent denied the petitioner's application of January 3, 2008 based on the failure to provide proof of this alleged pension income.
10. The respondent's records do not reflect any report of possible pension, public retirement, or union income prior to the March 22, 2006 application. The respondent believes the petitioner received this type of income based solely on the March 22, 2006 application. The preponderance of the cumulative evidence does not establish that the petitioner received any pension, union benefits, or public retirement benefits that are distinct from the SSDI benefits that were received.

CONCLUSIONS OF LAW

The respondent's interpretive FLORIDA on-line manual sets forth the following regarding a request for additional information:

> 0640.0401 Requests for Additional Information/Time Standards (MSSI,SFP)
>
> If the Department needs additional information or verification from the applicant, provide:
>
> 1. a written list of items required in order to complete the application process.
> 2. the date the items are due, in order to process the application timely, and
> 3. the consequences for not returning additional information by the due date.

The petitioner's representative received a request to provide verification of the alleged pension income. The respondent denied the petitioner's application of January 3, 2008 because this requested verification was not provided. However, the preponderance of the cumulative evidence does not actually establish that the petitioner had an actual pension income that was distinct from the SSDI income. Therefore, the respondent's request to provide verification of this alleged pension income was not valid. Thus, it is not correct to deny the petitioner's application based on the failure to follow through with this specific request for verification. The respondent's denial action at issue can not be upheld.

DECISION

This appeal is partially granted since the respondent's denial action of February 25, 2008 is not upheld. The respondent is ordered to re-open the

petitioner's January 3, 2008 application for ICP benefits, and re-determine ICP eligibility on any other relevant eligibility factor for the month of November 2007. This appeal is partially denied in that it is not known whether or not the petitioner will be actually determined eligible for ICP benefits for November 2007 after appropriate completion of this ordered re-review.

NOTICE OF RIGHT TO APPEAL

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

DONE AND ORDERED this 2nd day of May, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO. 08F-01938

PETITIONER,

Vs.

CASE NO. 1055301208

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 9, 2008, at 9:00 a.m., in [redacted], Florida. The petitioner is deceased. He was represented by [redacted], from the [redacted] Florida. The respondent was represented by [redacted] Florida Access specialist.

ISSUE

At issue is the Department's March 5, 2008, action of denying the petitioner's January 14, 2008 Institutional Care Program Medicaid application, due to not following through in establishing eligibility. The petitioner has the burden of proof.

FINDINGS OF FACT

1. According to the petitioner's representative, he passed away on February 12, 2008.

2. Included in the evidence is a copy of a Notice Of Case Action form dated March 5, 2008, stating that the petitioner's January 14, 2008 Institutional Care Program Medicaid application was denied because the Department did not receive information needed to process the case.

3. Included in the evidence is a copy of the petitioner's Account Activity statement from his Bank [redacted] from March 27, 2007 to September 29, 2007. The balance on March 27, 2007 was $14,523.13, and the balance on September 29, 2007 was $4,021.13. The balance of $4,021.13 was the lowest balance during this time period.

4. Included in the evidence is a copy of an Appointment Notice/Request for Assistance form dated January 17, 2008. On this form, the petitioner's representative is being requested to provide the Department with information by January 28, 2008.

5. The petitioner's representative was requested to provide the Department with proof of the petitioner's Bank [redacted] account balances for each month of October 2007 through January 2008. She was also requested to provide the Department with proof that the petitioner's assets were within the $2,000.00 asset limit in the Medicaid Program.

6. The January 17, 2008 form requesting the petitioner's representative to provide information, states that if the information is not provided, then the request for assistance would be denied.

7. When the requested information was not provided to the Department by the deadline of January 28, 2008, the petitioner's Institutional Care Program Medicaid application was denied.

8. According to the petitioner's representative at the hearing, the petitioner was in the nursing home from at least March 2007 to February 2008, and she is requesting Institutional Care Program Medicaid benefits for that time period.

9. According to the respondent's representative, there were previous Institutional Care Program Medicaid applications from the petitioner, and they were previously denied because the value of his assets exceeded the $2,000.00 program eligibility limit.

CONCLUSIONS OF LAW

In the Medicaid Program, in accordance with Fla. Admin. Code 65A-1.205(1):

> (a) Eligibility must be determined initially at application and if the applicant is determined eligible, at periodic intervals thereafter. The applicant is responsible to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility as determined by the eligibility specialist within time periods specified by the eligibility specialist.

In the eligibility process, certain information must be verified and documented. The eligibility specialist must obtain the facts of the financial situation of the household. The petitioner's Institutional Care Program Medicaid application was denied because the Department was not provided with requested information. This information requested is listed on a January 17, 2008 Request for Information form, with a deadline of January 28, 2008.

The Department had information that the petitioner's Bank of America account balance was higher than the $2,000.00 asset limit in the Medicaid Program, from March 2007 to September 2007. His representative was requested to verify the bank account balances for October 2007 to January 2008, to see if the balance went below the

$2,000.00 asset limit. Information was not provided to show that the petitioner's bank account balance was below the $2,000.00 asset limit.

The petitioner's representative asserted at the hearing that there was a previous investigation concerning whether the petitioner was being exploited because there were withdrawals from his bank account. She requested that this is taken into account in this decision. The petitioner's Bank [redacted] account was not below the $2,000.00 asset limit from March 2007 to September 2007, and it was not shown that the balance went under the asset limit. Also, the Department was not provided with the information that was requested. After careful consideration, it is determined that the Department's action to deny the Institutional Care Program Medicaid application, due to not following through in establishing eligibility, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO. 08F-01171

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 08 Lee
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 12, 2008, at 12:20 p.m., in [redacted] Florida. The petitioner was not present. He was represented by his mother, [redacted] The respondent was represented by [redacted] program operational administrator. Present as witnesses for the petitioner were [redacted] certified rehabilitation technology specialist; and [redacted] Present as witnesses for the agency were [redacted] physical therapist.

The respondent was allowed 10 days to communicate with the petitioner and determine whether a revised request for a wheelchair would be approved by Medicaid. An extension of time was allowed. On April 4, 2008, evidence was received from the respondent. It was accepted as Respondent's Exhibit 5.

ISSUE

At issue is the November 14, 2007 action by the respondent denying the petitioner's request for Medicaid payment for a manual wheelchair with power assist wheels. The petitioner has the burden of proof as the applicant for benefits.

FINDINGS OF FACT

1. On June 11, 2007, the Durable Medical Equipment (DME) provider submitted a prior authorization request for Medicaid to pay for a wheelchair with power assist wheels. The packet was reviewed by the physical therapist with the Bureau of Medicaid. On July 3, 2007, the agency requested further information from the provider.
2. On September 18, 2007, the provider returned information. On October 5, 2007, the agency sent a proposal for an ultra-lightweight wheelchair and specialized seating components to the provider. On October 26, 2007, a response was received from the provider reiterating the reasons for the original request. On November 14, 2007, the agency denied the request and noted that the offer to provide a lightweight manual wheelchair was refused.
3. On April 4, 2008, the respondent notified the hearing officer that they had approved the latest proposal from the DME Shoppe for a wheelchair for the petitioner.

CONCLUSIONS OF LAW

The Medicaid Program only provides for medical services that are defined as being "medically necessary," or of "medical necessity" as set forth in the Florida Administrative Code Rule 59G-1.010(166)(a). The care, goods or services must meet the conditions as follows:

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

The Florida Administrative Code Rule section 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.

The petitioner requested Medicaid payment for a new wheelchair through his DME provider. The request was denied. The DME provider revised the request. On April 4, 2008, the respondent notified the hearing officer that the parties reached an agreement. Medicaid has authorized payment for a new wheelchair. Since the parties have reached an agreement, there is no further need for a decision by the hearing officer.

DECISION

This appeal is moot.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 08F-01737

CASE NO. 1179034732

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 23 Pinellas
UNIT: 88605

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 30, 2008, at 12:15 p.m., in [redacted] Florida. The petitioner was not present and was represented by her husband, [redacted] The respondent was represented by [redacted] economic specialist supervisor. Witness for the respondent was [redacted] economic specialist II.

ISSUE

The petitioner is appealing the notice of February 21, 2008 for the respondent's actions for the increases in the petitioner's patient responsibility for the Institutional Care Program (ICP) benefits from $336.08 in July 2005 to $455.36 effective April 2008.

FINDINGS OF FACT

1. The petitioner has been receiving ICP benefits. The petitioner's eligibility is reviewed every June. The petitioner's husband is the community spouse. The husband's shelter costs are the rent as reported to the respondent and a $198 utility standard. The husband's reported shelter costs were $873 from July 2005 through July 2006, $828 from August 2006 through July 2007 and $833 from August 2007 through April 2008.

2. The household income is the petitioner's Railroad Retirement, Social Security benefits and pension. The husband's income is his Railroad Retirement which includes Social Security benefits. In January of each year, the amount of Social Security benefits increases. In April of each year, the petitioner had her husband's Railroad Retirement increases. The petitioner's pension of $150.82 remains the same. Both parties stipulated to the income for July 2005 through April 2008. The total gross household monthly income in 2005 was $2,358.57. The total gross household monthly income in 2006 was $2,435.64. The total gross household monthly income in 2007 was $2,500.13. The total gross household monthly income in 2008 was $2,524.36.

3. Every year the income limits for ICP and Medicaid are increased. The respondent reviewed the petitioner's income in at least January and June each year. The respondent computed the petitioner's patient responsibility based on reported changes in rent, reported changes in Social Security in January and June reviews which included the increases in Railroad Retirement benefits. The patient responsibility was based on the husband's shelter costs, husband's total

monthly gross income and the petitioner's total monthly gross income. From July 2005 through March 2006, the petitioner's petitioner responsibility was $336.09. From April 2006 through July 2006, the petitioner's patient responsibility was $405.64. From August 2006 through July 2007, the petitioner's patient responsibility was $417.64. From August 2007 through March 2008, the petitioner's patient responsibility was $434.13. Effective April 2008, the petitioner's petitioner responsibility was $455.36.

4. The petitioner's husband is disputing the amount of the patient responsibility. The husband has no resources other than his car. He attested that he was breaking even when the patient responsibility was $336.09 a month. He is requesting the patient responsibility remain at $336.09 and the additional diverted to him due to his and the petitioner's expenses that he is paying. In addition to his shelter costs, the husband has expenses of Medicare Part B payments, prescription co-payments, car insurance, gas and personal care. The petitioner's expenses that he is paying for are haircuts, television, liquid thickener, wheelchair parts, telephone message service, cosmetics, clothes and entertainment. The petitioner has not provided any bills to the respondent or at the hearing for the liquid thickener or the wheelchair parts.

CONCLUSIONS OF LAW

The Florida Administrative Code (2005) at 65A-1.714 set forth the "SSI-Related Medicaid Post-Eligibility Treatment of Income":

> After an individual satisfies all non-financial and financial eligibility criteria for Hospice, institutional care services or ALWHCBS, the department determines the amount of the individual's patient

> responsibility. This process is called post-eligibility treatment of income.
> (1) For Hospice and institutional care services, the following deductions are applied to the individual's income to determine patient responsibility:
> (a) Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance...
> (e) The department applies the formula and policies in 42 U.S.C. § 1396r-5 to compute the community spouse income allowance after the institutionalized individual is determined eligible for institutional care benefits. The standards used are in Rule 65A-1.716(5)(c), F.A.C. The current standard Food Stamp utility allowance is used to determine the community spouse's excess utility expenses.

The United States Code at 42 U.S.C. §1396a sets forth for post–eligibility treatment of income when there are incurred medical expenses for the institutionalized individual:

> ...with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver...
> there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including -
> (i) Medicare and other health insurance premiums, deductibles, or coinsurance, and
> (ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

The Code of Federal Regulations at 42 C.F.R. § 435.725 sets forth required deductions from the institutionalized individual's total income in determining what the agency must pay to the institution:

> (4) Expenses not subject to third party payment. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including--
> (i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

The rules, code and regulation indicate the required deductions from the individual's income to determine patient responsibility. The amounts required to be deducted include the personal needs allowance, maintenance needs of the spouse, maintenance needs of the family, and medical care expenses not subject to third party payment. The petitioner has additional medical expense. However, the petitioner did not verify any medical expenses paid by the husband. As the expenses have not been verified, no deduction can be given to reduce the petitioner's patient responsibility.

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

(c) Spousal Impoverishment Standards...

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

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

4. Food Stamp Standard Utility Allowance...

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

Florida Administrative Code at 65A-1.712(4)(f) permits possible adjustment to this methodology and the resulting income allowance as follows:

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

The State Medicaid Manual at Section 3713 sets forth the monthly income allowances for community spouses and states in relevant part:

> Unless alternative methods described in subsection C. apply, use the following methods to calculate maintenance needs allowances.
> A. Spousal Monthly Income Allowance.--Unless a spousal support order requires support in a greater amount, or a hearings officer has determined that a greater amount is needed because of exceptional circumstances resulting in extreme financial duress, deduct from community spouses gross monthly income which is otherwise available the following amounts up to the maximum amount allowed:
> o A standard maintenance amount.
> o Excess shelter allowances for couples' principal residences when the following expenses exceed 30% of the standard maintenance amount. Except as noted below, excess shelter is calculated on actual expenses for -
> - rent;
> - mortgage (including interest and principal);
> - taxes and insurance;
> - any maintenance charge for a condominium or cooperative; and
> - an amount for utilities, provided they are not part of the maintenance charge computed above. Utility expenses are calculated by using the standard deduction under the Food Stamp program that is appropriate to a couple's particular circumstance (or, at your option, actual utility expenses), unless such expenses are included as maintenance charges for condominiums or cooperatives...

The minimum maintenance income allowance in July 2004 was $1,562.

The minimum maintenance income allowance effective July 2005 was $1,604.

The minimum maintenance income allowance effective July 2006 was $1,650.

The minimum maintenance income allowance effective July 2007 was $1,712.

The husband's actual shelter costs did not exceed the minimum maintenance

income allowance in any year. The husband's shelter expenses do not demonstrate a need to increase the minimum maintenance income allowance in any year.

The husband's expenses other that shelter were considered. The rule sets forth that to meet the needs of the community spouse the minimum maintenance income allowance plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. §1396r-5. In examining the relative nature of what may be defined as an individual's "needs", it is necessary to define a standard of such "needs" that is consistent with the intent of public assistance programs in general, and more specifically with the Institutional Care Program. Since the Institutional Care Program sets the minimum monthly income allowance to equal 150 percent of the federally defined Poverty Level, it is evident that the intent of the Institutional Care Program is confined to address an individual's basic needs of food, shelter, medical costs, and work-related expenses. The standard established by Congress in 42 U.S.C. §1396r-5 provides that the minimum maintenance income allowance may be increased if the community spouse can establish that they have additional needs that are "exceptional circumstances resulting in significant financial duress." For the hearing officer to increase the minimum maintenance income allowance beyond the maximum allowed, any expense must pass a two-part test. First, the expense must be an exceptional circumstance and, second, the expense must create significant financial duress.

Black's Law Dictionary (6th Edition 1990) defines exceptional circumstance: "Conditions which are out of the ordinary course of events; unusual or extraordinary circumstances...". An expense related to a sudden and unexpected event is an exceptional circumstance. Expenses that are expected and are incurred in the normal course of everyday living are not exceptional circumstances. Expected everyday expenses of living, such as home ownership and medical expenses are not necessarily exceptional, extraordinary, uncommon or sudden in nature. The petitioner's husband has expenses. The expenses as described by the husband are indicated as his normal living expenses and expenses that are incurred for shelter and everyday medical expense. The husband did not demonstrate any exceptional expenses or circumstances that would indicate any additional deduction from the patient responsibility or additional diversion to him. The hearing officer reviewed all income and budgets. Based on the above cited authorities, the hearing officer concludes that the increases in patient responsibility for the Institutional Care Program from $336.08 in July 2005 to $455.36 effective April 2008 are correct and consistent with 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 department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file

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

DONE and ORDERED this 21st day of May, 2008,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO. 08F-01610

PETITIONER,

Vs.

CASE NO.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 28, 2008, at 12:12 p.m., in [redacted] Florida. The petitioner was not present and represented himself. The petitioner was represented by his mother and father, [redacted] The respondent was represented by [redacted] senior human program specialist. Present as a witness for the petitioner was [redacted], support coordinator. Present as a witness for the respondent was Jody Winter, physical therapist consultant with the agency.

ISSUE

At issue is the November 17, 2007 action by the agency denying the petitioner's request for Medicaid to pay for a ceiling hoist.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient. In November 2007, her Durable Medical Equipment (DME) provider submitted a request for a ceiling hoist to the prior authorization unit with Medicaid. On November 17, 2007, a notice was issued to the provider and the petitioner denying Medicaid payment for the hoist. The reason for the denial was listed as "documentation did not justify the medical necessity of the equipment."
2. On February 29, 2008, the Office of Appeal Hearings received a request for an appeal of this denial. The request was received via facsimile.

CONCLUSIONS OF LAW

The Florida Administrative Code at 65A-2.044 discusses the Right to Request a Hearing:

> Any applicant/recipient dissatisfied with the Department's action or failure to act has a right to request a Hearing. He/she may do so when it is believed that:
> (1) Opportunity to make application has been denied.
> (2) The application has been rejected.
> (3) The application has not been acted upon within a reasonable length of time.
> (4) The benefits have been modified or discontinued.
> (5) Reconsideration of the assistance/service benefits is refused or delayed.
> (6) Opportunity has not been given to make a choice of service.
> (7) Any other DCF action (or inaction) is incorrect.

Pursuant to the Fla. Admin. Code Rule 65-2.046 Time Limits in Which to request a Hearing, which states in part:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 days in all programs...The time period begins with the date following...(a) The date on the written

> notification of the decision on an application. (b) The date on the written notification of reduction or termination of program benefits. (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

The Findings of Fact show that the issue raised by the petitioner is the denial for payment of a ceiling hoist by Medicaid. The evidence establishes that this denial occurred on November 17, 2007. The petitioner requested an appeal of this denial on February 29, 2008. The petitioner did not request an appeal of this action within the required 90 days. Therefore, this issue is not within the jurisdiction of this hearing officer or the appeal process.

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 29th day of May, 2008,

in Tallahassee, Florida.

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

Copies Furnished To [redacted]

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

[redacted]

APPEAL NO. 08F-02126

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 16, 2007, at 1:45 p.m., in [redacted] Florida. The petitioner was not present. He was represented by his mother [redacted] The respondent was represented by [redacted] program operations administrator. Present on the telephone from Kepro was [redacted] medical director, and [redacted] registered nurse reviewer.

ISSUE

At issue is the Agency's March 4, 2008 action of denying the petitioner's request for 492 hour of skilled home nursing services for February 3, 2008 to April 2, 2008. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is a two year old child, date of birth .

2. Included in the evidence is a copy of a Recipient Denial Letter dated March 4, 2008, stating that a request for 492 hours of skilled home nursing services were denied for the petitioner from February 3, 2008 to April 2, 2008.

3. Included in the evidence is a copy of a Recipient Reconsideration Denial Upheld notice dated March 11, 2008. This notice states that the denial of the 492 hours of skilled home nursing services for the petitioner was upheld.

4. The notices sent to the petitioner explained that it was determined by Kepro that the medical care of the skilled home nursing services of 492 hours was determined to be not medically necessary.

5. The March 4, 2008 denial for services was reviewed by a Kepro physician consultant, board certified in pediatrics, and the March 11, 2008 reconsideration denial was reviewed by another Kepro physician consultant, board certified in pediatrics.

6. Included in the evidence is a copy of a Kepro Internal Focus Review Findings report on the petitioner dated January 30, 2008, stating that he was diagnosed with a short gestation, which was a 25-26 weeks of gestation, esophageal reflux, primary apnea of newborn, and chronic respiratory disease arising in the prenatal period.

7. Included in the evidence is a copy of a Kepro Synopsis of Case report, concerning the petitioner, who was a premature infant. It states that all problems except for occasional projectile vomiting occurred as a neonate in the hospital, and it should have been resolved. A grade 1 intraventricular hemorrhage (IVH) should be of little concern, and no mention of medications. It also states that it is unclear why the petitioner would require nursing services, and cannot attend a regular daycare center.

8. The petitioner's representative asserted that he had a grade 4 IVH instead of a grade 1. [redacted] asserted that according to information received from the petitioner's provider, Maxim Healthcare Services, he had a grade 1 IVH.

CONCLUSIONS OF LAW

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

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

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

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

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

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that skilled home nursing services must be ordered by the attending physician, and documented as medically necessary. The petitioner's request for 492 hours of skilled home nursing services for February 3, 2008 to April 2, 2008, was denied because it was determined that it was not medically necessary. The Agency's determination takes into account what would be medically necessary for the petitioner, and the physician that testified at the hearing agrees that the petitioner does not need skilled home nursing care. After careful consideration, it is determined that the Agency's action to deny the request for the skilled home nursing services, is upheld.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

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

in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished To: [redacted]

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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 08F-01424

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

CASE NO. 1195293658

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on April 15, 2008, at 12 p.m., in [redacted] Florida. The petitioner was not present. Present representing the petitioner was her son, [redacted] The Department was represented by [redacted] ACCESS economic self-sufficiency specialist by phone and [redacted] ACCESS supervisor.

ISSUE

The petitioner is appealing denial of Institutional Care Program benefits for the months of June 2007, July 2007 and September 2007 due to excess income.

FINDINGS OF FACT

1. On June 4, 2007, a facility in [redacted] Florida submitted an application for Institutional Care Program (ICP) benefits for the petitioner. At the time of application the

petitioner was residing at that facility in [redacted]. The petitioner was moved to a facility in [redacted] Florida in September 2007 and continues to reside at that facility.

2. At the time of the application, the petitioner's income was Social Security benefits of $761 and a veterans' survivor's pension from her late husband of $1,149.47. The petitioner's total gross monthly income was $1,918.47. Both parties stipulate to the correctness of the income figures. The petitioner's total monthly income exceeded the income standard for ICP benefits of $1,869 which was effective January 2007 through December 2007. Therefore, the petitioner was not eligible to receive ICP Medicaid unless a qualified income trust was established for her, funded each month and approved by the Department's district legal counsel.

3. The petitioner's son believes that he received no contact from the Department regarding the ICP application between June 4, 2007 and August 10, 2007. The petitioner's son further believes that he was first notified by the Department on August 22, 2007 that an income trust was required for the petitioner because her income exceeded program limits. The Department's business record substantiates this and indicates the processor had a telephone conversation with the petitioner's son about the amount of the VA income; she explained that the income trust must be funded and to fund it with a minimum of $50. The petitioner's son did fund the income trust in August 2007, but not in September 2007. It was funded ongoing beginning October 2007.

4. An income trust was established for the petitioner in 2004 when it appeared the petitioner required ICP Medicaid, but the petitioner's condition improved and the family did not pursue ICP Medicaid. A copy of this 2004 trust document was faxed to

the Department on August 24, 2007. The petitioner's son believes it was the facility that advised him in 2004 of the need for the income trust and referred him to the business that prepared the trust. An ICP application was filed in 2004 in Jacksonville. If he was advised of the need to fund the trust by the Department in 2004 he would not know about any changes in the income limits three years later. The petitioner's son believes that the Department was negligent in not timely informing him of the need to set up and fund the trust, resulting in ineligibility for three months. He believes the Department did not follow its own policy requiring staff to inform applicants of the requirement, when the income exceeds the ICP limit.

5. On October 1, 2007, the Department requested Power of Attorney authorizing petitioner's son to create the Qualified Income Trust in 2004. Unable to produce this authorization, a new Qualified Income Trust was established in October 2007. The new document is date stamped as having been received by the Department on October 22, 2007. The Department forwarded the income trust to the District legal counsel who routinely evaluates income trust documents for Institutional Care Program eligibility. The District legal counsel approved the income trust on November 8, 2007 and it was received by the processor on November 16, 2007. The Department completed the ICP application on November 19, 2007.

6. Both parties stipulate that the income trust was not funded for the months of June 2007, July 2007 and September 2007. Both parties stipulate the income trust was funded for August 2007 and October 2007 forward. The petitioner's son believes that had the Department not delayed in contacting him between June 4, 2007 and August 22, 2007, regarding the necessity of a trust for the petitioner, the trust would

have been established and funded June 2007 forward. The Department argued that because the facility actually filed the ICP application, the Department may not have been sure who to contact regarding the case. The Department also argued that having established an income trust in 2004, the petitioner's son was aware of its necessity and maintains the position that, because the income trust was not funded for the months detailed above, the petitioner was ineligible for ICP benefits during those months because the petitioner's income exceeded program limits. However, the Department representative testifying was unsure of the details surrounding this application as she was not the individual who processed the case.

CONCLUSIONS OF LAW

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

> (26) Qualified Income Trust: A trust established on or after October 1, 1993, for the benefit of an individual whose income exceeds the ICP income standard and who needs institutional care or HCBS. The trust must consist of only the individual's pension, Social Security and other income. The trust must be irrevocable and provide that upon the death of that individual the State shall receive all amounts remaining in the trust up to an amount equal to the total amount of medical assistance paid on behalf of that individual pursuant to the state's Title XIX state plan.

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

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

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

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

(1)(c) Time standards for processing applications vary by public assistance program. The time standard begins with the date on which the department or an outpost site receives a signed and dated application and ends with the date on which benefits are made available or a determination of ineligibility is made. For the Medicaid program, the time standard ends on the date an eligibility notice is mailed. Applications must be processed and determinations of eligibility made within the following time frames: ...
For all other Medical Assistance and State Funded Programs **45 days**.

Fla. Integrated Pub. Policy Manual, 165-22 passage 1840.0110 in part states:

Income Trusts (MSSI)
The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and

> Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
> To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:
> It is established on or after 10/01/93 for the benefit of the individual;
> It is irrevocable;
> It is composed only of the individual's income (social security, pensions, or other income sources); and
> The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf...
> An individual may choose to revoke an income trust at the time of their discharge from a Medicaid facility if the trust document allows them to do so. If revoked, Florida Medicaid must receive reimbursement (following above instructions) prior to any other beneficiary. ...
> **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.)

The ICP Medicaid application was not completed until five months after the application was made. The Findings of Fact show that the petitioner's income trust was not funded for months of June 2007, July 2007 and September 2007. Based on the above legal authorities, a requirement of eligibility is that the trust be funded for each month ICP eligibility is needed. It is also a requirement that the Department advise the individual that they cannot qualify for Medicaid ICP for any month in which the income is not placed in an executed income trust account in the same month in which the income is received.

The web application date was June 4, 2007. The Department did not follow up on the income amount or who the designated representative was until after the 45 day

processing time has elapsed. The Department did not advise the son of the need for the Qualified Income Trust or the funding requirement until after this time standard had elapsed. Once the Department advised of the need to set up and fund the trust in August 2007, the son funded the trust in August 2007, failed to fund it for September 2007 and funded it ongoing beginning October 2007. Therefore, the undersigned concludes the Department erred in not following its policy and the petitioner is to be considered ICP eligible for June and July 2007. However, because the son was made aware of the funding requirement in August 2007 and failed to fund the trust for September 2007, the petitioner is ineligible for ICP Medicaid for September 2007.

DECISION

The appeal is granted in part and denied in part. As stated in the above conclusions, the appeal is granted for June and July 2007 and denied for September 2007. The Department 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 respondent has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 22nd day of May, 2008,

in Tallahassee, Florida.

Leslie Green

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

Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO. 08F-1794

PETITIONER,

Vs.

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 31, 2008, at 2:34 p.m., in Miami, Florida. The petitioner, [redacted] was present and represented herself at the hearing. Representing the agency was Oscar Quintero, senior human services program specialist with the Agency for Health Care Administration (AHCA). Appearing as witnesses telephonically was Dr. Maurine Levy, medical director and Theresa Ashey, registered nurse reviewer, both with KēPRO (Keystone Peer Review Organization) South.

ISSUE

The petitioner is appealing the January 16, 2008, January 25, 2008 and March 12, 2008 prior authorization denial of services, for an inpatient hospitalization five (January 17-22, 2008) day stay for a right total knee replacement. The denial of the request was due to insufficient documentation on medical necessity. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner is sixty-two years old and a Medicaid beneficiary in the state of Florida. The petitioner has been diagnosed "Osteoarthrosis both knees."
2. On January 15, 2008, the provider (physician) submitted to AHCA a prior authorization request for a pending "right knee replacement" procedure to be performed on January 17, 2008. The request included a total of five days inpatient hospitalization through January 22, 2008.
3. This request was reviewed by KēPRO, an organization under contract with AHCA that conducts medical reviews of Medicaid prior authorizations, for inpatient hospital medical services for Medicaid recipients in the state of Florida. This review is for determining medical necessity under the terms of the Florida Medicaid Program. KēPRO considered all clinical information made available to them by the provider on the petitioner's condition.
4. Upon review by registered nurse reviewer, the clinical information submitted by the petitioner's physician did not meet the InterQual® criteria (procedures criteria used by first level reviewer) and AHCA rules on medical necessity. The request was referred to physician consultant board-certified in emergency medicine.
5. The physician reviewer denied the request documenting the reason for the denial as, "Absence of diagnostic data which may support the medical necessity of admission/requested inpt [inpatient] dates."

6. On January 16, 2008, the petitioner, hospital and attending physician were notified that the request was denied, because of on insufficient documentation to meet medical necessity.
7. On March 9, 2008, a second evaluation (not a reconsideration) was conducted by a physician consultant board certified in orthopedic surgery. Given the information available, the physician denies the request documenting, "...Minimal history, exam of the R knee, previous treatment, and radiographic findings were provided. R TKR [total knee replacement] is a reasonable request once this info is provided. 5 day stay is on the upper limit of normal for this type case. Are there other issues that require a longer postop stay and where are the clinical for the dates as this is a retro review." Again, there was lack of documentation to support medical necessity.
8. The provider (physician) was contacted telephonically in order to provide additional information. The same information as previously submitted was provided.
9. On March 12, 2008, a reconsideration review was conducted. The same information/documentation previously submitted was received. The request was reviewed by another board certified physician consultant who denied the request as it did not meet medical necessity. A Recipient Reconsideration Denial Upheld notice was sent to the petitioner and her physician.

10. On March 17, 2008, the medical director with KēPRO called the petitioner's physician (provider) requesting that the information be provided and specified what documentation was needed. The provider did not respond to her request.

CONCLUSIONS OF LAW

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

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

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

(a) Meet the following conditions:

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

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

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

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

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

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

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

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

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

The Florida Medicaid Coverage and Limitations Handbook, Hospital Services page 2-28 (June 2005) states as follows:

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

The petitioner states that she is in need of the knee replacement and will work with the physician in having the needed information/documentation provided to the agency.

After considering the evidence and all of the appropriate authorities set forth in the findings above, the hearing officer finds that the medical consultant's decision to deny the

request for inpatient hospitalization for January 17-22, 2008, due to insufficient documentation on medical necessity was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 6th day of May, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO. 08F-01248

PETITIONER,

Vs.

CASE NO. 1268008427

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 20, 2008, at 1:05 p.m., in [redacted] Florida. The petitioner was not present. He was represented by his wife [redacted] The respondent was represented by [redacted] Florida Access specialist.

ISSUE

At issue is the Department's determination of the petitioner's patient responsibility of $401.06 in the Institutional Care Program. The petitioner has the burden of proof.

FINDINGS OF FACT

1. As of the time of the hearing, the petitioner was a resident of the [redacted] Florida, and his wife, [redacted] lives in the community.

2. As of the time of the hearing, the petitioner's patient responsibility in the Institutional Care Program was $401.06. This is the monthly amount that he is expected to pay the nursing home.

3. Included in the Patient Responsibility Budget is a total gross unearned income amount of $1,565.00. The respondent's representative explained at the hearing that this is a total of the petitioner's monthly gross Social Security income of $1,365.00, plus a $200.00 monthly income amount from an annuity.

4. Subtracted from $1,565.00 in the budget is a personal need allowance of $35.00, and a maintenance need allowance of $1,128.94, for a patient responsibility of $401.06.

5. At the hearing, the petitioner's representative reported that the income from his annuity was lower than $200.00 monthly, and that her condominium maintenance fees increased. The respondent's representative asserted that if the petitioner verifies these changes, then the patient responsibility could be changed.

CONCLUSIONS OF LAW

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

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

4. Food Stamp Standard Utility Allowance: $198.
5. Cap of Community Spouse Income Allowance. The MMMIA plus excess shelter allowance cannot exceed the maximum amount allowed under 42 U.S.C. § 1396r-5. This standard changes January 1 of each year.

The Department determined a patient responsibility of $401.06 for the petitioner in the Institutional Care Program. Included in the Patient Responsibility Budget is the petitioner's monthly gross Social Security income of $1,365.00, plus income from a $200.00 monthly annuity, for a total gross income amount of $1,565.00. Subtracted from this is a personal need allowance of $35.00, and a maintenance need allowance of $1,128.94, for a patient responsibility of $401.06.

After careful consideration, it is concluded that the Department's determination of a $401.06 patient responsibility is upheld. At the hearing, the petitioner's representative reported that the income from his annuity was lower than $200.00 monthly, and that her condominium maintenance fees increased. The respondent's representative asserted that if the petitioner verifies these changes, then the patient responsibility could be changed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Stuart Imberman

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

Copies Furnished To: [redacted]

FILED

MAY 13 2008

OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

[redacted]

APPEAL NO. 08N-00046

PETITIONER,

Vs.

[redacted]

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on April 21, 2008, at 1:11 p.m., at the [redacted]. The petitioner was not present, but was represented at the hearing by [redacted], ombudsman and [redacted], ombudsman, from the Ombudsman Office. The respondent was represented at the hearing by [redacted] general counsel, [redacted]. Present as a witness was [redacted], administrator, [redacted]. Present as an expert witness from the facility was [redacted] Also appearing as a witness for the facility was [redacted], a resident and patient at the facility. [redacted] was present as a court reporter. The hearing was left open for two additional days in order for the petitioner's representative to provide the location and address of the petitioner. This was done within the time frame allotted.

ISSUE

The respondent notified the petitioner that he was to be discharged for the following reason(s): "The health of individuals in the facility would otherwise be endangered." and; "The safety of other individuals in the facility is endangered..." The respondent will have the burden of proof to establish by clear and convincing evidence that the discharge was in compliance with the requirements of 42 C.F.R. § 483.12 and Fla. Stat. ch. 400.0255.

FINDINGS OF FACT

1. The facility notified the petitioner on or about March 5, 2008 that he was to be discharged by April 5, 2008. The discharge location was indicated as [redacted] This is a hospital in [redacted] Florida. The discharge notice was signed by the petitioner's treating physician.

2. On March 5, 2008, the facility "Baker Act" the petitioner to [redacted] Respondent Exhibit 3. The "Baker Act" was executed by the above noted psychiatrist and expert witness.

3. The respondent also submitted into evidence, Respondent Exhibits 1 through 13, consisting of information from the facility's business record regarding the petitioner.

4. The expert witness testified that the petitioner was inebriated and had acted in a threatening manner towards his roommate a day before the above noted action. Alcohol and two large knives were found on the petitioner, Respondent Exhibit 1. After having a consultation with the petitioner, Respondent Exhibit 2; the psychiatrist determined that the petitioner was a threat to others at the facility. This witness testified that the petitioner has had a history of failed treatment and therapy for alcohol abuse, at this facility and outside the facility.

5. The witness, who is a resident, testified that on March 4, 2008 she was threatened by the petitioner that he was "going to rip her head off"; so she called the police, Respondent Exhibits 5 and 8. The police responded, but did not arrest the petitioner, as "they did not witness the situation."

6. As was reported by the petitioner's roommate, Respondent Composite Exhibit 11, in a written notarized statement, the petitioner had; "ran a knife (the dull edge) across my throat". The report also indicated that the roommate; "felt his life had been threatened" by the petitioner.

CONCLUSIONS OF LAW

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

> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
>
> (iii) The safety of individuals in the facility is endangered...
>
> (iv) The health of individuals in the facility would otherwise be endangered;
>
> This regulation continues and states in part:
>
> (3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by-
>
> (i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and
>
> (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

(4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident... (6) *Contents of the notice.* The written notice specified in paragraph (a)(4) of this section must include the following: ...(iii) The location to which the resident is transferred or discharged...

(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;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;

Fla. Stat. ch. 400.0255 states in part:

(6) Notwithstanding paragraph (5)(b), an emergency discharge or transfer may be implemented as necessary pursuant to state or federal law during the period of time after the notice is given and before the time a hearing decision is rendered.

As shown in the Findings of Fact, the facility notified the petitioner on or about March 5, 2008 that he was to be discharged by April 5, 2008, based on: "The health of individuals in the facility would otherwise be endangered." and "The safety of other individuals in the facility is endangered...". The respondent provided testimony and evidence to indicate the above discharge reasons would be correct.

The petitioner was Baker Act to the hospital on March 5, 2008 and now currently resides in an ALF.

The petitioner's representative disputed the way the facility transferred the petitioner. The petitioner's representative argued that the facility misrepresented their intention by first issuing a 30 day notice and then transferring the petitioner through the emergency process. The petitioner's representative argued that the hospital was not an appropriate location for discharge.

The respondent responded that the doctor discharged the petitioner from the facility. The respondent argued that the facility was not experienced at discharges and understood that the 30 day discharge was the appropriate discharge notice and that the emergency or Baker Act discharge was based on the immediate danger the petitioner imposed on the residents. The respondent argued that location of discharge was the psychiatric section of the hospital and was an appropriate location. The respondent argued that the petitioner was properly discharged based on the appropriate rules. The hearing officer agrees with the last respondent argument.

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

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

Robert Akel

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

Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO. 08N-00029

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Per notice, a nursing home discharge hearing was held before the undersigned hearing officer on March 28, 2008, at 3:22 p.m., at the nursing facility, at the petitioner's bedside. The facility was represented by [redacted] administrator. [redacted] also testified. The petitioner was present to testify and represented herself. [redacted], business office manager with the facility, appeared as a witness for the respondent.

ISSUE

At issue is the correctness of the facility's discharge action of February 4, 2008 to discharge the petitioner based on non-payment. The nursing facility has the burden of proof.

FINDINGS OF FACT

1. The petitioner was admitted to the respondent nursing facility on August 6, 2007. The petitioner has been a continuous facility resident since she was admitted.
2. The petitioner has been approved for Institutional Care Program and Medicaid (ICP) benefits for all the months of her stay at the nursing facility. Under the ICP Program, the petitioner owes the facility her patient responsibility portion of $502 to $514 monthly for each of the months of stay.
3. The petitioner had made only one payment to the facility of $221 in November 2007 as of the date of hearing. The petitioner believes she must pay the rent for her apartment in [redacted] because apartments are difficult to find there. She has been using her income to pay rent on that apartment. The petitioner had an outstanding balance owed the facility of $2,325 as of the date of hearing. The petitioner received monthly billing notices from the respondent as reflected in Respondent Exhibit 2.
4. On February 4, 2008, the petitioner received a thirty-day discharge notice due to non-payment. The discharge notice lists the petitioner's apartment in Arcadia as the intended discharge location.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42C.F.R.§431.200. Federal Regulations limit the reasons 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 because of non-payment. Federal Regulations do permit a discharge for this reason, as set forth at 42C.F.R. §483.12(a)(2)(v), as follows:

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

The petitioner was determined eligible for ICP Medicaid benefits for all the months of her stay at the facility. Findings establish that the petitioner received billing notices to pay her patient responsibility owed the nursing facility. The petitioner has made only one partial payment of $221 in November 2007. The petitioner had an outstanding balance of $2,325 owed the facility as of the hearing date. The petitioner has received reasonable and appropriate billing notices.

The Code of Federal Regulations at 42 C.F.R.§483.12(a)(6)(iii) requires the content of the discharge notice to include "the location to which the resident is transferred or discharged." Further, paragraph (a)(7) entitled "Orientation for transfer or discharge" shows that the facility "must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility." The facility listed the petitioner's apartment in [redacted] as the discharge location.

In summary, the respondent nursing facility has valid reason to discharge the petitioner based on non-payment. However, the nursing facility must provide

the petitioner sufficient preparation and orientation to a suitable discharge location before proceeding with this discharge action. Therefore, the nursing facility is concluded to have met its burden of proof in this specific discharge action based on non-payment.

DECISION

The appeal is denied. The facility is concluded to have met its burden to discharge the petitioner based on non-payment, as stated in the above conclusions. However, the respondent facility must provide the petitioner sufficient preparation and orientation to a suitable discharge location before proceeding with this discharge action.

NOTICE OF RIGHT TO APPEAL

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

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

PETITIONER,

Vs.

[redacted]

RESPONDENT.
_____/

APPEAL NO. 08N-00065

FINAL ORDER

Pursuant to notice an administrative hearing was convened at 2:30 p.m. on May 7, 2008 at the [redacted] The petitioner was not present but was duly represented by her daughter, [redacted], via telephone, with Long Term Care Ombudsmen staff [redacted] and [redacted] present in person to assist. The respondent was represented by [redacted] administrator, with testimony available from [redacted] facility financial specialist, and [redacted] corporate financial consultant.

ISSUE

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

FINDINGS OF FACT

1. The petitioner has been a resident of the nursing facility for an extended time. She suffers from Alzheimer's or a similar type disorder.

2. During the period of institutional care, full payment has not been received. Bills were issued requesting payment, and as of end of March 2008, balance due was $52,490.56, shown in Respondent's Exhibit 1 (discharge notice). Reason given for discharge was "...bill for services...has not been paid... ." Location for discharge was [redacted] to the daughter's residence.

3. The petitioner does not dispute the money is owed. Effort(s) to achieve Medicaid eligibility were not successful, but Medicaid eligibility is anticipated in near future, according to the daughter.

4. Discharge hearing was requested as shown in Petitioner's Exhibit 1.

5. The undersigned requested a survey be completed by the Agency for Health Care Administration. Such a survey would not necessarily be controlling for hearing purposes, but it could have relevance. The survey was conducted as shown in Hearing Officer's Exhibit 1. Regulatory violation was not found.

6. The petitioner's daughter is disabled. She believes she personally would not be able to provide care at her [redacted] residence for her mother.

7. The respondent did not mean to imply that the daughter would be the care provider. The respondent recognizes that the petitioner needs care and attention and that her funds could be used toward home health care and other in-home services from agencies in the area. The respondent also noted that placement at another care facility could occur either in Florida or near the daughter's residence.

8. The respondent noted that discharge to an unsafe location was not permissible, was not anticipated and that nursing facility staff would assist in safe relocation efforts.

CONCLUSIONS OF LAW

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

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

While agreeing that insufficient payment had occurred, the petitioner's daughter argued that the private residence [redacted] location for discharge was unacceptable. This is not a problem for the undersigned to remedy. The petitioner has income and her income may be used for her care at a private residence such as that of her daughter or

at an institution. The respondent may not discharge to an unsafe location and the respondent's staff is aware of such. Therefore unsafe discharge may not proceed.

However, it is concluded that inadequate payment has occurred following reasonable and appropriate notice to pay. On that merit, discharge to a safe location is appropriate. Despite preferences of the petitioner, and difficulties of the situation, burden of proof has been met by the respondent. Intent to discharge has been justified as set forth.

DECISION

The appeal is denied and discharge intent is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 21st day of May, 2008, in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

PETITIONER,

APPEAL NO. 08F-01308

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 08 Lee
UNIT: AHCA

CASE NO.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 12, 2008, at 10:54 in [redacted] Florida. The petitioner was present and represented himself. The agency was represented by [redacted], program operational administrator. Present as witnesses for the petitioner were [redacted], certified rehabilitation technology specialist; his mother [redacted] his father [redacted], counselor with Adult Services; and [redacted] L.P.N. and rehabilitation therapy specialist. Present as witnesses for the respondent were [redacted] physical therapist with the prior authorization unit; and [redacted] DME medical healthcare program specialist.

Both parties were allowed 20 days to consider a revised proposed wheelchair request and to respond to the hearing officer. On March 19, 2008,

evidence was received from the respondent. It was accepted as Respondent's Exhibit 6. On March 24, 2008, evidence was received from the respondent. It was accepted as Respondent's Exhibit 7.

ISSUE

At issue is the January 22, 2008 action by the respondent denying Medicaid payment for a new motorized wheelchair.

FINDINGS OF FACT

1. On November 1, 2007, the prior authorization unit with the Bureau of Medicaid received a request for a new wheelchair from the petitioner's Durable Medical Equipment (DME) provider. The request was reviewed by their physical therapist. On December 3, a request for additional information was sent to the DME provider.
2. The DME provider responded to the request for information on December 4, 2007. On January 11, 2008, the parties conferenced by telephone regarding the request. On January 22, 2008, the respondent denied the petitioner's request for the new motorized wheelchair.
3. On March 19, 2008, the respondent notified the hearing officer that both parties negotiated a new proposal for the wheelchair. It was approved. On March 24, 2008, the hearing officer received a copy of the approval for the new chair from the respondent.

CONCLUSIONS OF LAW

The Medicaid Program only provides for medical services that are defined as being "medically necessary," or of "medical necessity" as set forth in the

Florida Administrative Code Rule 59G-1.010(166)(a). The care, goods or services must meet the conditions as follows:

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

The Florida Administrative Code Rule section 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.

The petitioner requested Medicaid payment for a new wheelchair through his DME provider. The request was denied. The DME provider revised the request. On March 24, 2008, the respondent notified the hearing officer that the parties reached an agreement. Medicaid has authorized payment for a new wheelchair. Since the parties have reached an agreement, there is no further need for a decision by the hearing officer.

DECISION

This appeal is moot.

NOTICE OF RIGHT TO APPEAL

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

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

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 08F-00982

CASE NO. 1052775721

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on March 14, 2008, at 11:29 a.m., in [redacted], Florida. The petitioner was not present. The petitioner was represented by her daughters [redacted] and [redacted]. Present as witnesses for the petitioner were [redacted], administrator of [redacted] and [redacted], office manager of [redacted]. The Department was represented by [redacted] ACCESS economic self-sufficiency specialist I and [redacted] ACCESS supervisor.

ISSUE

The petitioner is appealing timely notification of increase in monthly patient responsibility in the Institutional Care Program (ICP) from $11 to $838 effective June 1, 2007. The Department had the burden of proof.

FINDINGS OF FACT

1. [redacted] ACCESS economic self-sufficiency specialist I with the Department, processed the May 2007 change to the petitioner's case as well as the approval of her husband's ICP Medicaid in May 2007.

2. The authorized representative for the petitioner was her daughter, [redacted] prior to the spouse entering the nursing home. She continued to be the authorized representative for the petitioner.

3. Prior to the action under appeal, petitioner's monthly patient responsibility was $11. The petitioner's husband resided in the community and received $827 monthly community spousal income allowance from the petitioner's income. Both parties stipulate the income, community spousal income allowance and patient responsibility figures are correct as shown in Respondent's Composite Exhibit 6.

4. The petitioner's husband was admitted to the same nursing home on March 20, 2007. His application for Institutional Care Program (ICP) Medicaid was approved in May 2007. Accordingly, he was no longer eligible for the community spousal income allowance. The petitioner's spousal diverted income was removed from her budget effective June 2007 increasing her monthly patient responsibility from $11 to $838. Both parties stipulate income and patient responsibility are correct as shown in Respondent's Composite Exhibit 6.

5. This change produced notices for the petitioner and notices for her spouse. The petitioner's patient responsibility increase, which is at issue, was contained in the

Notice of Case Action dated May 18, 2007 (Respondent's Composite Exhibit 3). The Department believes that notice was sent to the nursing home, the petitioner at the nursing home and to the petitioner's daughter, [redacted], as she is the petitioner's authorized representative and has the power of attorney for both the petitioner and her husband. However, the notice intended for the daughter, was addressed to [redacted] who is a representative of the nursing home and used the daughter's mailing address. It was not clear if this was the notice to the petitioner or her husband.

6. The petitioner's daughter believes that she did not receive the May 18, 2007 Notice of Cash Action and was unaware the petitioner's patient responsibility had increased until November 2007. Prior to her father being admitted into the nursing facility, all mail for petitioner was going to her father's address [redacted] in her care. After her father was admitted to the nursing home in March 2007, she contacted the local post office that same month, had her father's box closed and had all her parents' mail forwarded to her address [redacted]. She did not contact the Department to change her address as the petitioner's authorized representative. Due to confidentiality, Department notices are not forwarded, they are returned to the Department. It is the Department's procedure to then update the address and re-mail the notice. The Department admitted that when the notice sent to the petitioner's daughter returned in May 2007, the Department did not correctly update the name or address and re-send the notice. There was much

discussion about notices being sent and some returned. The Department has call centers that handle returned mail. There were two entries in the Department's electronic notes during the time frame at issue that indicate returned mail. However, there was only one scanned into document imaging. A notice was re-mailed. The Department did not show which of the notices this referred to. The undersigned could not determine if this was the petitioner's notice, the spouse's notice, the facility's notice, or the authorized representative's notice. The hearing officer finds that the daughter, as the authorized representative for the petitioner, did not receive the May 2007 notice informing of the increase in the petitioner's patient responsibility.

7. The nursing home administrator believes that the nursing facility did not receive the May 18, 2007 notice and was not aware that the petitioner's patient responsibility increased from $11 to $838 effective June 2007. The facility continued to bill the petitioner for the lower patient responsibility thru December 2007. Both parties stipulate that the address for the nursing facility is correct on the May 18, 2007 notice. The May 18, 2007 notice of change in petitioner's patient responsibility sent to the facility was sent to the correct address and did not return to the Department. [redacted] of the Department, read from the ICP electronic notes where she had entered a telephone call from [redacted] of the facility on June 8, 2007 questioning if the patient responsibility amounts were correct. [redacted] notes say that she copied the notices again, double-checked the computations and re-mailed the notices to the facility, which were to go out on June 11, 2007.

8. The facility administrator and the petitioner's daughter both believe they became aware of the change in patient responsibility in November 2007. On November 26, 2007, the Department issued a Notice of Case Action informing of an increase in petitioner's patient responsibility from $838 to $858 effective January 2008 due to the yearly increase in petitioner's Social Security income. The facility received this notice and called the Department to inquire about the substantial increase in the petitioner's patient responsibility.

9. The facility under-billed the petitioner from June 2007 thru December 2007 because it was unaware the petitioner's patient responsibility increased from $11 to $838. The facility overcharged Medicaid for the difference and received payment for the amounts billed. The facility testified it will have to repay Medicaid when the 2007 audit is completed. Anticipating the results of the Medicaid audit, the facility had to reconcile the petitioner's account, using the adjusted patient responsibility of $838 (instead of $11) for June 2007 thru December 2007 and has billed the petitioner's account for approximately $6000. Neither the facility nor the petitioner's representative provided a copy of the bill. The facility returned money throughout the time at issue to the family, as it believed this was excess money. The family used the money to pay off medical bills their parents owed.

10. Both the nursing facility and the petitioner's daughters believe the debt the petitioner owed to the facility was caused by Department notification error. The petitioner's representatives argued that a Benefit Recovery claim should be established

for the amount the petitioner owes the facility thus transferring the petitioner's debt from the nursing facility to the Department.

CONCLUSIONS OF LAW

Florida Administrative Code 65-2.046, Time Limits in Which to Request a Hearing, sets forth 90 days to request a hearing. This rule does not apply in the absence of a notice informing of hearing rights and the time limits to appeal. The Findings show that the petitioner's daughter/authorized representative did not receive the May 2007 notice increasing the petitioner's patient responsibility and therefore, the undersigned has jurisdiction and can proceed to determine if the action under appeal was correct.

Florida Administrative Code 65-2.060, Evidence, states:

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

Florida Administrative Code 65-2.066, Final Orders, states in part:

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

Federal Regulations at 42 C.F.R. 435.919, Timely and adequate notice concerning adverse actions, states in part:

> (a) The agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid. ...

The Department's Integrated Policy Manual 165-22, Section 3440.0207, Advance Notice of Adverse Action (MSSI, SFP), states

> Adverse actions include the reduction of a benefit, an increase in the Medically Needy Share of Cost or patient responsibility and the termination of an individual's or assistance group's eligibility for benefits. DCF is required to provide advance or adequate notice based upon the specific actions taken on an application or ongoing case. Advance and adequate notice are defined as follows: 1. Advance notice is a notice that is provided giving at least 10 days plus one additional day for mailing prior to the effective date of any adverse action. 2. Adequate notice is a notice that is provided prior to the date an individual or assistance group would receive benefits. In certain situations DCF is not required to provide advance notice before taking adverse action but is required to give adequate notice.

Florida Administrative Code 65-2.043, Hearings Request and Notification of Right to Hearings, states in relevant part:

> (1) Every applicant or recipient shall be informed in writing at the time of application and at the time of any action on his/her claim, of the right to a Hearing, the method of obtaining this Hearing, and that he/she may present his/her case or have legal counsel or an authorized representative present it.
> (2) In cases of intended action to discontinue, terminate, or reduce assistance, the Department shall give timely and adequate notice.
> (3) In Food Stamp cases: ... (4) In all other cases "timely" means that the notice is mailed at least 10 days before the date of action, that is, the date upon which the action would become effective. "Adequate" means a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, explanation of the individual's right to request an evidentiary hearing (if provided) and a State Agency hearing, and the circumstances under which assistance is continued if a hearing is requested. The specific regulations supporting the

action must be included for Medicaid actions.

The Department published an Application Processing handbook dated August 17, 2001. Page 2 states in part:

> Primary Information Person (PIP) ... For ICP cases, use the nursing home individual as the PIP. This allows the case name to be the client's name and avoids confusion for the nursing home. If there is a designated representative, indicate this on the AGBI (Benefit Issuance) screen. Record pertinent information regarding the designated representative on the AGAR (Authorized Representative) screen. Letters regarding eligibility will be sent to the designated representative, as well as the PIP, if there is one indicated on the AGAR screen.

The Department also published an SSI-Related FLORIDA Screen Guide in March 2004. Page 24 explains the computer screen that controls the nursing home notices and states in part:

> ...6. **Provider Address** controls notices to provider.
> - The nursing home address is required by the system.
> - If the address is not known (i.e., person is not placed yet): enter the worker's address. Do NOT enter address of designated representative or spouse!!!
> - Enter the PIN#, LOC, and effective date. This information will show up on the notice sent to the nursing home.

This issue involves an increase in the ICP Medicaid patient responsibility effective June 2007 and whether or not the proper person received a notice of the increase. A subsequent increased patient responsibility has been put into effect beginning January 1, 2008. Notices were acknowledged by all parties and this adverse action is not under appeal.

The petitioner's authorized representative is her daughter. Therefore, her daughter, acting on her mother's behalf, should have been the individual to receive the notice. No findings were made as to whether or not the facility received the notice at issue, as it was not the authorized representative. The findings show that the daughter did not receive the May 2007 notice informing of the petitioner's patient responsibility increase effective June 2007. According to the above authorities, the Department must give advance and adequate notice when the patient responsibility increases.

The burden of proof was on the Department as it increased the patient responsibility. According to the above authorities, the final order decision is to be based exclusively on evidence and other materials introduced at the hearing. The undersigned evaluated the evidence and testimony and concludes that the Department did not meet its burden to prove that the notice requirement above was met. Therefore, the Department's action of May 2007 to increase the petitioner's patient responsibility, without notice, is hereby reversed. The patient responsibility will remain $11 through December 2007.

An issue of overpayment was raised at the hearing. Reinstatement of the $11 patient responsibility may result in the petitioner receiving benefits to which she is not eligible for. However, if there is an issue of overpayment, it would be addressed separately following any notice by the Department to that effect.

DECISION

The appeal is granted. The Department's action is hereby reversed as stated above.

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 7th day of May, 2008, in Tallahassee, Florida.

Leslie Green

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

Copies Furnished To: [redacted]